# A NONSUBSTANTIVE REVISION OF STATUTES RELATING TO SOLVENCY OF INSURERS, PROPERTY AND CASUALTY INSURANCE, OTHER TYPES OF INSURANCE COVERAGE, AND UTILIZATION REVIEW AND INDEPENDENT REVIEW

Submitted to the 79th Legislature
as part of the
Texas Legislative Council's
Statutory Revision Program

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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logical order, employing a numbering system and format that will accommodate future expansion of the law, eliminating repealed, invalid, duplicative, and other ineffective provisions, and improving the draftsmanship of the law if practicable--all toward promoting the stated purpose of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 4, 10, 12, and 14, Insurance Code, and additional related chapters represent a nonsubstantive revision of certain provisions of the existing Insurance Code applicable to insurers and related entities, including provisions relating to solvency of insurers, property and casualty insurance, including policy forms and ratemaking, other types of insurance coverage, and utilization review and independent review. These titles and chapters 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 79th Legislature is added to the Insurance Code of 1951 as Titles 4, 10, 12, and 14 and as additional chapters in previously enacted titles of the Insurance Code and in other codes. Material incorporated into the revision of the Insurance Code by the 78th Legislature is designated 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 4, 10, 12, and 14, Insurance Code, and additional related chapters as enacted by the passage of H.B. No. 2017, Acts of the 79th Legislature, Regular Session, 2005. 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 4, 10, 12, and 14, Insurance Code, and the additional related chapters will not take effect until April 1, 2007.

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. 2017, are printed in Appendix A to the revisor's report. Appendix A also includes a section listing the laws repealed effective April 1, 2007, and a section stating the legislature's intent that the code be a nonsubstantive revision.

In reviewing the revisor's report to Titles 4, 10, 12, and 14, Insurance Code, and the additional related chapters, the reader should keep in mind the following:

(1) Except as provided by Section 30.003, Insurance Code, as amended by H.B. No. 2017, 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 Kristi Ayala, 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 1902. CERTAIN LIABILITY COVERAGE FOR PHYSICIANS AND HEALTH CARE PROVIDERS

CHAPTER 1903. LOSS CONTROL INFORMATION AND SERVICES

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CHAPTER 1951. GENERAL PROVISIONS: AUTOMOBILE INSURANCE

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CHAPTER 2002. POLICY PROVISIONS AND FORMS FOR FIRE INSURANCE AND ALLIED LINES, INCLUDING RESIDENTIAL PROPERTY INSURANCE

CHAPTER 2003. PROCEDURES FOR EVALUATING FIRE LOSS RISK

CHAPTER 2004. RESIDENTIAL PROPERTY INSURANCE IN UNDERSERVED AREAS

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CHAPTER 401. AUDITS AND EXAMINATIONS

SUBCHAPTER A. INDEPENDENT AUDIT OF FINANCIAL STATEMENTS

Revised Law

Sec. 401.001. DEFINITIONS. In this subchapter:

(1) "Accountant" means an independent certified public accountant or accounting firm that meets the requirements of Section 401.011.

(2) "Affiliate" has the meaning assigned by Section 823.003.

(3) "Health maintenance organization" means a health maintenance organization authorized to engage in business in this state.

(4) "Insurer" means an insurer authorized to engage in business in this state, including:

(A) a life, health, or accident insurance company;

(B) a fire and marine insurance company;

(C) a general casualty company;

(D) a title insurance company;

(E) a fraternal benefit society;

(F) a mutual life insurance company;

(G) a local mutual aid association;

(H) a statewide mutual assessment company;

(I) a mutual insurance company other than a mutual life insurance company;

(J) a farm mutual insurance company;

(K) a county mutual insurance company;

(L) a Lloyd's plan;

(M) a reciprocal or interinsurance exchange;

(N) a group hospital service corporation;

(O) a stipulated premium company; and

(P) a nonprofit legal services corporation.

(5) "Subsidiary" has the meaning assigned by Section 823.003. (V.T.I.C. Art. 1.15A, Secs. 3(1), (2), (5), (6).)

Source Law

Sec. 3. In this article:

(1) "Accountant" means an independent certified public accountant or accounting firm that meets the requirements of Section 12 of this article.

(2) "Affiliate" has the meaning assigned by Subsection (a) of Section 2 of Article 21.49-1 of this code.

(5) "Insurer" means an insurer authorized to do business under the law of this state and includes life, health, and accident insurance companies, fire and marine companies, general casualty companies, title insurance companies, fraternal benefit societies, mutual life insurance companies, local mutual aid associations, statewide mutual assessment

companies, mutual insurance companies other than life, farm mutual insurance companies, county mutual insurance companies, Lloyd's plans, reciprocal and interinsurance exchanges, group hospital service corporations, health maintenance organizations, stipulated premium insurance companies, and nonprofit legal services corporations.

(6) "Subsidiary" has the meaning assigned by Section 2 of Article 21.49-1 of this code.

Revisor's Note

(1) Section 3(5), V.T.I.C. Article 1.15A, defines "insurer" to mean an insurer authorized to do business under the law of this state, including certain listed entities. For accuracy, the revised law omits "health maintenance organizations" from the listed entities and substitutes a separate definition of that term because a "health maintenance organization" is not a traditional insurer. Throughout this subchapter the revised law substitutes "insurer or health maintenance organization" for "insurer."

(2) Section 3(3), V.T.I.C. Article 1.15A, defines "board" as the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred the 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. For this reason, the revised law omits the definition of "board." The omitted law reads:

> (3) "Board" means the State Board of Insurance.

(3) Section 3(4), V.T.I.C. Article 1.15A, defines "commissioner" to mean the commissioner of insurance. The revised law omits the definition as unnecessary because Section 31.001 of this code defines "commissioner" to mean the commissioner of insurance for purposes of this code and other

insurance laws of this state. The omitted law reads:

(4) "Commissioner" means the commissioner of insurance.

Revised Law

Sec. 401.002. PURPOSE OF SUBCHAPTER. The purpose of this subchapter is to require an annual audit by an independent certified public accountant of the financial statements reporting the financial condition and the results of operations of each insurer or health maintenance organization. (V.T.I.C. Art. 1.15A, Sec. 1.)

Source Law

Art. 1.15A

Sec. 1. The purpose of this article is to require an annual examination by an independent certified public accountant of the financial statements reporting the financial condition and the results of operations of each insurer.

Revisor's Note

Section 1, V.T.I.C. Article 1.15A, refers to an annual "examination" by an independent certified public accountant. Throughout this subchapter, the revised law substitutes "audit" for "examination" in relation to the activities of a certified public accountant because that is the activity that an accountant is required to perform under this subchapter. The revised law retains "examination" in relation to an activity performed by the Texas Department of Insurance.

Revised Law

Sec. 401.003. EFFECT OF SUBCHAPTER ON AUTHORITY TO EXAMINE. This subchapter does not limit the commissioner's authority to order or the department's authority to conduct an examination of an insurer or health maintenance organization under this code or the commissioner's rules. (V.T.I.C. Art. 1.15A, Sec. 8.)

Source Law

Sec. 8. This article does not prohibit, preclude, or limit the board from ordering, conducting, or performing an examination of any

insurer under this code or the board's rules.

Revisor's Note

Section 8, V.T.I.C. Article 1.15A, states that the article does not "prohibit, preclude, or limit" the commissioner of insurance or the Texas Department of Insurance from "ordering, conducting, or performing an examination" of an insurer or health maintenance organization. The revised law omits the references to "prohibit" and "preclude" as unnecessary because they are included within the meaning of "limit." The revised law omits the reference to "performing" as unnecessary because it is included in the meaning of "conducting."

Revised Law

Sec. 401.004. FILING AND EXTENSIONS FOR FILING OF AUDITED FINANCIAL REPORT. (a) Unless exempt under Section 401.006, 401.007, or 401.008 and except as otherwise provided by Sections 401.005 and 401.016, an insurer or health maintenance organization shall:

(1) have an annual audit performed by an accountant; and

(2) file with the commissioner on or before June 30 an audited financial report for the preceding calendar year.

(b) The commissioner may require an insurer or health maintenance organization to file an audited financial report on a date that precedes June 30. The commissioner must notify the insurer or health maintenance organization of the filing date not later than the 90th day before that date.

(c) An insurer or health maintenance organization may request an extension of the filing date by submitting the request in writing before the 10th day preceding the filing date. The request must include sufficient detail for the commissioner to make an informed decision on the requested extension. The commissioner may extend the filing date for one or more 30-day periods if the

commissioner determines that there is good cause for the extension based on a showing by the insurer or health maintenance organization and the insurer's or health maintenance organization's accountant of the reasons for requesting the extension. (V.T.I.C. Art. 1.15A, Secs. 2, 9(a), (b), (c).)

Source Law

> Sec. 2. This article applies to each insurer except an insurer exempt under Section 4, 6, or 7 of this article.
>
> Sec. 9. (a) Each insurer shall have an annual audit by an accountant and shall file an audited financial report for the preceding calendar year with the commissioner on or before June 30 of each year.
>
> (b) Extension of the filing date for the audited financial report may be granted by the commissioner for 30-day periods on a showing by the insurer and its accountant of reasons for requesting the extension and determination by the commissioner of good cause for an extension. The request for extension must be submitted in writing before the 10th day preceding the date the report is due to be filed and must include sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.
>
> (c) The commissioner may require an insurer to file the audited financial report on a date before June 30 of a particular year if the commissioner notifies the insurer of the date not later than the 90th day before the date on which the report is to be filed.

Revisor's Note

Section 2, V.T.I.C. Article 1.15A, states that the article applies to each insurer or health maintenance organization except an entity exempt under Sections 4, 6, or 7, revised as Sections 401.006, 401.007, and 401.008, respectively. Other sections of V.T.I.C. Article 1.15A also provide alternatives for those insurers or health maintenance organizations, including Sections 10A and 13, revised as Sections 401.005 and 401.016, respectively. Therefore, the revised law adds a reference to those sections for the reader's convenience.

Revised Law

Sec. 401.005. ALTERNATIVE FILING FOR CANADIAN OR BRITISH INSURERS OR HEALTH MAINTENANCE ORGANIZATIONS. (a) Instead of the

audited financial report required by Section 401.004, an insurer or health maintenance organization domiciled in Canada or the United Kingdom may file the insurer's or health maintenance organization's annual statement of total business on the form filed by the insurer or health maintenance organization with the appropriate regulatory authority in the country of domicile. The statement must be audited by an independent accountant chartered in the country of domicile.

(b) The chartered accountant must be registered with the commissioner under Section 401.014(a). The registration must be accompanied by a statement, signed by the accountant, indicating that the accountant is aware of the requirements of this subchapter and affirming that the accountant will express the accountant's opinion in conformity with those requirements. (V.T.I.C. Art. 1.15A, Sec. 10A.)

Source Law

> Sec. 10A. (a) In lieu of the audited financial report required under Section 9 of this article, an insurer domiciled in Canada or the United Kingdom may file its annual statement of total business on the form filed by the company with the appropriate regulatory authority in the country of domicile. The statement must be audited by an independent accountant chartered in the country of domicile.
>
> (b) The chartered accountant shall register with the commissioner under Section 11(a) of this article, and the registration must be accompanied by a statement, signed by the accountant, indicating that the accountant is aware of the requirements of this article and affirming that the accountant will express the accountant's opinion in conformity with those requirements.

Revised Law

Sec. 401.006. EXEMPTION FOR CERTAIN SMALL INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS. (a) An insurer or health maintenance organization that has less than $1 million in direct premiums written in this state during a calendar year is exempt from the requirement to file an audited financial report if the insurer or health maintenance organization submits an affidavit, made under oath by one of the insurer's or health maintenance organization's officers, that specifies the amount of direct premiums written in this state during that period.

(b) Notwithstanding Subsection (a), the commissioner may require an insurer or health maintenance organization, other than a fraternal benefit society that does not have any direct premiums written in this state for accident and health insurance during a calendar year, to comply with this subchapter if the commissioner finds that the insurer's or health maintenance organization's compliance is necessary for the commissioner to fulfill the commissioner's statutory responsibilities.

(c) An insurer or health maintenance organization that has assumed premiums of at least $1 million under reinsurance agreements is not exempt under Subsection (a). (V.T.I.C. Art. 1.15A, Sec. 4.)

Source Law

> Sec. 4. (a) Except as provided by Subsections (b) and (c) of this section, an insurer otherwise subject to this article that has less than $1 million in direct premiums written in this state during a calendar year, in lieu of the annual examination required by this article for that calendar year, may submit an affidavit under oath of an officer of the insurer that specifies the amount of direct premiums written in this state, and such insurer shall be exempt from the audit required by this article.
>
> (b) The commissioner may require an insurer that is exempt under Subsection (a) of this section to comply with this article if the commissioner finds that the insurer's compliance is necessary for the commissioner to fulfill the commissioner's statutory responsibilities; provided that this subsection shall not apply to any fraternal benefit society qualifying for exemption under Subsection (a) of this section which has no direct premiums written in this state for accident and health insurance during a calendar year.
>
> (c) An insurer that has assumed premiums of $1 million or more under reinsurance agreements is not exempt under Subsection (a) of this section.

Revised Law

Sec. 401.007. EXEMPTION FOR CERTAIN FOREIGN OR ALIEN INSURERS OR HEALTH MAINTENANCE ORGANIZATIONS. (a) A foreign or alien insurer or health maintenance organization that files an audited financial report in another state in accordance with that state's requirements for audited financial reports may be exempt from filing a report under this subchapter if the commissioner finds that the other state's requirements are substantially similar to the requirements prescribed by this subchapter.

(b) An insurer or health maintenance organization exempt under this section shall file with the commissioner a copy of:

(1) the audited financial report, the report on significant deficiencies in internal controls, and the accountant's letter of qualifications filed with the other state; and

(2) any notification of adverse financial conditions report filed with the other state.

(c) The reports and letter required by Subsection (b)(1) must be filed in accordance with the filing dates prescribed by Sections 401.004 and 401.019. The report required by Subsection (b)(2) must be filed in accordance with the filing date prescribed by Section 401.017. (V.T.I.C. Art. 1.15A, Sec. 6.)

Source Law

> Sec. 6. (a) A foreign or alien insurer that files an audited financial report in another state, pursuant to that state's requirement for audited financial reports, may be exempt from filing a report under this article if the commissioner finds that the other state's requirements are substantially similar to the requirements in this article.
>
> (b) A copy of the audited financial report, the report on significant deficiencies in internal controls, and the accountant's letter of qualifications filed with the other state must be filed with the commissioner in accordance with the filing dates provided by Sections 9 and 16 of this article.
>
> (c) A copy of a notification of adverse financial conditions report filed with the other state by a person exempt under this section must be filed with the commissioner within the time provided by Section 15 of this article.

Revised Law

Sec. 401.008. HARDSHIP EXEMPTION. (a) An insurer or health maintenance organization that is not eligible for an exemption under Section 401.006 or 401.007 may apply to the commissioner for a hardship exemption.

(b) Subject to Subsection (c), the commissioner may grant an exemption under this section if the commissioner finds, after reviewing the application, that compliance with this subchapter would constitute a severe financial or organizational hardship for the insurer or health maintenance organization. The commissioner

may grant the exemption at any time for one or more specified periods.

(c) The commissioner may not grant an exemption under this section if:

(1) the exemption would diminish the department's ability to monitor the financial condition of the insurer or health maintenance organization; or

(2) the insurer or health maintenance organization:

(A) during the five-year period preceding the date the application for the exemption is made:

(i) has been placed under supervision, conservatorship, or receivership;

(ii) has undergone a change in control, as described by Section 823.005; or

(iii) has been subject to a significant number of complaints, as determined by the commissioner;

(B) has been identified by the department as troubled;

(C) has been or is the subject of a disciplinary action by the department; or

(D) is not complying with the law or with a rule adopted by the commissioner. (V.T.I.C. Art. 1.15A, Secs. 7(a), (b), (c).)

Source Law

Sec. 7. (a) An insurer otherwise subject to this article and not eligible for an exemption under Section 4 or 6 of this article may apply to the commissioner for a financial hardship exemption.

(b) Except as provided by Subsection (c) of this section, the commissioner may grant an exemption under this section if the commissioner finds, after review of the application, that compliance with this rule would constitute a severe financial or organizational hardship on the insurer. An exemption may be granted at any time and from time to time for a specified period or periods.

(c) The commissioner may not grant an exemption under this section if the exemption diminishes the department's ability to monitor the financial condition of the insurer and may not grant an exemption to an insurer that:

(1) has been placed under supervision, conservatorship, or receivership during the five-year

period immediately preceding the date on which application for the exemption is made;

(2) has undergone a change in control, as defined by Section 2, Article 21.49-1 of this code during the five-year period immediately preceding the date on which application for the exemption is made;

(3) has been identified by the department as a troubled insurer;

(4) has been subject to a significant number of complaints, as determined by the commissioner, during the five-year period immediately preceding the date on which application for the exemption is made;

(5) has been or is the subject of a disciplinary action by the board; or

(6) is not in compliance with any law or any rule adopted by the board or commissioner.

Revisor's Note

(1) Section 7(b), V.T.I.C. Article 1.15A, provides that the commissioner may grant an exemption "at any time and from time to time." The revised law omits the reference to "from time to time" because "from time to time" is included within the meaning of "at any time."

(2) Section 7(c), V.T.I.C. Article 1.15A, refers to the five-year period "immediately preceding" the date an application is made. Throughout this chapter, the revised law omits "immediately" in this context as unnecessary because "the period preceding" means "the period immediately preceding."

(3) Section 7(c)(2), V.T.I.C. Article 1.15A, refers to a change in "control, as defined by Section 2, Article 21.49-1 of this code." V.T.I.C. Article 21.49-1 was revised in Chapter 823 of this code. The relevant section of Chapter 823 is Section 823.005, which describes "control," and the revised law is drafted accordingly.

(4) Section 7(d), V.T.I.C. Article 1.15A, allows an appeal of a determination made under that article to be taken under V.T.I.C. Article 1.04, revised in 1999 as Subchapter D, Chapter 36, of this code. The revised law omits the provision as redundant

because such a determination 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:

> (d) An insurer that is aggrieved by a determination of the commissioner under this section may appeal that determination under Article 1.04 of this code.

Revised Law

Sec. 401.009. CONTENTS OF AUDITED FINANCIAL REPORT. (a) An audited financial report required under Section 401.004 must:

(1) describe the financial condition of the insurer or health maintenance organization as of the end of the most recent calendar year and the results of the insurer's or health maintenance organization's operations, changes in financial position, and changes in capital and surplus for that year;

(2) conform to the statutory accounting practices prescribed or otherwise permitted by the insurance regulator in the insurer's or health maintenance organization's state of domicile; and

(3) include:

(A) the report of an accountant;

(B) a balance sheet that reports admitted assets, liabilities, capital, and surplus;

(C) a statement of gain or loss from operations;

(D) a statement of cash flows;

(E) a statement of changes in capital and surplus;

(F) any notes to financial statements;

(G) supplementary data and information, including any additional data or information required by the commissioner; and

(H) information required by the department to conduct the insurer's or health maintenance organization's examination under Subchapter B.

(b) The notes to financial statements required by Subsection (a)(3)(F) must include:

(1) a reconciliation of any differences between the audited statutory financial statements and the annual statements filed under this code, with a written description of the nature of those differences;

(2) any notes required by the appropriate National Association of Insurance Commissioners annual statement instructions or by generally accepted accounting principles; and

(3) a summary of the ownership of the insurer or health maintenance organization and that entity's relationship to any affiliated company.

(c) An insurer or health maintenance organization required under Section 401.004 to file an audited financial report that does not retain an independent certified public accountant to perform an annual audit for the previous year may not be required to include in the report audited statements of operations, cash flows, or changes in capital and surplus for the first year. The insurer or health maintenance organization must include those statements in the first-year report and label the statements as unaudited. The insurer or health maintenance organization must include in the first-year report all other reports described by Section 401.004.

(d) The commissioner shall adopt rules governing the information to be included in the audited financial report under Subsection (a)(3)(H). (V.T.I.C. Art. 1.15A, Secs. 10(a), (b), (c), (e), (f).)

Source Law

Sec. 10. (a) The audited financial report shall report the financial condition of the insurer as of the end of the most recent calendar year and the results of the insurer's operations, changes in financial position, and changes in capital and surplus for that year in conformity with statutory accounting practices prescribed or otherwise permitted by the insurance regulator in the state of domicile.

(b) The audited financial report must include the following:

(1) the report of an accountant;

(2) a balance sheet that reports admitted assets, liabilities, capital, and surplus;

(3) a statement of gain or loss from operations;

(4) a statement of cash flows;

(5) a statement of changes in capital and surplus;

(6) any notes to financial statements; and

(7) supplementary data and information including any additional data or information required by the commissioner.

(c) The notes to the financial statements required by Subdivision (6) of Subsection (b) of this section must include:

(1) a reconciliation of differences, if any, between the audited statutory financial statements and the annual statements filed pursuant to this code with a written description of the nature of these differences;

(2) any notes required by the appropriate National Association of Insurance Commissioners annual statement instructions or by generally accepted accounting principles; and

(3) a summary of the ownership of the insurer and the relationship of the insurer to any affiliated company.

(e) Insurers required to be examined under Section 2 of this article who did not retain an independent certified public accountant to perform an annual examination for the previous year shall not be required to include the following reports covered by the accountant's opinion for the first year, although such statements shall be presented and labeled unaudited:

(1) Statement of operations.

(2) Statement of cash flows.

(3) Statements of changes in capital and surplus.

All other reports described in Section 9 must be included. For the succeeding year and each year thereafter, such insurers shall file with the commissioner all reports required by this article.

(f) The audited financial report must also include information required by the department to conduct the examination of the insurer under Article 1.15 of this code. The commissioner shall adopt rules governing the information to be included in the report under this subsection.

Revised Law

Sec. 401.010. REQUIREMENTS FOR FINANCIAL STATEMENTS IN AUDITED FINANCIAL REPORT. (a) An accountant must audit the financial reports provided by an insurer or health maintenance organization for purposes of an audit under this subchapter. The accountant who audits the reports must conduct the audit in accordance with generally accepted auditing standards and must consider other procedures described in the Financial Condition Examiner's Handbook adopted by the National Association of Insurance Commissioners.

(b) The financial statements included in the audited financial report must be prepared in a form and using language and groupings substantially the same as those of the relevant sections of the insurer's or health maintenance organization's annual statement filed with the commissioner. Beginning in the second year in which an insurer or health maintenance organization is required to file an audited financial report, the financial statements must also be comparative, presenting the amounts as of December 31 of the reported year and the amounts as of December 31 of the preceding year. (V.T.I.C. Art. 1.15A, Secs. 10(d), 14.)

Source Law

[Sec. 10]

(d) The financial statements included in the audited financial report must be prepared in a form and using language and groupings substantially the same as the relevant sections of the insurer's annual statement filed with the commissioner. Except in the first year in which an insurer is required to file an audited financial report, the financial statements also must be comparative, presenting the amounts as of December 31 of the reported year and the amounts as of December 31 of the preceding year.

Sec. 14. (a) The financial reports furnished under Section 8 of this article must be examined by an accountant.

(b) The examination of an insurer's financial reports shall be conducted in accordance with generally accepted auditing standards. Consideration should also be given to such other procedures illustrated in the Examiner's Handbook promulgated by the National Association of Insurance Commissioners.

Revisor's Note

(1) Section 14(a), V.T.I.C. Article 1.15A, refers to "reports furnished under Section 8," revised as Section 401.003 of this chapter. The revised law omits the reference to Section 8 as misleading because that section does not currently relate to reports or audits, nor did it relate to reports or audits at the time Section 14(a) was enacted.

(2) Section 14(b), V.T.I.C. Article 1.15A, refers to the "Examiner's Handbook" adopted by the National Association of Insurance Commissioners. The correct name of the handbook is the "Financial

Condition Examiner's Handbook," and the revised law is drafted accordingly.

Revised Law

Sec. 401.011. QUALIFICATIONS OF ACCOUNTANT; ACCEPTANCE OF AUDITED FINANCIAL REPORT. (a) Except as provided by Subsections (c) and (d), the commissioner shall accept an audited financial report from an independent certified public accountant or accounting firm that:

(1) is a member in good standing of the American Institute of Certified Public Accountants and is in good standing with all states in which the accountant or firm is licensed to practice, as applicable; and

(2) conforms to the American Institute of Certified Public Accountants Code of Professional Conduct and to the rules of professional conduct and other rules of the Texas State Board of Public Accountancy or a similar code.

(b) If the insurer or health maintenance organization is domiciled in Canada, the commissioner shall accept an audited financial report from an accountant chartered in Canada. If the insurer or health maintenance organization is domiciled in Great Britain, the commissioner shall accept an audited financial report from an accountant chartered in Great Britain.

(c) A partner or other person responsible for rendering a report for an insurer or health maintenance organization for seven consecutive years may not, during the two-year period after that seventh year, render a report for the insurer or health maintenance organization or for a subsidiary or affiliate of the insurer or health maintenance organization that is engaged in the business of insurance. The commissioner may determine that the limitation provided by this subsection does not apply to an accountant for a particular insurer or health maintenance organization if the insurer or health maintenance organization demonstrates to the satisfaction of the commissioner that the limitation's application to the insurer or health maintenance organization would be unfair

because of unusual circumstances. In making the determination, the commissioner may consider:

(1) the number of partners or individuals the accountant employs, the expertise of the partners or individuals the accountant employs, or the number of the accountant's insurance clients;

(2) the premium volume of the insurer or health maintenance organization; and

(3) the number of jurisdictions in which the insurer or health maintenance organization engages in business.

(d) The commissioner may not accept an audited financial report prepared wholly or partly by an individual who the commissioner finds:

(1) has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act (18 U.S.C. Section 1961 et seq.), or a state or federal criminal offense involving dishonest conduct;

(2) has violated the insurance laws of this state with respect to a report filed under this subchapter; or

(3) has demonstrated a pattern or practice of failing to detect or disclose material information in reports filed under this subchapter. (V.T.I.C. Art. 1.15A, Secs. 12(a), (b), (c).)

Source Law

Sec. 12. (a) Except as provided by Subsections (b) and (c) of this section, the commissioner shall accept an audited financial report from an accountant who is an independent certified public accountant in good standing with the American Institute of Certified Public Accountants and in all states in which the accountant or firm is licensed to practice and who conforms to the Code of Professional Ethics of the American Institute of Certified Public Accountants and to the rules and regulations and Code of Ethics and Rules of Professional Conduct of the Texas State Board of Public Accountancy or a similar code. In the case of an insurer domiciled in Canada, the commissioner shall accept an audited financial report from an accountant chartered in Canada, and, in the case of an insurer domiciled in Great Britain, the commissioner shall accept an audited financial report from an accountant chartered in Great Britain.

(b) A partner or other person responsible for rendering a report for an insurer for seven consecutive years may not render a report for that

insurer, or any of the subsidiaries or affiliates of the insurer that are engaged in the business of insurance, during the two years following the seventh year. The commissioner may determine that the limitation in this subsection does not apply to the accountant for a particular insurer if the insurer demonstrates, to the satisfaction of the commissioner, that its application to the insurer would be unfair because of unusual circumstances. In making the determination, the commissioner may consider:

(1) the number of partners or individuals employed by the accountant, the expertise of the partners or individuals employed by the accountant, or the number of insurance clients of the accountant;

(2) the premium volume of the insurer; and

(3) the number of jurisdictions in which the insurer transacts business.

(c) The commissioner may not accept an audited financial report prepared in whole or in part by an individual who the commissioner finds:

(1) has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act (18 U.S.C. Sections 1961 through 1968), or any state or federal criminal offense involving dishonest conduct;

(2) has violated the insurance laws of this state with respect to any report filed under this article; or

(3) has demonstrated a pattern or practice of failing to detect or disclose material information in reports filed under this article.

Revisor's Note

(1) Section 12(a), V.T.I.C. Article 1.15A, refers to the "Code of Professional Ethics" of the American Institute of Certified Public Accountants. The revised law substitutes a reference to the "Code of Professional Conduct" for the reference to the "Code of Professional Ethics" because that is the accurate name of that institute's code.

(2) Section 12(a), V.T.I.C. Article 1.15A, refers to the "Code of Ethics and Rules of Professional Conduct of the Texas State Board of Public Accountancy." The Texas State Board of Public Accountancy does not have a code of ethics. The ethics provisions applicable to accountants and accounting firms are contained in that board's rules of professional conduct. For that reason the revised law omits the reference to the code of ethics.

Revised Law

Sec. 401.012. HEARING ON ACCOUNTANT QUALIFICATIONS; REPLACEMENT OF ACCOUNTANT. The commissioner may hold a hearing to determine if an accountant is qualified and independent. If, after considering the evidence presented, the commissioner determines that an accountant is not qualified and independent for purposes of expressing an opinion on the financial statements in an audited financial report filed under this subchapter, the commissioner shall issue an order directing the insurer or health maintenance organization to replace the accountant with a qualified and independent accountant. (V.T.I.C. Art. 1.15A, Secs. 12(d), (e).)

Source Law

> (d) The commissioner may hold a hearing to determine if an accountant is qualified and independent and, considering the evidence presented, may rule that the accountant is not qualified and independent for purposes of expressing an opinion on the financial statements in the audited financial report filed under this article.
>
> (e) If the commissioner rules that an accountant is not qualified and independent, the commissioner shall issue an order directing the insurer to replace the accountant with a qualified and independent accountant.

Revised Law

Sec. 401.013. ACCOUNTANT'S LETTER OF QUALIFICATIONS. (a) The audited financial report required under Section 401.004 must be accompanied by a letter provided by the accountant who performed the audit stating:

(1) the accountant's general background and experience;

(2) the experience of each individual assigned to prepare the audit in auditing insurers or health maintenance organizations and whether the individual is an independent certified public accountant; and

(3) that the accountant:

(A) is properly licensed by an appropriate state licensing authority, is a member in good standing of the American Institute of Certified Public Accountants, and is otherwise

qualified under Section 401.011;

(B) is independent from the insurer or health maintenance organization and conforms to the standards of the profession contained in the American Institute of Certified Public Accountants Code of Professional Conduct, the statements of that institute, and the rules of professional conduct adopted by the Texas State Board of Public Accountancy, or a similar code;

(C) understands that:

(i) the audited financial report and the accountant's opinion on the report will be filed in compliance with this subchapter; and

(ii) the commissioner will rely on the report and opinion in monitoring and regulating the insurer's or health maintenance organization's financial position; and

(D) consents to the requirements of Section 401.020 and agrees to make the accountant's work papers available for review by the department or the department's designee.

(b) Subsection (a)(2) does not prohibit an accountant from using any staff the accountant considers appropriate if use of that staff is consistent with generally accepted auditing standards. (V.T.I.C. Art. 1.15A, Sec. 16A.)

Source Law

Sec. 16A. (a) The audited financial report must be accompanied by a letter furnished by the accountant stating:

(1) that the accountant is independent with respect to the insurer and conforms to the standards of the profession contained in the Code of Professional Ethics, the statements of the American Institute of Certified Public Accountants, and the Rules of Professional Conduct of the Texas Board of Public Accountancy, or a similar code;

(2) the background and experience of the accountant in general, the experience in audits of insurers of each individual assigned to prepare the audit, and whether the individual is an independent certified public accountant;

(3) that the accountant understands that the annual audited financial report and the accountant's opinion on the report will be filed in compliance with this article and that the commissioner will rely on the report and opinion in the monitoring and regulation of the financial position of insurers;

(4) that the accountant consents to the requirements of Section 17 of this article and that the

accountant agrees to make the accountant's work papers available for review by the commissioner or the commissioner's designee;

(5) that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the American Institute of Certified Public Accountants; and

(6) that the accountant is in compliance with the requirements of Section 12 of this article.

(b) Subsection (a)(2) of this section does not prohibit an accountant from using any staff the accountant considers appropriate if use of that staff is consistent with the generally accepted auditing standards.

Revisor's Note

(1) Section 16A(a)(1), V.T.I.C. Article 1.15A, refers to the "Code of Professional Ethics" and the statements of the American Institute of Certified Public Accountants. The revised law substitutes a reference to the "Code of Professional Conduct" for the reference to the "Code of Professional Ethics" for the reason stated in Revisor's Note (1) to Section 401.011 of this code.

(2) Section 16A(a)(4), V.T.I.C. Article 1.15A, requires an accountant to make the accountant's work papers available for review by the "commissioner or the commissioner's designee." The revised law substitutes a reference to the Texas Department of Insurance because other provisions, including Section 17, V.T.I.C. Article 1.15A, revised in this chapter as Section 401.020, and Section 8, V.T.I.C. Article 1.15, revised in this chapter as Section 401.057, authorize the department to examine work papers.

Revised Law

Sec. 401.014. REGISTRATION OF ACCOUNTANT. (a) Not later than December 31 of the calendar year to be covered by an audited financial report required by this subchapter, an insurer or health maintenance organization must register in writing with the commissioner the name and address of the accountant retained to prepare the report.

(b) The insurer or health maintenance organization must

include with the registration a statement signed by the accountant:

(1) indicating that the accountant is aware of the requirements of this subchapter and of the rules of the insurance department of the insurer's or health maintenance organization's state of domicile that relate to accounting and financial matters; and

(2) affirming that the accountant will express the accountant's opinion on the financial statements in terms of the statements' conformity to the statutory accounting practices prescribed or otherwise permitted by the insurance department described by Subdivision (1) and specifying any exceptions the accountant believes are appropriate.

(c) The commissioner may not accept an audited financial report prepared by an accountant who is not registered under this section.

(d) The commissioner may not accept the registration of a person who does not qualify under Section 401.011 or does not comply with the other requirements of this subchapter. (V.T.I.C. Art. 1.15A, Sec. 11.)

Source Law

Sec. 11. (a) Each insurer must register with the commissioner the name and address of the accountant retained to prepare an audited financial report required by this article. The registration must be made in writing not later than December 31 of the calendar year to be covered by the audited financial report.

(b) The registration must be accompanied by a statement signed by the accountant indicating that the accountant is aware of the requirements of this article, and of the rules and regulations of the insurance department of the insurer's state of domicile that relate to accounting and financial matters and affirming that the accountant will express the accountant's opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that department, specifying any exceptions the accountant believes are appropriate.

(c) The commissioner may not accept an audited financial report from an insurer that is prepared by an accountant that is not registered under this section.

(d) The commissioner may not accept registration under this section for a person who does not comply with Section 12 of this article and with the other requirements of this article.

Revisor's Note

Section 11(b), V.T.I.C. Article 1.15A, refers to "rules and regulations." Throughout this chapter, 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. 401.015. RESIGNATION OR DISMISSAL OF ACCOUNTANT; STATEMENT CONCERNING DISAGREEMENTS. (a) If an accountant who signed an audited financial report for an insurer or health maintenance organization resigns as accountant for the insurer or health maintenance organization or is dismissed by the insurer or health maintenance organization after the report is filed, the insurer or health maintenance organization shall notify the department not later than the fifth business day after the date of the resignation or dismissal.

(b) Not later than the 10th business day after the date the insurer or health maintenance organization notifies the department under Subsection (a), the insurer or health maintenance organization shall file a written statement with the commissioner advising the commissioner of any disagreements between the accountant and the insurer's or health maintenance organization's personnel responsible for presenting the insurer's or health maintenance organization's financial statements that:

(1) relate to accounting principles or practices, financial statement disclosure, or auditing scope or procedures;

(2) occurred during the 24 months preceding the date of the resignation or dismissal; and

(3) would have caused the accountant to note the disagreement in connection with the audited financial report if the disagreement were not resolved to the satisfaction of the accountant.

(c) The statement required by Subsection (b) must include a description of disagreements that were resolved to the accountant's satisfaction and those that were not resolved to the accountant's satisfaction.

(d) The insurer or health maintenance organization shall file with the statement required by Subsection (b) a letter signed by the accountant stating whether the accountant agrees with the insurer's or health maintenance organization's statement and, if not, the reasons why the accountant does not agree. If the accountant fails to provide the letter, the insurer or health maintenance organization shall file with the commissioner a copy of a written request to the accountant for the letter. (V.T.I.C. Art. 1.15A, Sec. 12A.)

Source Law

> Sec. 12A. (a) If the accountant who signed an audited financial report resigns as accountant for the insurer or is dismissed by the insurer after the report is filed, the insurer shall notify the department not later than the fifth business day after the date of resignation or dismissal.
>
> (b) Not later than the 10th business day after the insurer gives the notification required by Subsection (a) of this section, the insurer shall file a written statement with the commissioner advising the commissioner of any disagreements between the accountant and personnel of the insurer responsible for presentation of its financial statements relating to accounting principles or practices, financial statement disclosure, or auditing scope or procedures that occurred during the 24-month period immediately preceding the date of resignation or dismissal and that, if not resolved to the satisfaction of the accountant, would have caused the accountant to note the disagreement in connection with the audited financial report. The statement must include both disagreements that were resolved to the accountant's satisfaction and those that were not resolved to the accountant's satisfaction.
>
> (c) The insurer shall file with the statement required under Subsection (b) of this section a letter signed by the accountant stating whether the accountant agrees with the insurer's statement and, if not, stating the reasons why the accountant does not agree. If the accountant is unwilling or unable to provide the letter, the insurer shall file with the commissioner a copy of a written request to the accountant for the letter.

Revised Law

Sec. 401.016. AUDITED COMBINED OR CONSOLIDATED FINANCIAL STATEMENTS. (a) An insurer or health maintenance organization

described by Section 401.001(3) or (4) that is required to file an audited financial report under this subchapter may apply in writing to the commissioner for approval to file audited combined or consolidated financial statements instead of separate audited financial reports if the insurer or health maintenance organization:

(1) is part of a group of insurers or health maintenance organizations that uses a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's or health maintenance organization's reserves; and

(2) cedes all of the insurer's or health maintenance organization's direct and assumed business to the pool.

(b) An insurer or health maintenance organization must file an application under Subsection (a) not later than December 31 of the calendar year for which the audited combined or consolidated financial statements are to be filed.

(c) An insurer or health maintenance organization that receives approval from the commissioner under this section shall file a columnar combining or consolidating worksheet for the audited combined or consolidated financial statements that includes:

(1) the amounts shown on the audited combined or consolidated financial statements;

(2) the amounts for each insurer or health maintenance organization stated separately;

(3) the noninsurance operations shown on a combined or individual basis;

(4) explanations of consolidating and eliminating entries; and

(5) a reconciliation of any differences between the amounts shown in the individual insurer or health maintenance organization columns of the worksheet and comparable amounts shown on the insurer's or health maintenance organization's annual

statements.

(d) An insurer or health maintenance organization that does not receive approval from the commissioner to file audited combined or consolidated financial statements for the insurer or health maintenance organization and any of the insurer's or health maintenance organization's subsidiaries or affiliates shall file a separate audited financial report. (V.T.I.C. Art. 1.15A, Sec. 13.)

Source Law

> Sec. 13. (a) An insurer may make written application to the commissioner for approval to file audited combined or consolidated financial statements instead of separate annual audited financial reports if the insurer is part of a group of insurance companies that uses a pooling or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool. The application for approval must be filed on or before December 31 of the calendar year for which the combined or consolidated audited financial statements are to be filed.
>
> (b) An insurer that receives approval from the commissioner under Subsection (a) of this section shall file a columnar consolidating or combining worksheet for consolidated or combined financial statements that must include the following:
>
> (1) amounts shown on the consolidated or combined audited financial statements;
>
> (2) amounts for each insurer stated separately;
>
> (3) noninsurance operations shown on a combined or individual basis;
>
> (4) explanations of consolidating and eliminating entries; and
>
> (5) reconciliation of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the insurers' annual statements.
>
> (c) An insurer who does not receive approval from the commissioner to file an audited combined or consolidated financial statements for the insurer and any of its subsidiaries or affiliates shall file a separate audited financial report.

Revised Law

Sec. 401.017. NOTICE OF ADVERSE FINANCIAL CONDITION OR MISSTATEMENT OF FINANCIAL CONDITION. (a) An insurer or health maintenance organization required to file an audited financial report under this subchapter shall require the insurer's or health maintenance organization's accountant to immediately notify the board of directors of the insurer or health maintenance organization or the insurer's or health maintenance organization's

audit committee in writing of any determination by that accountant that:

(1) the insurer or health maintenance organization has materially misstated the insurer's or health maintenance organization's financial condition as reported to the commissioner as of the balance sheet date being audited; or

(2) the insurer or health maintenance organization does not meet the minimum capital and surplus requirements prescribed by this code for the insurer or health maintenance organization as of that date.

(b) An insurer or health maintenance organization that receives a notice described by Subsection (a) shall:

(1) provide to the commissioner a copy of the notice not later than the fifth business day after the date the insurer or health maintenance organization receives the notice; and

(2) provide to the accountant evidence that the notice was provided to the commissioner.

(c) If the accountant does not receive the evidence required by Subsection (b)(2) on or before the fifth business day after the date the accountant notified the insurer or health maintenance organization under Subsection (a), the accountant shall file with the commissioner a copy of the accountant's written notice not later than the 10th business day after the date the accountant notified the insurer or health maintenance organization.

(d) An accountant is not liable to an insurer or health maintenance organization or the insurer's or health maintenance organization's policyholders, shareholders, officers, employees, directors, creditors, or affiliates for a statement made under this section if the statement was made in good faith to comply with this section. (V.T.I.C. Art. 1.15A, Secs. 15(a), (b), (d).)

Source Law

Sec. 15. (a) An insurer required to furnish an audited financial report shall require the accountant to immediately notify in writing the board of directors of the insurer or its audit committee of a determination by that accountant that:

(1) the insurer has materially misstated its financial condition as reported to the commissioner as of the balance sheet date currently under examination; or

(2) the insurer does not meet the minimum capital and surplus requirements provided by this code for that insurer as of that date.

(b) The insurer shall furnish to the commissioner a copy of the accountant's written notice not later than the fifth business day after the date on which the insurer receives the notice from the accountant and shall provide the accountant with evidence that the notice has been furnished to the commissioner. If the accountant does not receive the evidence on or before the fifth business day after the date on which the accountant notified the insurer, the accountant shall, not later than the 10th business day after the date on which the accountant notified the insurer, file a copy of the written notice with the commissioner.

(d) An accountant is not liable to the insurer, its policyholders, shareholders, officers, employees or directors, creditors or affiliates, for any statement made under Subsections (a) and (b) of this section if the statement was made in good faith to comply with those subsections.

Revised Law

Sec. 401.018. INFORMATION DISCOVERED AFTER DATE OF AUDITED FINANCIAL REPORT. If, after the date of an audited financial report filed under this subchapter, the accountant becomes aware of facts that might have affected the report, the accountant must take action as prescribed in Volume 1, AU Section 561, Professional Standards of the American Institute of Certified Public Accountants. (V.T.I.C. Art. 1.15A, Sec. 15(c).)

Source Law

(c) If the accountant, subsequent to the date of the audited financial report filed under this article, becomes aware of facts that might have affected the report, the accountant must take action as prescribed in Volume 1, Section AU 561, Professional Standards of the American Institute of Certified Public Accountants.

Revised Law

Sec. 401.019. REPORT ON SIGNIFICANT DEFICIENCIES IN INTERNAL CONTROL. (a) In addition to the audited financial report required by this subchapter, each insurer or health maintenance organization shall provide to the commissioner a written report of significant deficiencies required and prepared by an accountant in accordance with the Professional Standards of the American

Institute of Certified Public Accountants.

(b) The insurer or health maintenance organization shall annually file with the commissioner the report required by this section not later than the 60th day after the date the audited financial report is filed. The insurer or health maintenance organization shall also provide a description of remedial actions taken or proposed to be taken to correct significant deficiencies, if the actions are not described in the accountant's report.

(c) The report must follow generally the form for communication of internal control structure matters noted in an audit described in Statement on Auditing Standard (SAS) No. 60, AU Section 325, Professional Standards of the American Institute of Certified Public Accountants. (V.T.I.C. Art. 1.15A, Sec. 16.)

Source Law

> Sec. 16. (a) In addition to the audited financial report, each insurer shall furnish to the commissioner the written report of significant deficiencies required and prepared in accordance with the Professional Standards of the American Institute of Certified Public Accountants.
>
> (b) The report required by this section must be filed annually by the insurer with the commissioner not later than the 60th day after the date the audited financial report is filed. The insurer is also required to provide a description of remedial actions taken or proposed to correct significant deficiencies, if the actions are not described in the accountant's report.
>
> (c) The report must follow generally the form for communication of internal control structure matters noted in an audit described in SAS No. 60, Section AU 325, Professional Standards of the American Institute of Certified Public Accountants.

Revised Law

Sec. 401.020. ACCOUNTANT WORK PAPERS. (a) In this section, "work papers" means the records kept by an accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached that are pertinent to the accountant's audit of an insurer's or health maintenance organization's financial statements. The term includes work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules, and commentaries prepared or obtained by the accountant in the course

of auditing the financial statements that support the accountant's opinion.

(b) An insurer or health maintenance organization required to file an audited financial report under this subchapter shall require the insurer's or health maintenance organization's accountant to make available for review by the department's examiners the work papers and any record of communications between the accountant and the insurer or health maintenance organization relating to the accountant's audit that were prepared in conducting the audit. The insurer or health maintenance organization shall require that the accountant retain the work papers and records of communications until the earlier of:

(1) the date the department files a report on the examination covering the audit period; or

(2) the seventh anniversary of the date of the last day of the audit period.

(c) The department may copy and retain the copies of pertinent work papers when the department's examiners conduct a review under Subsection (b). The review is considered an investigation, and work papers obtained during that investigation may be made confidential by the commissioner, unless the work papers are admitted as evidence in a hearing before a governmental agency or in a court. (V.T.I.C. Art. 1.15A, Sec. 17.)

Source Law

Sec. 17. (a) Work papers are the records kept by the accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant's examination of the financial statements of an insurer and may include work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules, or commentaries prepared or obtained by the accountant in the course of the accountant's examination of the financial statements of an insurer that support the accountant's opinion.

(b) Each insurer required to file an audited financial report shall require the accountant to make available for review by the department's examiners the work papers and any record of communications related to the audit between the accountant and the insurer prepared in the conduct of the examination. The insurer shall require that the accountant retain the

audit work papers and records of communications until the department has filed a report on examination covering the period of the audit, but not longer than seven years after the period reported.

(c) In the conduct of the periodic review by the department's examiners, photocopies of pertinent audit work papers may be made and retained by the board. Reviews by the department's examiners are considered investigations, and all work papers obtained during the course of those investigations may be made confidential by the commissioner, unless admitted as evidence in a hearing before a governmental agency or in a court of competent jurisdiction.

Revisor's Note

Section 17(c), V.T.I.C. Article 1.15A, refers to evidence admitted in a court "of competent jurisdiction." The revised law omits the quoted language 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. 401.021. PENALTY FOR FAILURE TO COMPLY. (a) If an insurer or health maintenance organization fails to comply with this subchapter, the commissioner shall order that the insurer's or health maintenance organization's annual audit be performed by a qualified independent certified public accountant.

(b) The commissioner shall assess against the insurer or health maintenance organization the cost of auditing the insurer's or health maintenance organization's financial statement under this section.

(c) The insurer or health maintenance organization shall pay to the commissioner the amount of the assessment not later than the 30th day after the date the commissioner issues the notice of assessment to the insurer or health maintenance organization.

(d) Money collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account for use by the commissioner and the department to pay the expenses incurred under this subchapter. (V.T.I.C. Art. 1.15A, Sec. 9(d).)

Source Law

(d) If the insurer fails to comply with this article, the commissioner shall order the audit performed by an independent qualified certified public accountant and assess against the insurer the cost of auditing the insurer's financial statement under this article, and the insurer shall pay the amount of the assessment to the commissioner not later than the 30th day after the date the commissioner issues the notice of assessment to the insurer. Money collected under this section shall be deposited in the state treasury to the credit of the State Board of Insurance operating fund for the use of the board and the department for the purpose of paying the expenses incurred under the article.

Revisor's Note

Section 9(d), V.T.I.C. Article 1.15A, refers to 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.

[Sections 401.022-401.050 reserved for expansion]

SUBCHAPTER B. EXAMINATION OF CARRIERS

Revised Law

Sec. 401.051. DUTY TO EXAMINE CARRIERS. (a) The department or an examiner appointed by the department shall visit at the carrier's principal office:

(1) each carrier that is organized under the laws of this state; and

(2) each other carrier that is authorized to engage in business in this state.

(b) The department or an examiner appointed by the department may visit the carrier for the purpose of investigating the carrier's affairs and condition. The department or an examiner appointed by the department shall examine the carrier's financial condition and ability to meet the carrier's liabilities and

compliance with the laws of this state that affect the conduct of the carrier's business.

(c) The department or an examiner appointed by the department may conduct the visit and examination of a carrier described by Subsection (a)(2) alone or with representatives of the insurance supervising departments of other states. (V.T.I.C. Art. 1.15, Sec. 1 (part); Art. 1.19 (part).)

Source Law

> Art. 1.15
>
> Sec. 1. The State Board of Insurance shall . . . in person or by one or more examiners commissioned by such Board in writing, visit each carrier organized under the laws of this state and examine its financial condition and its ability to meet its liabilities, as well as its compliance with the laws of Texas affecting the conduct of its business; and such Board shall similarly, in person or by one or more commissioned examiners, visit and examine, either alone or jointly with representatives of the insurance supervising departments of other states, each insurance carrier not organized under the laws of this state but authorized to transact business in this state. . . .
>
> Art. 1.19. The Board of Insurance Commissioners for the purpose of examination authorized by law, has power either in person or by one or more examiners by it commissioned in writing:
>
> . . .
>
> 3. To visit at its principal office, wherever situated, any insurance company doing business in this State, for the purpose of investigating its affairs and conditions, and . . . .

Revisor's Note

(1) Section 1, V.T.I.C. Article 1.15, and V.T.I.C. Article 1.19 state that the Texas Department of Insurance may visit an insurance carrier in person or by one or more examiners "commissioned" by the department. The substance of Articles 1.15 and 1.19 was originally enacted by Sections 41 and 66, Chapter 108, Acts of the 31st Legislature, Regular Session, 1909, and included the references to "commissioned" examiners. V.T.I.C. Article 1.04A, enacted by Chapter 1082, Acts of the 71st Legislature, Regular Session, 1989, and revised in this chapter in relevant part as Section 401.101, provides that the department may use

a salaried department examiner or the services of any qualified person or firm to examine an insurance organization. Throughout this chapter, the revised law omits references to the requirement that an examiner be "commissioned" as impliedly repealed by Article 1.04A, and substitutes references to an examiner "appointed" by the department. However, the revised law retains the references to a person being "commissioned" in relation to instances in which the department may decide to commission the person. See, for example, Section 401.104 of this chapter.

(2) V.T.I.C. Article 1.15 and V.T.I.C. Article 1.19 contain substantially duplicative provisions relating to examinations. V.T.I.C. Article 1.19 refers to the authority of the commissioner to visit an "insurance company," whereas Section 1, V.T.I.C. Article 1.15, refers to the commissioner's authority to visit a "carrier." The revised law substitutes "carrier" for the reference to "insurance company" for consistency throughout this subchapter and because "insurance company" is included within the meaning of "carrier."

Revised Law

Sec. 401.052. FREQUENCY OF EXAMINATION. (a) The department shall visit and examine a carrier:

(1) annually during the first three years after the carrier is organized or incorporated; and

(2) except as provided by Subsection (b), once every three years after the period described by Subdivision (1), or on a more frequent basis as the department considers necessary.

(b) If the commissioner determines that the financial strength of a carrier justifies less frequent examinations than those required under Subsection (a)(2), the department may conduct the examination at intervals not less frequent than every five

years. The commissioner shall adopt rules governing the determination under this subsection of whether the financial strength of a carrier justifies less frequent examinations. (V.T.I.C. Art. 1.15, Secs. 1 (part), 10.)

Source Law

> Sec. 1. The State Board of Insurance shall once each year for the first three (3) years after organization or incorporation, and thereafter once in each three (3) years, or oftener, if the Board deems necessary, . . . visit each carrier . . . and examine . . . .
>
> Sec. 10. If the Commissioner determines that the financial strength of a carrier justifies less-frequent examinations than are required by Section 1 of this article, the Commissioner may conduct the examination of a carrier at intervals not to exceed five years. The Commissioner shall adopt rules governing the determination of whether the financial strength of a carrier justifies examination under this section. This section applies only to examination of a carrier that has been incorporated or organized for more than three years.

Revised Law

Sec. 401.053. EXAMINATION PERIOD. Unless the department requests that an examination cover a longer period, the examination must cover the period beginning on the last day covered by the most recent examination and ending on December 31 of the year preceding the year in which the examination is being conducted. (V.T.I.C. Art. 1.04A (part).)

Source Law

> Art. 1.04A. [In making examinations of any insurance organization as provided by law,] . . . Such examination shall cover the period of time that the department requests. In the event the department does not specify a longer period of time, such examination shall be from the time of the last examination theretofore made by the department to December 31st of the year preceding the examination then being made. . . .

Revised Law

Sec. 401.054. POWERS RELATED TO EXAMINATION. The department or the examiner appointed by the department:

(1) has free access, and may require the carrier or the carrier's agent to provide free access, to all books and papers of the carrier or the carrier's agent that relate to the carrier's

business and affairs; and

(2) has the authority to summon and examine under oath, if necessary, an officer, agent, or employee of the carrier or any other person in relation to the carrier's affairs and condition. (V.T.I.C. Art. 1.15, Sec. 1 (part); Art. 1.19 (part).)

Source Law

[Art. 1.15]

Sec. 1. . . . Such Board or its commissioned examiners shall have free access to all the books and papers of the carrier or agents thereof relating to the business and affairs of such carrier, and shall have power to summon and examine under oath, if necessary, the officers, agents, and employees of such carrier and any other person relative to the affairs of such carrier. . . .

Art. 1.19. The Board of Insurance Commissioners for the purpose of examination authorized by law, has power . . . :

1. To require free access to all books and papers within this State of any insurance companies, or the agents thereof, doing business within this State.

2. To summon and examine any person within this State, under oath, which it or any examiner may administer, relative to the affairs and conditions of any insurance company.

. . .

Revisor's Note

V.T.I.C. Article 1.19 provides that the Texas Department of Insurance may examine any person in this state under oath and that the department or an appointed examiner may administer the oath. The revised law omits the reference to administering the oath because the power to examine under oath includes the power to administer the oath.

Revised Law

Sec. 401.055. EFFECT OF SUBCHAPTER ON AUTHORITY TO USE INFORMATION. This subchapter does not limit the commissioner's authority to use a final or preliminary examination report, an examiner's or company's work papers or other documents, or any other information discovered or developed during an examination in connection with a legal or regulatory action that the commissioner, in the commissioner's sole discretion, considers appropriate.

(V.T.I.C. Art. 1.15, Sec. 7.)

Source Law

> Sec. 7. Nothing contained in this article shall be construed to limit the Commissioner's authority to use any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commissioner of Insurance may, in his or her sole discretion deem appropriate.

Revised Law

Sec. 401.056. RULES RELATED TO REPORTS AND HEARINGS. The commissioner by rule shall adopt:

(1) procedures governing the filing and adoption of an examination report;

(2) procedures governing a hearing to be held under this subchapter; and

(3) guidelines governing an order issued under this subchapter. (V.T.I.C. Art. 1.15, Sec. 6.)

Source Law

> Sec. 6. The Board, by rule, shall adopt procedures for filing and adoption of examination reports and for hearings to be held under this article and guidelines governing orders issued under this article.

Revised Law

Sec. 401.057. USE OF AUDIT AND WORK PAPERS. (a) In this section, "work papers" has the meaning assigned by Section 401.020(a).

(b) In conducting an examination under this subchapter, the department shall use audits and work papers that the carrier makes available to the department and that are prepared by an accountant or accounting firm meeting the qualifications of Section 401.011. The department may conduct a separate audit of the carrier if necessary. Work papers developed in the audit shall be maintained in the manner provided by Sections 401.020(b) and (c).

(c) The carrier shall provide the department with:

(1) the work papers of an accountant or accounting firm or the carrier; and

(2) a record of any communications between the accountant or accounting firm and the carrier that relate to an audit.

(d) The accountant or accounting firm shall deliver the information described by Subsection (c) to the examiner. The examiner shall retain the information during the department's examination of the carrier.

(e) Information obtained under this section is confidential and may not be disclosed to the public except when introduced as evidence in a hearing. (V.T.I.C. Art. 1.15, Sec. 8.)

Source Law

> Sec. 8. (a) In conducting an examination under this article, the department shall use audits and work papers prepared by an accountant or accounting firm that meets the requirements of Section 12, Article 1.15A, of this code that are made available to the department by the carrier. If necessary, the department may conduct a separate audit of the carrier.
>
> (b) The carrier shall provide the department with the work papers of an accountant or accounting firm or the carrier and a record of any communications between the accountant or accounting firm and the carrier that relate to the audit. The accountant or accounting firm shall deliver that information to the department's examiners, who shall retain the information during the course of the department's examination of the carrier. Information obtained under this section is confidential and may not be disclosed to the public except when introduced as evidence in a hearing.
>
> (c) For purposes of this section, "work papers" has the meaning assigned by Section 17(a), Article 1.15A, of this code. Work papers developed in an audit conducted under this section shall be maintained in the manner provided by Sections 17(b) and (c), Article 1.15A, of this code.

Revised Law

Sec. 401.058. CONFIDENTIALITY OF REPORTS AND RELATED INFORMATION. (a) A final or preliminary examination report and any information obtained during an examination are confidential and are not subject to disclosure under Chapter 552, Government Code.

(b) Subsection (a) applies if the examined carrier is under supervision or conservatorship. Subsection (a) does not apply to an examination conducted in connection with a liquidation or receivership under this code or another insurance law of this

state. (V.T.I.C. Art. 1.15, Sec. 9.)

Source Law

Sec. 9. A final or preliminary examination report, and any information obtained during the course of an examination, is confidential and is not subject to disclosure under the open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes), and its subsequent amendments. This section applies if the carrier examined is under supervision or conservation but does not apply to an examination conducted in connection with a liquidation or a receivership under this code or another insurance law of this state.

Revisor's Note

Section 9, V.T.I.C. Article 1.15, refers to the "open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes), and its subsequent amendments." That statute was codified in 1993 as Chapter 552, Government Code. The revised law is drafted accordingly throughout this chapter.

In addition, throughout this chapter, the revised law omits references to "its 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.

Revised Law

Sec. 401.059. DETERMINATION OF VALUE. In determining the value or market value of an investment in or on real estate or an improvement to real estate by a carrier authorized to engage in business in this state, the department, in administering this code, may consider any factor or matter that the department considers proper and material, including:

(1) an appraisal by a real estate board or other qualified person;

(2) an affidavit by another person familiar with those values;

(3) a tax valuation;

(4) the cost of acquisition after deducting for depreciation and obsolescence;

(5) the cost of replacement;

(6) sales of other comparable property;

(7) enhancement in value from any cause;

(8) income received or to be received; and

(9) any improvements made. (V.T.I.C. Art. 1.15, Sec. 2.)

Source Law

Sec. 2. The State Board of Insurance in administering any provision of the Insurance Code, Acts 1951, 51st Legislature, Chapter 491, shall be authorized and empowered in determining "value" or "market value" of any investment in or upon real estate or the improvements thereon by any carrier authorized to do business in the State of Texas to consider any and all matters and things relating thereto, including but not restricted to, appraisals by real estate boards or other qualified persons, affidavits by other persons familiar with such values, tax valuations, cost of acquisition, with proper deductions for depreciation and obsolescence, cost of replacement, sales of other comparable property, enhancement in value from whatever cause, income received or to be received, improvements made or any other factor or any other evidence which to said Board may be deemed proper and material.

Revisor's Note

(1) Section 2, V.T.I.C. Article 1.15, refers to "any provision of the Insurance Code, Acts 1951, 51st Legislature, Chapter 491." The reference contains a typographical error, and clearly should refer to Chapter 491, Acts of the 52nd Legislature, 1951, meaning the Insurance Code. For many years, a company publishing the laws of the State of Texas has included in published versions of the Insurance Code portions of law that were never formally added to the Insurance Code by the legislature. Those provisions have been revised as part of the Insurance Code. However, because those provisions cannot be interpreted to authorize a determination of "value" or "market value"

of real property or improvements on real property as contemplated by Section 2, V.T.I.C. Article 1.15, it is appropriate in this context to substitute "this code" for "the Insurance Code, Acts 1951, 51st Legislature, Chapter 491." The revised law is drafted accordingly.

(2) Section 2, V.T.I.C. Article 1.15, uses the phrase "including but not restricted to." "[B]ut not restricted to" is omitted from the revised law 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. 401.060. RIGHT TO INFORMATION RELATING TO DETERMINATION OF VALUE OR MARKET VALUE. (a) If the department determines the value or market value of an insurer's investment in or on real estate or an improvement to real estate, the insurer is entitled to make a written request for a written finding by the commissioner in relation to that determination.

(b) Not later than the 10th day after the date the commissioner receives a request under Subsection (a), the commissioner shall enter a written order or finding that:

(1) states separately the department's findings on each factor or matter on which the department relied in making the determination; and

(2) includes the name and address of each person who provided evidence relating to a factor or matter on which the department relied in making the determination.

(c) The commissioner shall provide to the insurer that requested a written finding under this section a copy of the finding or order. (V.T.I.C. Art. 1.15, Sec. 3.)

Source Law

Sec. 3. Any insurer whose investment in or upon real estate or the improvements thereon may have been determined or found by said Board shall be entitled to make a written request to the Board for a written finding by the Board; and upon such request being made to the Board, the Board shall, within ten (10) days after receipt of such request, enter its written order or finding setting out separately its finding upon each factor or matter upon which its said determination or finding of "value" or "market value" was made and shall in such written order or finding give the names and addresses of all persons who furnished such evidence as to each such matter, factor or thing and upon whom the Board relied in making such determination or finding and shall deliver a copy of such written finding or order to the carrier so requesting the same.

Revised Law

Sec. 401.061. DISCIPLINARY ACTION FOR FAILURE TO COMPLY WITH SUBCHAPTER. A carrier is subject to disciplinary action under Chapter 82 if the carrier or the carrier's agent fails or refuses to comply with:

(1) this subchapter or a rule adopted under this subchapter; or

(2) a request by the department or an appointed examiner to be examined or to provide information requested as part of an examination. (V.T.I.C. Art. 1.15, Sec. 5.)

Source Law

Sec. 5. If a carrier or an agent of a carrier fails or refuses to comply with this article or rules adopted under this article or to comply with a request of the Board or a commissioned examiner to be examined or to provide information requested as part of an examination by the Board or commissioned examiner, the carrier is subject to disciplinary action under Article 1.10, Section 7, of this code, and the Commissioner of Insurance may institute disciplinary action pursuant to Article 1.10, Section 7, Insurance Code.

Revisor's Note

V.T.I.C. Article 1.19 in part requires the Texas Department of Insurance to revoke the certificate of authority of an insurer that refuses to permit an examination. The substance of that article was originally enacted by Section 66, Chapter 108, Acts of the 31st Legislature, Regular Session, 1909, and was

codified as V.T.I.C. Article 1.19 by Chapter 491, Acts of the 52nd Legislature, Regular Session, 1951. The revised law omits the provision as impliedly repealed by Section 5, V.T.I.C. Article 1.15, which was enacted by Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, and provides for disciplinary action under Section 7, V.T.I.C. Article 1.10, revised as Chapter 82 of this code, for an insurer's refusal to be examined. The omitted law reads:

> 3. . . . shall revoke the certificate of authority of any such company in this State refusing to permit such examination. . . .

Revised Law

Sec. 401.062. STAY OF RULE, ORDER, DECISION, OR FINDING. The filing of a petition under Subchapter D, Chapter 36, for judicial review of a rule, order, decision, or finding of the commissioner or department under this subchapter operates as a stay of the rule, order, decision, or finding until the court directs otherwise. (V.T.I.C. Art. 1.15, Sec. 4.)

Source Law

> Sec. 4. Any rule, regulation, order, decision or finding of the Board under this Act shall be subject to review in accordance with Article 1.04 of this code. The filing of such suit shall operate as a stay of any such rule, regulation, order, decision or finding of the Board until the court directs otherwise.

Revisor's Note

Section 4, V.T.I.C. Article 1.15, states that a rule, order, decision, or finding of the commissioner of insurance or the Texas Department of Insurance is subject to review under V.T.I.C. Article 1.04, revised in 1999 as Subchapter D, Chapter 36, of this code. The revised law omits the reference to a rule, order, decision, or finding being subject to review under Article 1.04 because a rule, order, decision, or finding 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.

[Sections 401.063-401.100 reserved for expansion]

SUBCHAPTER C. EXAMINERS AND ACTUARIES

Revised Law

Sec. 401.101. USE OF DEPARTMENT EXAMINER OR OTHER QUALIFIED PERSON OR FIRM. The department may use a salaried department examiner or may appoint a qualified person or firm to perform an examination of an insurance organization as provided by law or to assist in the performance of an examination. (V.T.I.C. Art. 1.04A (part).)

Source Law

> Art. 1.04A. In making examinations of any insurance organization as provided by law, the department may use its own salaried examiners or may use the services of persons or firms qualified to perform such examinations or assist in the performance of such examinations. . . .

Revised Law

Sec. 401.102. LEGISLATIVE INTENT AS TO APPOINTMENT OR EMPLOYMENT OF EXAMINERS AND ACTUARIES. (a) The legislature recognizes that experienced, highly qualified examiners and actuaries are necessary for the department to effectively monitor and regulate the solvency of insurers in this state. It is the intent of the legislature that the department, in appointing or employing an examiner or actuary, select a person who:

(1) has substantial experience in financial matters relating to insurance or other areas of financial activity that are compatible with the business of insurance; and

(2) is recognized for the outstanding quality of the person's work in relation to areas of responsibility typically assigned to an examiner or actuary in the insurance field.

(b) The legislature pledges to provide to the department the necessary funding to implement this section and to support the department in the department's efforts to attract the highly qualified persons necessary to fulfill regulatory responsibilities

relating to insurer solvency assigned to those persons under the insurance laws of this state. (V.T.I.C. Art. 1.17A.)

Source Law

> Art. 1.17A. (a) The Legislature recognizes that experienced, highly qualified examiners and actuaries are necessary for the department to monitor and regulate effectively the solvency of insurers in this state. It is the intent of the Legislature that the department, in appointing or employing examiners or actuaries, select persons who have substantial experience in financial matters relating to insurance or other areas of financial activity that are compatible with the business of insurance and who are recognized for the outstanding quality of their work in relation to areas of responsibility typically assigned to examiners and actuaries in the insurance field.
>
> (b) The Legislature pledges to provide to the department the necessary funding to implement this article and to support the department in its efforts to attract the highly qualified persons necessary to fulfill regulatory responsibilities relating to insurer solvency assigned to them under the insurance laws of this state.

Revised Law

Sec. 401.103. APPOINTMENT OF EXAMINERS AND ACTUARIES. (a) The department shall appoint:

(1) a chief examiner and the number of assistant examiners the department considers necessary to conduct examinations of insurance companies, corporations, and associations at the expense of the insurance company, corporation, or association as provided by law; and

(2) the number of actuaries the department considers necessary to:

(A) advise the department in connection with the performance of the department's duties; and

(B) otherwise aid and counsel the department in connection with the examinations.

(b) The department may increase or decrease the number of examiners or actuaries as needed for examination duties. (V.T.I.C. Art. 1.17 (part).)

Source Law

> Art. 1.17. The State Board of Insurance shall appoint a chief examiner and such number of assistant examiners as it deems necessary for the purpose of

making examinations of insurance companies, corporations, or associations at the expense of such companies, corporations, or associations as are provided for by law. The State Board of Insurance shall also appoint the number of actuaries it considers necessary to advise it in connection with the performance of its duties and for aid, advice, and counsel in connection with such examinations. Such examiners and actuaries shall perform all the duties relative to examinations. . . .

All such examiners and actuaries shall be employed subject to the will of the State Board of Insurance and the number of such examiners and actuaries may be increased or decreased from time to time to suit the needs of the examining work.

. . .

Revisor's Note

(1) V.T.I.C. Article 1.17 states that examiners and actuaries appointed under that article "shall perform all the duties relative to examinations." The substance of Article 1.17 was originally enacted by the second Section 3, Chapter 152, Acts of the 42nd Legislature, Regular Session, 1931, and included the references to the examiners and actuaries performing all duties relative to examinations. V.T.I.C. Article 1.04A, as amended by Chapter 1082, Acts of the 71st Legislature, Regular Session, 1989, and revised in this chapter in relevant part as Section 401.101, provides that the Texas Department of Insurance may use a salaried department examiner or the services of any qualified person or firm to make an examination. Therefore, the revised law omits the quoted provision of Article 1.17 as impliedly repealed by Article 1.04A.

(2) V.T.I.C. Article 1.17 states that an examiner or actuary is employed "subject to the will" of the Texas Department of Insurance. The revised law omits that provision as unnecessary because under the employment-at-will doctrine that applies to all public employees, an examiner or actuary automatically serves at the will of the hiring agency.

(3) V.T.I.C. Article 1.17 states that the

purpose of that article and V.T.I.C. Articles 1.16 and 1.18 is to provide for the examination of all corporations, firms, or persons engaged in writing insurance in this state. The revised law omits that provision as unnecessary because V.T.I.C. Article 1.15, revised in relevant part in this chapter in Section 401.051, provides for the examination of all carriers organized under the laws of this state or authorized to engage in business in this state. The omitted law reads:

> Art. 1.17. . . . It is the purpose of this Article and Articles 1.16 and 1.18 of this Code to provide for the examination by the State Board of Insurance of all corporations, firms, or persons engaged in the business of writing insurance of any kind in this State whether now subject to the supervision of the State Board of Insurance or not.
>
> . . .

Revised Law

Sec. 401.104. APPOINTMENT OF EXAMINERS, ACTUARIES, AND OTHER PERSONS FOR CERTAIN EXAMINATIONS. (a) The department may commission a department actuary, the chief examiner, another department examiner or employee, or any other person to conduct or assist in the examination of a company that is not organized under the laws of this state.

(b) The department may compensate a person described by Subsection (a). If the department compensates the person, the person may not receive any other compensation while the person is assigned to the examination.

(c) Except as provided by this section and Section 401.152, a department actuary or examiner may not continue to serve in that capacity if the person directly or indirectly accepts employment or compensation for a service rendered or to be rendered from any insurance company for any reason. (V.T.I.C. Art. 1.17 (part).)

Source Law

Art. 1.17. . . . Where the State Board of Insurance shall deem it advisable it may commission

any actuary of the Board, the chief examiner, or any other examiner or employee of the Board, or any other person, to conduct or assist in the examination of any company not organized under the laws of Texas and allow them compensation as herein provided, except that they may not be otherwise compensated during the time they are assigned to such foreign company examinations. Other than as provided herein, neither any actuary nor any examiner of the State Board of Insurance may continue to serve as such if, while holding such position, he directly or indirectly accepts from any insurance company any employment or pay or compensation or gratuity on account of any service rendered or to be rendered on any account whatsoever.

Revisor's Note

(1) V.T.I.C. Article 1.17 provides that "[o]ther than as provided herein," an actuary or examiner may not continue to serve in that capacity if the person directly or indirectly accepts from an insurer employment or compensation for a service rendered or to be rendered. The substance of Article 1.17 was originally enacted by Chapter 152, Acts of the 42nd Legislature, Regular Session, 1931, as the second "Section 3." The provisions enacted by Chapter 152, Acts of the 42nd Legislature, Regular Session, 1931, which also contained the substance of V.T.I.C. Articles 1.15, 1.16, and 1.18, originally applied only to examinations of domestic insurers, required that an actuary or examiner be paid a salary, and prohibited an actuary or examiner from continuing to serve in that capacity if the person directly or indirectly accepted compensation from an insurer. In 1939, the provisions enacted by Chapter 152, Acts of the 42nd Legislature, Regular Session, 1931, were amended by Chapter 2, Acts of the 46th Legislature, Regular Session, to allow for the examination of insurers not organized under the laws of this state. The amendment provided that those insurers being examined were responsible for paying the examiners' compensation and expenses and modified the prohibition on accepting direct or indirect compensation so that the provision stated that

"[o]ther than as thus provided" an actuary or examiner could not continue to serve in that capacity if the person directly or indirectly accepted compensation from an insurer. It is apparent from the context of the quoted language that the quoted language referred to other provisions enacted by Chapter 152, Acts of the 42nd Legislature, Regular Session, 1931, as amended. Chapter 491, Acts of the 52nd Legislature, Regular Session, 1951, codified these provisions as V.T.I.C. Articles 1.15, 1.16, 1.17, and 1.18. The provisions relating to the compensation of actuaries and examiners for examining insurers not organized under the laws of this state were codified in V.T.I.C. Article 1.17, the relevant provisions of which are revised in this section, and V.T.I.C. Article 1.16, the relevant provisions of which are revised in this chapter as Section 401.152. Therefore, the revised law substitutes a reference to "[e]xcept as provided by this section and Section 401.152" for the source law reference to "[o]ther than as provided herein."

(2) V.T.I.C. Article 1.17 prohibits a person from continuing to serve as an actuary or examiner of the Texas Department of Insurance if the person receives "pay or compensation or gratuity" from an insurance company for any service rendered or to be rendered. The revised law omits "pay" and "gratuity" as unnecessary because, in context, those terms are included within the meaning of "compensation."

Revised Law

Sec. 401.105. OATH OF EXAMINERS AND ASSISTANTS. Before entering into the duties of appointment as an examiner or assistant examiner, an individual must take and file in the office of the secretary of state an oath to:

(1) support the constitution of this state;

(2) faithfully conduct the individual's duties of office;

(3) make fair and impartial examinations;

(4) not accept, directly or indirectly, as a gift or emolument any pay for the discharge of the individual's duty, other than the compensation to which the individual is entitled by law; and

(5) not reveal the condition of a corporation, firm, or person or any information secured while examining a corporation, firm, or person to anyone other than:

(A) the department or an authorized representative of the department; or

(B) as required when testifying in an administrative hearing under this code or another insurance law of this state or in court. (V.T.I.C. Art. 1.18 (part).)

Source Law

> Art. 1.18. Each examiner and assistant examiner, before entering upon the duties of his appointment shall take and file in the office of the Secretary of State an oath to support the Constitution of this State, to faithfully demean himself in office, to make fair and impartial examinations, and that he will not accept as presents or emoluments any pay, directly or indirectly, for the discharge of his duty, other than the remuneration fixed and accorded to him by law; and that he will not reveal the condition of, nor any information secured in the course of any examination of any corporation, firm or person examined by him, to anyone except the Members of the State Board of Insurance, or their authorized representative, or when required as witness in an administrative hearing before the Board or the Commissioner or in Court.
>
> . . .

Revisor's Note

(1) V.T.I.C. Article 1.18 refers to the "remuneration" accorded an examiner or assistant examiner by law. The revised law substitutes "compensation" for "remuneration" because the terms are synonymous and the former is more commonly used.

(2) V.T.I.C. Article 1.18 refers to an administrative hearing before the "[c]ommissioner."

Formerly administrative hearings required to be held under this code or another insurance law of this state were held before the commissioner. In 1993, the legislature enacted V.T.I.C. Article 1.33B, revised in Chapter 40 of this code, which provides that certain administrative hearings be conducted by the State Office of Administrative Hearings. Therefore, to continue the application of the revised law to the hearings in question, the revised law substitutes a reference to an administrative hearing "under this code or another insurance law of this state" for the reference to a hearing before the "[c]ommissioner."

Revised Law

Sec. 401.106. RIGHT OF ACTION ON BOND. If an examiner or assistant examiner knowingly makes a false report or gives any information in violation of law that relates to an examination of a corporation, firm, or person, the corporation, firm, or person has a right of action on a bond authorized under Chapter 653, Government Code, for the entity's injuries in a suit brought in the name of the state at the relation of the entity. (V.T.I.C. Art. 1.18 (part).)

Source Law

> Art. 1.18. . . . In case any such examiner or assistant examiner shall knowingly make any false report or give any information in violation of law relative to any such examination of any corporation, firm or person so examined, any such corporation, firm or person shall have a right of action on a bond authorized under Chapter 653, Government Code, for his injuries in a suit brought in the name of the State at the relation of the injured party.

[Sections 401.107-401.150 reserved for expansion]

SUBCHAPTER D. EXAMINATION EXPENSES

Revised Law

Sec. 401.151. EXPENSES OF EXAMINATION OF DOMESTIC INSURER. (a) A domestic insurer examined on behalf of this state by the department or under the department's authority shall pay the expenses of the examination in an amount the commissioner certifies as just and reasonable.

(b) The department shall collect an assessment at the time of the examination to cover all expenses attributable directly to that examination, including:

(1) the salaries and expenses of department employees; and

(2) expenses described by Section 803.007.

(c) The department shall also impose an annual assessment on domestic insurers in an amount sufficient to meet all other expenses and disbursements necessary to comply with the laws of this state relating to the examination of insurers.

(d) In determining the amount of the assessment under Subsection (c), the department:

(1) shall consider:

(A) the insurer's annual premium receipts or admitted assets, or both, that are not attributable to 90 percent of pension plan contracts as defined by Section 818(a), Internal Revenue Code of 1986; or

(B) the total amount of the insurer's insurance in force; and

(2) may not consider insurance premiums for insurance contracted for by a state or federal governmental entity to provide welfare benefits to designated welfare recipients or contracted for 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.).

(e) The amount of all examination and evaluation fees paid to the state by an insurer in each taxable year shall be allowed as a credit on the amount of premium taxes due under this subchapter. (V.T.I.C. Art. 1.16, Secs. (a), (b) (part); Art. 1.19 (part).)

Source Law

Art. 1.16. (a) The expenses of all examinations of domestic insurance companies made on behalf of the State of Texas by the State Board of Insurance or under its authority shall be paid by the corporations examined in such amount as the Commissioner of Insurance shall certify to be just and reasonable.

(b) Assessments for the expenses of such

domestic examination which shall be sufficient to meet all the expenses and disbursements necessary to comply with the provisions of the laws of Texas relating to the examination of insurance companies and to comply with the provisions of this Article and Articles 1.17 and 1.18 of this Code, shall be made by the State Board of Insurance upon the corporations or associations to be examined taking into consideration annual premium receipts, and/or admitted assets that are not attributable to 90 percent of pension plan contracts as defined in Section 818(a) of the Internal Revenue Code of 1986 (26 U.S.C. Section 818(a)), and/or insurance in force; provided such assessments shall be made and collected as follows: (1) expenses attributable directly to a specific examination including employees' salaries and expenses and expenses provided by Article 1.28 of this Code shall be collected at the time of examination; (2) assessments calculated annually for each corporation or association which take into consideration annual premium receipts, and/or admitted assets that are not attributable to 90 percent of pension plan contracts as defined in Section 818(a) of the Internal Revenue Code of 1986 (26 U.S.C. Section 818(a)), and/or insurance in force shall be assessed annually for each such corporation or association. In computing the assessments, the board may not consider insurance premiums for insurance contracted for by a state or federal governmental entity to provide welfare benefits to designated welfare recipients or contracted for 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.). The amount of all examination and evaluation fees paid in each taxable year to the State of Texas by an insurance carrier shall be allowed as a credit on the amount of premium taxes due under this article. . . .

[Art. 1.19]

3. . . . The reasonable expenses of all such examination shall be paid by the company examined.

. . .

Revisor's Note

(1) Section (b), V.T.I.C. Article 1.16, refers to expenses and disbursements necessary to comply with the laws of this state "relating to the examination of insurance companies" and with "Articles 1.17 and 1.18" of this code. The revised law omits the reference to V.T.I.C. Articles 1.17 and 1.18 as unnecessary because those articles are included within the laws of this state "relating to the examination of insurance companies."

(2) Section (b), V.T.I.C. Article 1.16, refers to expenses attributable directly to a specific

examination, including "expenses provided by Article 1.28 of this Code." V.T.I.C. Article 1.28 was revised as Chapter 803 of this code. The only section of Chapter 803 that relates to expenses is Section 803.007, and the revised law is drafted accordingly.

Revised Law

Sec. 401.152. EXPENSES OF EXAMINATION OF OTHER INSURERS. (a) An insurer not organized under the laws of this state shall reimburse the department for the salary and expenses of each examiner participating in an examination of the insurer and for other department expenses that are properly allocable to the department's participation in the examination.

(b) An insurer shall pay the expenses under this section regardless of whether the examination is made only by the department or jointly with the insurance supervisory authority of another state.

(c) The insurer shall pay the expenses directly to the department on presentation of an itemized written statement from the commissioner.

(d) The commissioner shall determine the salary of an examiner participating in an examination of an insurer's books or records located in another state based on the salary rate recommended by the National Association of Insurance Commissioners or the examiner's regular salary rate.

(e) The limitations provided by Sections 803.007(1) and (2)(B) for a domestic company apply to a foreign insurer. (V.T.I.C. Art. 1.16, Secs. (b) (part), (f) (part).)

Source Law

> (b) . . . The limitations provided by Sections 803.007(1) and (2)(B) of this code for domestic insurance companies apply to foreign insurance companies.
>
> (f) In case of an examination of a company not organized under the laws of Texas, whether such examination is made by the Texas authorities alone, or jointly with the insurance supervisory authorities of another state or states, the expenses of such examination due to Texas' participation therein shall

be borne by the company under examination. Payment of such cost shall be made by the company upon presentation of itemized written statement by the Commissioner of Insurance and shall consist of the examiners' remuneration and expenses, and the other expenses of the State Board of Insurance properly allocable to the examination. Payment shall be made directly to the State Board of Insurance, and . . . . The remuneration of examiners participating in examinations of insurance company books or records located in states other than Texas shall be fixed by the Commissioner of Insurance based on the salary rate recommended by the National Association of Insurance Commissioners or the examiners' regular salary rate.

Revisor's Note

Section (f), V.T.I.C. Article 1.16, refers to certain examinations being made by "Texas authorities" and to "Texas' participation" in those examinations. For clarity, the revised law substitutes references to the "department" for the quoted references because the Texas Department of Insurance is the state authority that would conduct or participate in those examinations.

Revised Law

Sec. 401.153. REIMBURSEMENT OF EXPENSES OF CERTAIN PERSONS OR FIRMS. (a) A person or firm appointed by the department to examine an insurer or to assist in the insurer's examination shall be paid for those services at the usual and customary rates charged for those services. The insurer being examined shall pay the fee for those services.

(b) The commissioner may disapprove the payment of a fee under Subsection (a) if the fee is excessive in relation to the services actually performed. (V.T.I.C. Art. 1.04A (part).)

Source Law

Art. 1.04A. . . . All fees paid to those persons or firms whose services are used shall be paid at the usual and customary rates charged for the performance of those services, subject to the right of the Commissioner to disapprove for payment any fees that are excessive in relation to the services actually performed. Such payment shall be made by the insurance organization being examined and . . . .

Revised Law

Sec. 401.154. TAX CREDIT AUTHORIZED. An insurer is

entitled to a credit on the amount of premium or other taxes to be paid by the insurer for all examination fees paid under Section 401.153. The insurer may take the credit for the taxable year during which the examination fees are paid and may take the credit to the same extent the insurer may take a credit for examination fees paid when a salaried department examiner conducts the examination. (V.T.I.C. Art. 1.04A (part).)

Source Law

> Art. 1.04A. . . . all such examination fees so paid shall be allowed as a credit on the amount of premium or other taxes to be paid by any such insurance organization for the taxable year during which examination fees are paid just as examination fees are credited when the department uses its own salaried examiners.

Revised Law

Sec. 401.155. ADDITIONAL ASSESSMENTS. (a) The department shall impose additional assessments against insurers on a pro rata basis as necessary to:

(1) cover all expenses and disbursements required by law; and

(2) comply with this subchapter and Sections 401.103, 401.104, 401.105, and 401.106.

(b) The department shall use any surplus resulting from an assessment under this section to reduce the amount of subsequent assessments. (V.T.I.C. Art. 1.16, Sec. (e).)

Source Law

> (e) If at any time it shall appear that additional pro rata assessments are necessary to cover all of the expenses and disbursements required by law and necessary to comply with this Article and Articles 1.17 and 1.18 of this Code, the same shall be made, and any surplus arising from any and all such assessments, over and above such expenses and disbursements, shall be applied in reduction of subsequent assessments.

Revised Law

Sec. 401.156. DEPOSIT AND USE OF ASSESSMENT AND FEE. (a) The department shall deposit an assessment or fee collected under this subchapter to the credit of the Texas Department of Insurance operating account.

(b) Money deposited under this section shall be used to pay the salaries and expenses of actuaries and examiners and all other expenses relating to examinations of insurers. (V.T.I.C. Art. 1.16, Secs. (d) (part), (f) (part).)

Source Law

> (d) All sums collected by the State Board of Insurance provided in this Article shall be deposited in the State Treasury to the credit of the State Board of Insurance operating fund; and the salaries and expenses of the actuaries and examiners, and all other expenses relating to such examinations, shall be paid . . . .
>
> (f) . . . all money collected by assessment on foreign companies for the cost of examination shall be deposited in the State Treasury by the State Board of Insurance to the credit of the State Board of Insurance operating fund and . . . .

Revisor's Note

Section (d), V.T.I.C. Article 1.16, states that expenses of an examination shall be paid on the certificate of the Texas Department of Insurance by warrant of the comptroller drawn on the Texas Department of Insurance operating account. Section (f), V.T.I.C. Article 1.16, states that money in the account shall be spent as authorized by the General Appropriations Act only on warrants issued by the comptroller on requisition by the department. The revised law omits as unnecessary that part of Section (f) relating to the expenditure of money as authorized by the General Appropriations Act 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 the provisions in Sections (d) and (f) relating to warrants issued by the comptroller on requisition of the department because they are substantially duplicative of provisions contained in Chapter 2103, Government Code, which is a comprehensive law covering procedures for withdrawing

money from the state treasury. The omitted law reads:

> (d) . . . upon the certificate of the State Board of Insurance by warrant of the Comptroller of Public Accounts drawn upon such fund.
>
> (f) . . . shall be spent as provided by the General Appropriations Act only on warrants issued by the Comptroller of Public Accounts pursuant to duly certified requisitions of the State Board of Insurance. . . .

Revisor's Note
(End of Subchapter)

Section (c), V.T.I.C. Article 1.16, added by Chapter 161, Acts of the 69th Legislature, Regular Session, 1985, provides for the reimbursement of travel expenses for Texas Department of Insurance employees. The revised law omits the section as impliedly repealed by a 1997 amendment to Chapter 660, Government Code. Section 660.003(a), Government Code, provides that Chapter 660, the General Appropriations Act, and the rules adopted by the comptroller under Chapter 660 govern the procedures, amounts, timing, limits, required documentation, permissible payees, distinctions among different types of state employees, and all other details concerning travel expense payments or reimbursements by a state agency. The omitted law reads:

> (c) Examiners and other personnel employed by the State Board of Insurance when traveling on official state business related to the examination of insurance companies outside this state shall be reimbursed for the actual cost of transportation, lodging, meals, subsistence expenses, and parking fees or shall be paid a per diem rate established by the State Board of Insurance based on local economic conditions. The State Board of Insurance shall establish guidelines and procedures for the efficient and effective administration of these travel payment procedures and shall periodically revise and update these guidelines and procedures including the maximum actual or per diem allowance.

[Sections 401.157-401.200 reserved for expansion]

SUBCHAPTER E. CONFIDENTIALITY OF CERTAIN INFORMATION

Revised Law

Sec. 401.201. CONFIDENTIALITY OF EARLY WARNING SYSTEM INFORMATION. Information relating to the financial solvency of an organization regulated by the department under this code or another insurance law of this state that is obtained by the department's early warning system is confidential and is not subject to disclosure under Chapter 552, Government Code. (V.T.I.C. Art. 1.15B.)

Source Law

> Art. 1.15B. Any information relating to the financial solvency of any organization regulated by the department under this code or another insurance law of this state obtained by the department's early warning system is confidential and is not subject to disclosure under the open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes), and its subsequent amendments.

CHAPTER 402. DISCLOSURE OF MATERIAL TRANSACTIONS

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CHAPTER 402. DISCLOSURE OF MATERIAL TRANSACTIONS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 402.001. APPLICABILITY OF CHAPTER. (a) Except as provided by Subsection (b), this chapter applies to:

(1) each of the following domestic or commercially domiciled insurers:

(A) a capital stock insurance company;

(B) a mutual insurance company;

(C) a title insurance company;

(D) a fraternal benefit society;

(E) a Lloyd's plan;

(F) a reciprocal or interinsurance exchange;

(G) a group hospital service corporation or a nonprofit hospital, medical, or dental service corporation;

(H) a risk retention group; and

(I) a nonprofit legal services corporation; and

(2) a domestic or commercially domiciled health maintenance organization.

(b) This chapter does not apply to a domestic insurer that engages in the business of insurance only in this state or to a domestic health maintenance organization that engages in the business of a health maintenance organization only in this state

until the insurer or health maintenance organization is authorized to engage in the business of insurance or the business of a health maintenance organization, as applicable, in another state. (V.T.I.C. Art. 21.49-8, Sec. 1.)

Source Law

Art. 21.49-8

Sec. 1. (a) Except as provided by Subsection (b) of this section, this article applies to the following domestic insurers and commercially domiciled insurers:

(1) a capital stock company;

(2) a mutual company;

(3) a title insurance company;

(4) a fraternal benefit society;

(5) a Lloyd's plan company;

(6) a reciprocal or interinsurance exchange;

(7) a group hospital service corporation;

(8) a health maintenance organization;

(9) a risk retention group;

(10) a nonprofit legal service corporation; and

(11) a nonprofit hospital, medical, or dental service corporation.

(b) A domestic insurer listed under Subsection (a) of this section that does business only in this state is exempt from the application of this article until the insurer obtains authority to conduct the business of insurance in another state.

Revisor's Note

Section 1(a), V.T.I.C. Article 21.49-8, provides that the article applies to certain listed domestic and commercially domiciled "insurers." 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 chapter.

Revised Law

Sec. 402.002. GENERAL REPORTING REQUIREMENTS. (a) An insurer or health maintenance organization shall file with the department a report, including any necessary exhibit or other attachment, that discloses:

(1) the material acquisition or disposition of assets;

or

(2) the material nonrenewal, cancellation, or revision of a ceded reinsurance agreement.

(b) The insurer or health maintenance organization shall file the report required under Subsection (a) not later than the 15th day after the last day of the calendar month in which any transaction for which a report is required occurs. (V.T.I.C. Art. 21.49-8, Secs. 2(a) (part), (b), (c).)

Source Law

> Sec. 2. (a) . . . each insurer shall file a report with the commissioner that discloses:
>
> (1) material acquisitions and dispositions of assets; or
>
> (2) material nonrenewals, cancellations, or revisions of ceded reinsurance agreements.
>
> (b) The report required under Subsection (a) of this section must be filed not later than the 15th day after the last day of the calendar month in which any of the affected transactions occur.
>
> (c) The insurer also shall file one complete copy of the report, including any necessary exhibits or other attachments, with the department.

Revisor's Note

Section 2(a), V.T.I.C. Article 21.49-8, requires an insurer or health maintenance organization to file a report with the commissioner of insurance concerning material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements. Section 2(c), V.T.I.C. Article 21.49-8, provides that the insurer or health maintenance organization also shall file "one complete copy of the report" with the Texas Department of Insurance. Under Section 31.021 of this code, the commissioner has a duty to administer and enforce this code and has the powers and duties vested in the department by this code. Therefore, filing the required report with the commissioner is equivalent to filing the report with the department, and the revised law is drafted to reflect that only one filing is required. Furthermore, since only one report is

filed, the revised law also omits as unnecessary the reference to "one complete copy of the report."

Revised Law

Sec. 402.003. EXCEPTIONS TO REPORTING REQUIREMENTS. An insurer or health maintenance organization is not required to file a report under Section 402.002 if:

(1) the acquisition or disposition of assets or the nonrenewal, cancellation, or revision of a ceded reinsurance agreement is not material; or

(2) the insurer's or health maintenance organization's material acquisition or disposition of assets or material nonrenewal, cancellation, or revision of a ceded reinsurance agreement has been submitted to the commissioner for review, approval, or information under another provision of this code or another law, regulation, or requirement. (V.T.I.C. Art. 21.49-8, Secs. 2(a) (part), 3(a) (part), 4(a) (part).)

Source Law

> Sec. 2. (a) Unless the material acquisition and disposition of assets and the nonrenewal, cancellation, or revisions of material ceded reinsurance agreements have been submitted to the commissioner for review, approval, or information under other provisions of this code or other laws, regulations, or requirements, . . . .
>
> Sec. 3. (a) An insurer is not required to report an acquisition or disposition of assets under Section 2 of this article if the acquisition or disposition is not material. . . .
>
> Sec. 4. (a) An insurer is not required to report a nonrenewal, cancellation, or revision of a ceded reinsurance agreement under Section 2 of this article if the nonrenewal, cancellation, or revision is not material. . . .

Revised Law

Sec. 402.004. REPORT MADE ON NONCONSOLIDATED BASIS. (a) An insurer or health maintenance organization shall report each material acquisition or disposition and each material nonrenewal, cancellation, or revision of a ceded reinsurance agreement on a nonconsolidated basis unless the insurer or health maintenance organization:

(1) is part of a consolidated group of insurers or health maintenance organizations that uses a pooling arrangement or a 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's or health maintenance organization's reserves; and

(2) has ceded substantially all of the insurer's or health maintenance organization's direct and assumed business to the pooling arrangement.

(b) For purposes of Subsection (a), an insurer or health maintenance organization is considered to have ceded substantially all of the insurer's or health maintenance organization's direct and assumed business to a pooling arrangement if:

(1) the insurer or health maintenance organization has, during a calendar year, less than $1 million total direct and assumed written premiums that are not subject to a pooling arrangement; and

(2) the net income of the business that is not subject to the pooling arrangement represents less than five percent of the insurer's or health maintenance organization's capital and surplus.

(V.T.I.C. Art. 21.49-8, Secs. 3(e), (f), 4(f), (g).)

Source Law

[Sec. 3]

(e) An insurer shall report material acquisitions and dispositions on a nonconsolidated basis unless the insurer:

(1) is part of a consolidated group of insurers that uses a pooling arrangement or a 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves; and

(2) ceded substantially all of its direct and assumed business to the pooling arrangement.

(f) For purposes of Subsection (e), an insurer is considered to have ceded substantially all of its direct and assumed business to a pooling arrangement if:

(1) the insurer has, during a calendar year, less than $1 million total direct and assumed written premiums that are not subject to a pooling arrangement; and

(2) the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

[Sec. 4]

(f) An insurer shall report all material nonrenewals, cancellations, or revisions of ceded

reinsurance agreements on a nonconsolidated basis unless the insurer:

(1) is part of a consolidated group of insurers that uses a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves; and

(2) ceded substantially all of its direct and assumed business to the pooling arrangement.

(g) For purposes of Subsection (f) of this section, an insurer is considered to have ceded substantially all of its direct and assumed business to a pooling arrangement if:

(1) the insurer has, during a calendar year, less than $1 million total direct and assumed written premiums that are not subject to the pooling arrangement; and

(2) the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

Revised Law

Sec. 402.005. CONFIDENTIALITY OF REPORT. (a) A report obtained by or disclosed to the commissioner under this chapter is confidential and is not subject to a subpoena, other than a grand jury subpoena.

(b) The report may not be disclosed by the commissioner, the National Association of Insurance Commissioners, or any other person without the prior written consent of the affected insurer or health maintenance organization unless the commissioner, after providing notice and an opportunity for a hearing to the affected insurer or health maintenance organization, determines that the interest of shareholders, holders of policies or evidences of coverage, or the public will be served by publishing the report. If the commissioner makes that determination, the department may:

(1) disclose the report to the public; and

(2) publish any part of the report in a manner the commissioner considers appropriate.

(c) The report may be disclosed to the insurance department of another state or another authorized governmental agency without complying with Subsection (b). (V.T.I.C. Article 21.49-8, Sec. 2(d).)

Source Law

(d) A report obtained by or disclosed to the commissioner under this article is confidential and is not subject to a subpoena, other than a grand jury subpoena. The report may not be disclosed by the

commissioner, the National Association of Insurance Commissioners, or any other person, except to the insurance department of another state or another authorized governmental agency, without the prior written consent of the affected insurer, unless the commissioner, after notice to the affected insurer and an opportunity for a hearing, determines that the interest of policyholders, shareholders, or the public will be served by the publication of the report. If the commissioner does so determine, the department may disclose a report to the public and may publish all or any part of the report in any manner considered appropriate by the commissioner.

Revisor's Note

Section 2(d), V.T.I.C. Article 21.49-8, refers to the commissioner of insurance making a determination concerning the interest of "policyholders." Because that section applies to health maintenance organizations as well as traditional insurers, and because health maintenance organizations do not have "policyholders," the revised law adds a reference to "holders of . . . evidences of coverage" to clarify that the commissioner of insurance must consider the interest of persons provided coverage by health maintenance organizations.

[Sections 402.006-402.050 reserved for expansion]

SUBCHAPTER B. ACQUISITION AND DISPOSITION OF ASSETS

Revised Law

Sec. 402.051. ACQUISITIONS AND DISPOSITIONS CONSIDERED MATERIAL. For purposes of this chapter, an acquisition, or the aggregate of a series of related acquisitions during a 30-day period, or a disposition, or the aggregate of a series of related dispositions during a 30-day period, is material if it:

(1) is not recurring;

(2) is not in the ordinary course of business; and

(3) involves more than five percent of the reporting insurer's or health maintenance organization's total admitted assets as reported in the insurer's or health maintenance organization's most recent statutory statement filed with the department. (V.T.I.C. Art. 21.49-8, Sec. 3(a) (part).)

Source Law

Sec. 3. (a) . . . For purposes of this article, an acquisition, or the aggregate of a series of related acquisitions during a 30-day period, or a disposition, or the aggregate of a series of related dispositions during a 30-day period, is material if it:

(1) is not recurring;

(2) is not in the ordinary course of business; and

(3) involves more than five percent of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the department.

Revised Law

Sec. 402.052. ACQUISITIONS AND DISPOSITIONS SUBJECT TO CHAPTER. (a) An asset acquisition subject to this chapter includes a purchase, lease, exchange, merger, consolidation, succession, or other acquisition of assets, except the construction or development of real property by or for the reporting insurer or health maintenance organization or the acquisition of materials for that purpose.

(b) An asset disposition subject to this chapter includes a sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment, whether for the benefit of a creditor or otherwise, abandonment, destruction, or other disposition of assets. (V.T.I.C. Art. 21.49-8, Secs. 3(b), (c).)

Source Law

(b) An asset acquisition subject to this article includes each purchase, lease, exchange, merger, consolidation, succession, or other acquisition, other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for that purpose.

(c) An asset disposition subject to this article includes each sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment, whether for the benefit of creditors or otherwise, abandonment, destruction, or other disposition.

Revised Law

Sec. 402.053. CONTENT OF REPORT CONCERNING MATERIAL ACQUISITIONS AND DISPOSITIONS. In a report of a material acquisition or disposition of assets under Section 402.002, an insurer or health maintenance organization shall disclose:

(1) the date of the transaction;

(2) the manner of acquisition or disposition;

(3) a description of the assets involved;

(4) the nature and amount of the consideration given or received;

(5) the purpose of the transaction;

(6) the manner by which the amount of consideration was determined;

(7) the gain or loss recognized or realized as a result of the transaction; and

(8) the name of each person from whom the assets were acquired or to whom they were disposed. (V.T.I.C. Art. 21.49-8, Sec. 3(d).)

Source Law

(d) The following information must be disclosed in a report of a material acquisition or disposition of assets:

(1) the date of the transaction;

(2) the manner of acquisition or disposition;

(3) a description of the assets involved;

(4) the nature and amount of the consideration given or received;

(5) the purpose of or reason for the transaction;

(6) the manner by which the amount of consideration was determined;

(7) the gain or loss recognized or realized as a result of the transaction; and

(8) the name of each person from whom the assets were acquired or to whom they were disposed.

Revisor's Note

Section 3(d)(5), V.T.I.C. Article 21.49-8, provides that an insurer or health maintenance organization shall disclose "the purpose of or reason for" certain transactions. The revised law omits the reference to the "reason for" because the "reason for" is included within the meaning of "the purpose of."

[Sections 402.054-402.100 reserved for expansion]

SUBCHAPTER C. NONRENEWAL, CANCELLATION, AND REVISION OF CEDED REINSURANCE AGREEMENTS

Revised Law

Sec. 402.101. NONRENEWALS, CANCELLATIONS, AND REVISIONS

CONSIDERED MATERIAL. For purposes of this chapter, a nonrenewal, cancellation, or revision of a ceded reinsurance agreement is material if, on an annual basis, as reported in an insurer's or health maintenance organization's most recent statutory statement filed with the department, the nonrenewal, cancellation, or revision affects:

(1) for property and casualty business, including accident and health business when written as property and casualty business, more than 50 percent of the insurer's or health maintenance organization's ceded written premium; or

(2) for life, annuity, and accident and health business, more than 50 percent of the total reserve credit taken for business ceded by the insurer or health maintenance organization. (V.T.I.C. Art. 21.49-8, Sec. 4(a) (part).)

Source Law

> Sec. 4. (a) . . . For purposes of this article, a nonrenewal, cancellation, or revision is material if it affects, on an annual basis, as indicated in the insurer's most recently filed statutory statement:
>
> (1) for property and casualty business, including accident and health business when written as property and casualty business, more than 50 percent of an insurer's ceded written premium; or
>
> (2) for life, annuity, and accident and health business, more than 50 percent of the total reserve credit taken for business ceded.

Revisor's Note

Section 4(a), V.T.I.C. Article 21.49-8, refers to specified percentages of ceded written premium and of the total reserve credit taken for business ceded "as indicated in the insurer's most recently filed statutory statement." The revised law modifies the quoted language for consistency with the terminology used in Section 3(a)(3), V.T.I.C. Article 21.49-8, revised in this chapter as Section 402.051(3).

Revised Law

Sec. 402.102. CONDITIONS UNDER WHICH REPORT CONCERNING NONRENEWAL, CANCELLATION, OR REVISION REQUIRED. Except as

provided by Section 402.103, an insurer or health maintenance organization shall file a report of a material nonrenewal, cancellation, or revision of ceded reinsurance under Section 402.002, without regard to which party initiated the nonrenewal, cancellation, or revision, if:

(1) the entire cession has been canceled, nonrenewed, or revised, and ceded indemnity and loss adjustment expense reserves after the nonrenewal, cancellation, or revision represent less than 50 percent of the comparable reserves that would have been ceded had the nonrenewal, cancellation, or revision not occurred;

(2) an authorized or accredited reinsurer has been replaced by an unauthorized reinsurer on an existing cession, and the result of the revision affects more than 10 percent of the cession; or

(3) a collateral requirement previously established for an unauthorized reinsurer has been reduced, in that the requirement to collateralize incurred but unreported claim reserves has been waived for at least one unauthorized reinsurer newly participating in an existing cession, and the result of the revision affects more than 10 percent of the cession. (V.T.I.C. Art. 21.49-8, Secs. 4(c), (d).)

Source Law

(c) Subject to the requirements imposed under Subsections (a) and (b) of this section, an insurer shall file a report without regard to which party initiated the nonrenewal, cancellation, or revision of ceded reinsurance when one or more of the following conditions exist:

(1) the entire cession has been canceled, nonrenewed, or revised and ceded indemnity and loss adjustment expense reserves after the nonrenewal, cancellation, or revision represent less than 50 percent of the comparable reserves that would have been ceded had the nonrenewal, cancellation, or revision not occurred;

(2) an authorized or accredited reinsurer has been replaced on an existing cession by an unauthorized reinsurer; or

(3) collateral requirements previously established for unauthorized reinsurers have been reduced in that the requirement to collateralize incurred but not reported claim reserves has been waived for one or more unauthorized reinsurers newly participating in an existing cession.

(d) Subject to the requirement of materiality,

for purposes of Subsections (c)(2) and (3) of this section, an insurer shall file a report if the result of the revision affects more than 10 percent of the cession.

Revised Law

Sec. 402.103. CONDITIONS UNDER WHICH REPORT CONCERNING NONRENEWAL, CANCELLATION, OR REVISION NOT REQUIRED. An insurer or health maintenance organization is not required to file a report under Section 402.002 if the insurer's or health maintenance organization's ceded written premium of the total reserve credit taken for business ceded is, on an annual basis, less than an amount equal to:

(1) 10 percent of direct and assumed written premiums; or

(2) 10 percent of the statutory reserve requirement before a cession. (V.T.I.C. Art. 21.49-8, Sec. 4(b).)

Source Law

(b) An insurer is not required to report if the insurer's ceded written premium of the total reserve credit taken for business ceded represents, on an annual basis, less than:

(1) 10 percent of direct and assumed written premiums; or

(2) 10 percent of the statutory reserve requirement before a cession.

Revised Law

Sec. 402.104. CONTENT OF REPORT CONCERNING MATERIAL NONRENEWALS, CANCELLATIONS, AND REVISIONS. In a report of a material nonrenewal, cancellation, or revision of a ceded reinsurance agreement under Section 402.002, an insurer or health maintenance organization shall disclose:

(1) the effective date of the nonrenewal, cancellation, or revision;

(2) a description of the transaction that identifies the initiator of the transaction;

(3) the purpose of the transaction; and

(4) if applicable, the identity of each replacement reinsurer. (V.T.I.C. Art. 21.49-8, Sec. 4(e).)

Source Law

(e) An insurer shall disclose the following information in a report of a material nonrenewal, cancellation, or revision of a ceded reinsurance agreement:

(1) the effective date of the nonrenewal, cancellation, or revision;

(2) a description of the transaction that identifies the initiator of the transaction;

(3) the purpose of or reason for the transaction; and

(4) if applicable, the identity of the replacement reinsurers.

Revisor's Note

Section (4)(e)(3), V.T.I.C. Article 21.49-8, provides that an insurer or health maintenance organization shall disclose "the purpose of or reason for" certain transactions. The revised law omits the reference to the "reason for" for the reason stated in the revisor's note to Section 402.053.

Revisor's Note
(End of Chapter)

V.T.I.C. Article 21.49-8 was enacted by Chapter 614, Acts of the 74th Legislature, Regular Session, 1995. Section 18(c) of that act provided that Article 21.49-8 "takes effect only on certification by the commissioner of insurance that the National Association of Insurance Commissioners has provided to the commissioner in writing a total budgetary disclosure as to the use by that association of funds received by that association from states that are members of the association. The commissioner shall issue a finding regarding the certification and shall publish the finding in the Texas Register." Notification of the commissioner's finding was filed by the commissioner on December 19, 1995, and published in the Texas Register on December 26, 1995. The revised law is drafted accordingly.

CHAPTER 403. DIVIDENDS

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Sec. 403.002. DIVIDENDS TO POLICYHOLDERS IN COMMERCIAL LINES . . . . . 80

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CHAPTER 403. DIVIDENDS

SUBCHAPTER A. PAYMENT OF DIVIDENDS

Revised Law

Sec. 403.001. LIMITATION ON DIVIDENDS. An insurer organized under the laws of this state, including a life, health, fire, marine, or inland marine insurance company, may not pay a dividend except from surplus profits arising from the insurer's business. (V.T.I.C. Arts. 21.31 (part), 21.32 (part).)

Source Law

> Art. 21.31. It shall not be lawful for any insurance company organized under the laws of this State to make any dividend, except from surplus profits arising from its business. . . .

> Art. 21.32. No life, health, fire, marine, or inland insurance company, organized under the laws of this state, shall make any dividend except from the surplus profits arising from its business. . . .

Revisor's Note

(1) V.T.I.C. Article 21.32 refers to an "inland insurance company." Throughout this chapter, the revised law substitutes references to an "inland marine insurance company" for references to an "inland insurance company" for consistency of terminology

within this code.

(2) V.T.I.C. Articles 21.31 and 21.32 provide that an insurer may not "make any dividend." The revised law substitutes "pay a dividend" for "make any dividend" because, in context, the phrases are synonymous and "pay a dividend" is more commonly used.

Revised Law

Sec. 403.002. DIVIDENDS TO POLICYHOLDERS IN COMMERCIAL LINES. (a) An insurer may pay to a commercial policyholder or group of commercial policyholders a dividend that covers more than one class or line of commercial business only:

(1) after the insurer establishes on an aggregate basis adequate loss reserves for the classes or lines of commercial insurance included within the dividend; and

(2) if the insurer has sufficient surplus from which to pay the dividend.

(b) Not later than the 15th day before an insurer pays a dividend described by Subsection (a), the insurer shall file with the department notice of the insurer's intent to pay the dividend.

(c) The classes or lines of commercial business for which dividends are authorized under this section include any commercial class or line of commercial business regulated by Title 10 or Chapter 5.

(d) An insurer's limitation of a dividend on one or more classes or lines of commercial business to a group of commercial policyholders is not unfair discrimination if the group:

(1) has clearly identifiable underwriting characteristics; or

(2) is an association or group of business entities engaged in similar undertakings. (V.T.I.C. Art. 5.41-2.)

Source Law

Art. 5.41-2

Sec. 1. An insurer may pay to a commercial policyholder or group of commercial policyholders a dividend which covers more than one class or line of commercial business. This dividend may only be paid to

the policyholder or group of policyholders after adequate loss reserves are established on an aggregate basis for the classes or lines of commercial insurance included within the dividend, and the insurer must have sufficient surplus from which to pay the dividend. An insurer shall file a notice of its intent to pay such dividend with the department at least 15 days prior to the payment of the dividend.

Sec. 2. Limitation of the payment of a dividend on one or more classes or lines of commercial business to a group of commercial policyholders shall not be unfair discrimination so long as the group has clearly identifiable underwriting characteristics or is an association or group of business entities engaged in similar undertakings.

Sec. 3. The classes or lines of commercial business for which dividends are authorized under this article include any or all of the commercial classes or lines of commercial business regulated by this chapter.

Revisor's Note

Section 3, V.T.I.C. Article 5.41-2, refers to commercial classes or lines of commercial business regulated by "this chapter," meaning V.T.I.C. Chapter 5. Portions of that chapter are revised in part in various titles of this code. The relevant provisions of Chapter 5 that regulate commercial classes and lines of commercial business that are revised are revised in Title 10 of this code. For that reason, the revised law substitutes a reference to "Title 10 or Chapter 5" for the reference to "this chapter."

[Sections 403.003-403.050 reserved for expansion]

SUBCHAPTER B. ESTIMATE OF PROFITS

Revised Law

Sec. 403.051. ESTIMATE OF PROFITS. An insurer organized under the laws of this state may not include the following in the estimate of the insurer's profits for the purpose of paying dividends under Section 403.001:

(1) the reserve on all unexpired risks computed in the manner provided by this code;

(2) the amount of all unpaid losses, whether adjusted or unadjusted; and

(3) all other debts due and payable, or to become due and payable, by the insurer. (V.T.I.C. Art. 21.31 (part).)

Source Law

Art. 21.31. [It shall not be lawful for any insurance company organized under the laws of this State to make any dividend, except from surplus profits arising from its business.] In estimating such profits, there shall be reserved therefrom the lawful reserve on all unexpired risks and also the amount of all unpaid losses, whether adjusted or unadjusted, and all other debts due and payable, or to become due and payable, by the company. . . .

Revisor's Note

V.T.I.C. Article 21.31 refers to the "lawful reserve" on unexpired risks. For clarity, the revised law substitutes a reference to the "reserve . . . computed in the manner provided by this code" for the reference to the "lawful reserve" because, in this context, a "lawful reserve" is a reserve computed in the manner prescribed by this code.

Revised Law

Sec. 403.052. ESTIMATE OF PROFITS OF CERTAIN INSURERS. A life, health, fire, marine, or inland marine insurance company organized under the laws of this state may not include the following in the estimate of the company's profits for the purpose of paying dividends under Section 403.001:

(1) the reserve on all unexpired risks computed in the manner provided by this code;

(2) the amount of all unpaid losses, whether adjusted or unadjusted;

(3) each amount due the company on bonds, mortgages, stocks, or book-accounts on which no part of the principal or interest has been paid during the year preceding the estimate of profits and for which:

(A) a suit for foreclosure or collection has not been commenced; or

(B) a judgment obtained in a suit for foreclosure or collection has remained unsatisfied for a period of more than two years and no interest has been paid on the judgment; and

(4) if no interest has been paid on a judgment described by Subdivision (3)(B), any interest that is due or accrued on the judgment and remains unpaid. (V.T.I.C. Art. 21.32 (part).)

Source Law

> Art. 21.32. [No life, health, fire, marine, or inland insurance company, organized under the laws of this state, shall make any dividend except from the surplus profits arising from its business.] In estimating such profits, there shall be reserved therefrom the lawful reserve on all unexpired risks computed in the manner as provided elsewhere in this Code, and also there shall be reserved the amount of all unpaid losses, whether adjusted or unadjusted; all sums due the company on bonds, mortgages, stocks and book-accounts, of which no part of the principal or the interest thereon has been paid during the year preceding such estimate of profits, and upon which suit for foreclosures or collections has not been commenced, or which after judgment has been obtained thereon shall have remained more than two years unsatisfied, and upon which interest shall not have been paid. In case of any such judgment, the interest due or accrued thereon and remaining unpaid shall also be reserved. . . .

Revisor's Note

(1) V.T.I.C. Article 21.32 provides the methodology by which a "life, health, fire, marine, or inland insurance company, organized under the laws of this state" estimates the company's surplus profits for the purpose of paying dividends. However, V.T.I.C. Article 21.31, revised in relevant part in this chapter as Section 403.051, provides the methodology by which an "insurance company organized under the laws of this State" estimates surplus profits for the same purpose. Because a "life, health, fire, marine, or inland insurance company, organized under the laws of this state" referenced in Article 21.32 is also an "insurance company organized under the laws of this state" to which Article 21.31 applies, it is ambiguous whether Article 21.32 is an exception to Article 21.31 for the specified companies or whether both Articles 21.31 and 21.32 apply to those

companies. The revised law is drafted to preserve that ambiguity.

(2) V.T.I.C. Article 21.32 refers to the "lawful reserve" on unexpired risks "computed in the manner as provided elsewhere in this Code." The revised law omits the reference to "lawful" for the reason stated in the revisor's note to Section 403.051.

Revised Law

Sec. 403.053. ACQUIRED EARNED SURPLUS. (a) This section applies only to:

(1) a stock domestic insurance company authorized to engage in the business of life, accident, or health insurance in this state;

(2) a stock foreign or alien life, health, or accident insurance company;

(3) a stock insurance company authorized to engage in the business of property, casualty, or fire insurance; and

(4) a domestic Lloyd's plan, reciprocal or interinsurance exchange, or title insurance company.

(b) In determining the amount of "surplus profits arising from the insurer's business" or "earned surplus" for the purpose of paying dividends to shareholders, the insurer may include the acquired earned surplus of an insurance subsidiary acquired by the insurer to the extent that:

(1) the inclusion is permitted by an order of the commissioner made in accordance with commissioner rules; and

(2) the earned surplus of the acquired subsidiary on the date of acquisition that exists on the date of the commissioner's order is not otherwise reflected in the insurer's earned surplus. (V.T.I.C. Art. 21.32A.)

Source Law

Art. 21.32A. For the purpose of determining the legality of a dividend to shareholders paid by stock domestic insurance companies authorized to transact life, accident, and health insurance business in Texas, all stock foreign and alien life, health, and

accident insurance companies, stock insurance companies authorized to transact property and casualty business and fire insurance business and domestic Lloyds', reciprocals, and title insurance companies under the laws of the State of Texas, the "earned surplus" or "surplus profits arising from the business" of the insurance company may include the acquired "earned surplus" of an insurance subsidiary which has been acquired by the insurance company, to the extent allowed by an order of the commissioner made in accordance with the rules of the board but only to the extent that the "earned surplus" of the acquired subsidiary on the date of acquisition, and in existence on the date of the order, is not otherwise reflected in the "earned surplus" of the insurance company.

Revisor's Note

(1) V.T.I.C. Article 21.32A refers to domestic "Lloyds'" and "reciprocals." For consistency of terminology within this code, the revised law substitutes a reference to a "Lloyd's plan" for the reference to "Lloyds'," and substitutes a reference to a "reciprocal or interinsurance exchange" for the reference to "reciprocals."

(2) V.T.I.C. Article 21.32A refers to the "board," meaning the State Board of Insurance. Subsequent references in this chapter are 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. Throughout this chapter, references to the Board of Insurance Commissioners or the State Board of Insurance have been changed appropriately.

[Sections 403.054-403.100 reserved for expansion]

SUBCHAPTER C. PENALTIES

Revised Law

Sec. 403.101. PENALTIES. (a) The department may revoke the charter of an insurer organized under the laws of this state that pays a dividend in violation of Sections 403.001 and 403.051. If the department revokes an insurer's charter under this subsection, the department shall immediately revoke the insurer's certificate of authority.

(b) Not later than the 10th day before the date on which the department intends to revoke an insurer's certificate of authority under this section, the department shall give the insurer written notice of the department's intent. The notice must include the specific reasons for the revocation. (V.T.I.C. Art. 21.31 (part).)

Source Law

> Art. 21.31. [It shall not be lawful for any insurance company organized under the laws of this State to make any dividend, except from surplus profits arising from its business. . . .] Any dividends made contrary to any provision of this article shall subject the company making them to a forfeiture of its charter; and the Board shall forthwith revoke its certificate of authority. The Board shall give such company at least ten (10) days' notice in writing of its intention to revoke such certificate, stating specifically the reasons why it intends to revoke same.

Revisor's Note

(1) V.T.I.C. Article 21.31 states that dividends made contrary to any provision of this chapter "subject the company making them to a forfeiture of its charter" and "the Board shall forthwith revoke its certificate of authority." The revised law clarifies that the Texas Department of Insurance shall revoke an insurer's certificate of authority if the department revokes the insurer's charter under this section.

(2) V.T.I.C. Article 21.31 requires the Texas Department of Insurance to revoke an insurer's certificate of authority "forthwith" in certain

circumstances. The revised law substitutes "immediately" for "forthwith" because the terms have the same meaning in this context and "immediately" is more modern.

Revised Law

Sec. 403.102. PENALTIES FOR CERTAIN INSURERS. The department may revoke the charter of a life, health, fire, marine, or inland marine insurance company organized under the laws of this state that pays a dividend in violation of Sections 403.001 and 403.052. If the department revokes a company's charter under this section, the department shall immediately revoke the company's certificate of authority. (V.T.I.C. Art. 21.32 (part).)

Source Law

> Art. 21.32. [No life, health, fire, marine, or inland insurance company, organized under the laws of this state, shall make any dividend except from the surplus profits arising from its business. . . .] Any dividend made contrary to any provision of this Article shall subject the company making it to a forfeiture of its charter, and the Board shall forthwith revoke its certificate of authority.

Revisor's Note

(1) V.T.I.C. Article 21.32 specifies certain penalties for a "life, health, fire, marine, or inland insurance company, organized under the laws of this state" that pays a dividend in violation of Article 21.32. V.T.I.C. Article 21.31, revised in relevant part in this chapter as Section 403.101, provides the same penalties for an "insurance company organized under the laws of this State" that pays a dividend in violation of Article 21.31, but further requires that the Texas Department of Insurance provide notice to the insurer before imposing the penalties. Because a "life, health, fire, marine, or inland insurance company, organized under the laws of this state" referenced in Article 21.32 is also an "insurance company organized under the laws of this state" to

which Article 21.31 applies, it is ambiguous whether Article 21.32 is an exception to Article 21.31 for the companies to which Article 21.32 applies, or whether both Articles 21.31 and 21.32 apply to those companies. The revised law is drafted to preserve that ambiguity.

(2) V.T.I.C. Article 21.32 states that a dividend made contrary to any provision of this chapter "subject the company making it to a forfeiture of its charter" and "the Board shall forthwith revoke its certificate of authority." The revised law clarifies that the Texas Department of Insurance shall revoke a specified insurance company's certificate of authority only if the department revokes the company's charter.

(3) V.T.I.C. Article 21.32 requires the Texas Department of Insurance to revoke a specified insurance company's certificate of authority "forthwith" in certain circumstances. For the reason stated in Revisor's Note (2) to Section 403.101, the revised law substitutes "immediately" for "forthwith."

CHAPTER 404. FINANCIAL CONDITION

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CHAPTER 404. FINANCIAL CONDITION

SUBCHAPTER A. HAZARDOUS FINANCIAL CONDITION

Revised Law

Sec. 404.001. DEFINITION. In this subchapter, "insurer" includes:

(1) a capital stock insurance company;

(2) a reciprocal or interinsurance exchange;

(3) a Lloyd's plan;

(4) a fraternal benefit society;

(5) a mutual company, including a mutual assessment company;

(6) a statewide mutual assessment company;

(7) a local mutual aid association;

(8) a burial association;

(9) a county mutual insurance company;

(10) a farm mutual insurance company;

(11) a fidelity, guaranty, or surety company;

(12) a title insurance company;

(13) a stipulated premium company;

(14) a group hospital service corporation;

(15) a health maintenance organization;

(16) a risk retention group; and

(17) any other organization or person engaged in the business of insurance. (V.T.I.C. Art. 1.32, Sec. 1(a) (part).)

Source Law

Art. 1.32

Sec. 1. (a) "Insurer" shall include but not be limited to capital stock companies, reciprocal or interinsurance exchanges, Lloyds associations, fraternal benefit societies, mutual and mutual assessment companies of all kinds and types, state-wide assessment associations, local mutual aids, burial associations, county and farm mutual associations, fidelity, guaranty, and surety companies, trust companies organized under the provisions of Chapter 7 of the Texas Insurance Code of 1951, as amended, title insurance companies, stipulated premium insurance companies, group

hospital service companies, health maintenance organizations, risk retention groups, and all other organizations, corporations, or persons transacting an insurance business, . . . .

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 1.32, provides that "'[i]nsurer' shall include but not be limited to" certain entities. The revised law omits "but not be limited to" as unnecessary because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, 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.

(2) Section 1(a), V.T.I.C. Article 1.32, refers to "capital stock companies," "Lloyds associations," "state-wide assessment associations," "local mutual aids," "county and farm mutual associations," "stipulated premium insurance companies," and "group hospital service companies." For consistency with terminology used in this code, the revised law substitutes "capital stock insurance company" for "capital stock companies," "Lloyd's plan" for "Lloyds associations," "statewide mutual assessment company" for "state-wide assessment associations," "local mutual aid association" for "local mutual aids," "county mutual insurance company" and "farm mutual insurance company" for "county and farm mutual associations," "stipulated premium company" for "stipulated premium insurance companies," and "group hospital service corporation" for "group hospital service companies."

(3) Section 1(a), V.T.I.C. Article 1.32, refers to "trust companies organized under the provisions of Chapter 7 of the Texas Insurance Code of 1951, as

amended." Before 1957, trust companies were organized and regulated under V.T.I.C. Chapter 7. Chapter 388, Acts of the 55th Legislature, Regular Session, 1957, repealed V.T.I.C. Chapter 7, as it existed at that time, and the Texas Department of Insurance no longer regulates any trust companies. Trust companies are currently regulated by the Texas Department of Banking under Chapter 181, Finance Code. Accordingly, the revised law omits the reference to trust companies organized under V.T.I.C. Chapter 7.

(4) Section 1(a), V.T.I.C. Article 1.32, refers to "organizations, corporations, or persons transacting an insurance business." The revised law omits the reference to "corporations" as unnecessary because "organization" includes a corporation.

(5) Sections (1)(b) and (c), V.T.I.C. Article 1.32, 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 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. The definition of "commissioner" is unnecessary because Section 31.001 of this code defines "commissioner" as the commissioner of insurance for purposes of this code. The omitted law reads:

> (b) "Board" means the State Board of Insurance of Texas.
>
> (c) "Commissioner" means the Commissioner of Insurance of Texas.

Revised Law

Sec. 404.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a person or organization engaged in the business of

insurance without regard to whether the person or organization is listed in Section 404.001, unless another statute specifically cites this subchapter and exempts the person or organization from this subchapter. (V.T.I.C. Art. 1.32, Sec. 1(a) (part).)

Source Law

> (a) ["Insurer" shall include . . . all other organizations, corporations, or persons transacting an insurance business,] whether or not named above, unless such insurers are by statute specifically, by naming this article, exempted from the operation of this article.

Revised Law

Sec. 404.003. ORDER TO REMEDY CONDITION. (a) If the financial condition of an insurer, when reviewed as provided by Subsection (b), indicates a condition that might make the insurer's continued operation hazardous to the insurer's policyholders or creditors or to the public, the commissioner may, after notice and hearing, order the insurer to take action reasonably necessary to remedy the condition.

(b) The insurer's financial condition must be reviewed under Subsection (a) in conjunction with one or more of the following:

(1) the kinds and nature of risks insured;

(2) the loss experience and ownership of the insurer;

(3) the ratio of total annual premium and net investment income to commission expenses, general insurance expenses, policy benefits paid, and required policy reserve increases;

(4) the insurer's method of operation, affiliations, or investments;

(5) any contracts that lead or may lead to contingent liability; or

(6) agreements in respect to guaranty and surety.

(c) In an order issued under Subsection (a), the commissioner may take any action the commissioner considers reasonably necessary to remedy the condition described by

Subsection (a), including:

(1) requiring an insurer to:

(A) reduce the total amount of present and potential liability for policy benefits by reinsurance;

(B) reduce the volume of new business accepted;

(C) suspend or limit writing new business for a period;

(D) reduce general insurance and commission expenses by specified methods; or

(E) increase the insurer's capital and surplus by contribution; or

(2) suspending or canceling the insurer's certificate of authority.

(d) The commissioner may use the remedies available under Subsection (c) in conjunction with the provisions of Chapter 83 if the commissioner determines that the financial condition of the insurer is hazardous and can be reasonably expected to cause significant and imminent harm to the insurer's policyholders or the public. (V.T.I.C. Art. 1.32, Sec. 2.)

Source Law

Sec. 2. Whenever the financial condition of an insurer when reviewed in conjunction with the kinds and nature of risks insured, the loss experience and ownership of the insurer, the ratio of total annual premium and net investment income to commission expenses, general insurance expenses, policy benefits paid, and required policy reserve increases, its method of operation, its affiliations, its investments, any contracts which lead or may lead to contingent liability, or agreements in respect to guaranty and surety, indicate a condition such that the continued operation of the insurer might be hazardous to its policyholders, creditors, or the general public, then the commissioner may, after notice and hearing, order the insurer to take such action as may be reasonably necessary to rectify the existing condition, including but not necessarily limited to one or more of the following steps:

(a) reduce the total amount of present and potential liability for policy benefits by reinsurance;

(b) reduce the volume of new business being accepted;

(c) reduce general insurance and commission expenses by specified methods;

(d) suspend or limit the writing of new business for a period of time;

(e) increase the insurer's capital and surplus by contribution; or

(f) suspend or cancel the certificate of authority. The commissioner may use the remedies available under this section in conjunction with the provisions of Article 1.10A of this code when the commissioner determines that the financial condition of the insurer is hazardous and can be reasonably expected to cause significant and imminent harm to it policyholders or the general public.

Revisor's Note

Section 2, V.T.I.C. Article 1.32, states that the commissioner of insurance may order an insurer to take any action "as may be reasonably necessary" to remedy the insurer's hazardous financial condition, "including but not necessarily limited to" certain listed actions. The revised law omits the reference to "but not necessarily limited to" for the reason stated in Revisor's Note (1) to Section 404.001.

Revised Law

Sec. 404.004. CONSTRUCTION WITH LAW RELATING TO CAPITAL AND SURPLUS. The commissioner's authority under Section 404.003 to require an increase in an insurer's capital and surplus by contribution, and any capital and surplus requirements imposed by the commissioner under that section, prevail over:

(1) the capital and surplus requirements of:

(A) Sections 822.054, 822.201-822.203, 822.205, 822.210-822.212, 841.054, 841.201, 841.204, 841.205, 841.207, 884.206, 884.308, and 884.309; and

(B) Subchapter G, Chapter 841;

(2) any other provision of this code or other law establishing capital and surplus requirements for insurers; and

(3) any rule adopted under a law described by Subdivision (1) or (2). (V.T.I.C. Art. 1.32, Sec. 2A.)

Source Law

Sec. 2A. The commissioner's authority under Section 2 of this article to require an increase in an insurer's capital and surplus by contribution prevails over the capital and surplus requirements of Articles 2.01, 2.02, 2.20, 3.02, and 22.13 of this code, over any other article of this code or other law establishing capital and surplus requirements for

insurers, or any rules adopted under those articles or laws, and in the event of any conflict between capital and surplus requirements imposed by the commissioner under Section 2 of this article and capital and surplus requirements imposed under Articles 2.01, 2.02, 2.20, 3.02, or 22.13 of this code, any other article of this code or other law establishing capital and surplus requirements for insurers, or any rules adopted under those articles or laws, the capital and surplus requirements imposed by the commissioner under Section 2 of this article prevail.

Revisor's Note

Section 2A, V.T.I.C. Article 1.32, refers to the capital and surplus requirements of V.T.I.C. Articles 2.01, 2.02, 2.20, 3.02, and 22.13. The portions of these articles pertaining to the amount or form of capital and surplus required were revised by Chapter 1419, Acts of the 77th Legislature, Regular Session, 2001, as Sections 822.054, 822.201-822.203, 822.205, 822.210-822.212, 841.054, 841.201, 841.204, 841.205, 841.207, 884.206, 884.308, and 884.309 and Subchapter G, Chapter 841, of this code. The revised law is drafted accordingly.

Revised Law

Sec. 404.005. STANDARDS AND CRITERIA FOR EARLY WARNING. (a) The commissioner by rule may:

(1) establish uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to the insurer's policyholders or creditors or to the public; and

(2) establish standards for evaluating the financial condition of an insurer.

(b) Standards established by the commissioner under this section must be consistent with the purposes of Section 404.003. (V.T.I.C. Art. 1.32, Sec. 3.)

Source Law

Sec. 3. The board is authorized, by rule and regulations, to fix uniform standards and criteria for early warning that the continued operation of an insurer might be hazardous to its policyholders, creditors, or the general public, and to fix standards for evaluating the financial condition of an insurer,

which standards shall be consistent with the purposes expressed in Section 2 of this article.

Revisor's Note

Section 3, V.T.I.C. Article 1.32, refers to certain standards and criteria established by "rule 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. 404.006. AGREEMENT WITH ANOTHER JURISDICTION. The commissioner may enter into an agreement with the insurance regulatory authority of another jurisdiction concerning the management, volume of business, expenses of operation, plans for reinsurance, rehabilitation, or reorganization, and method of operations of, and type of risks to be insured by, an insurer that is:

(1) licensed in the other jurisdiction; and

(2) considered to be in a hazardous financial condition or in need of a specific remedy that may be imposed by the commissioner and the insurance regulatory authority of the other jurisdiction. (V.T.I.C. Art. 1.32, Sec. 4.)

Source Law

Sec. 4. The commissioner is authorized to enter into arrangements or agreements with the insurance regulatory authorities of other jurisdictions concerning the management, volume of business, type of risks to be insured, expenses of operation, plans for reinsurance, rehabilitation, or reorganization, and method of operations of an insurer that is licensed in such other jurisdictions and that is deemed to be in a hazardous financial condition or needful of specific remedies which may be imposed by the commissioner and insurance regulatory authorities of such other jurisdictions.

Revisor's Note

Section 4, V.T.I.C. Article 1.32, refers to "arrangements or agreements." The revised law omits the reference to "arrangements" as unnecessary because

"agreement" includes an arrangement.

Revisor's Note
(End of Subchapter)

The revised law omits as unnecessary Section 5, V.T.I.C. Article 1.32, 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 the statute provides otherwise or unless the statutes are in conflict. The general principle applies to this revision. The omitted law reads:

> Sec. 5. Authority granted by the provisions of this article is in addition to other provisions of law and not in substitution, restriction, or diminution thereof.

[Sections 404.007-404.050 reserved for expansion]

SUBCHAPTER B. IMPAIRMENT OF STOCK OR SURPLUS

Revised Law

Sec. 404.051. IMPAIRMENT PROHIBITED. (a) The impairment of the capital stock of a stock insurance company is prohibited.

(b) Impairment of the following surpluses in excess of that provided by Section 404.053 is prohibited:

(1) the surplus of a stock insurance company; or

(2) the minimum required aggregate surplus of a:

(A) mutual company;

(B) Lloyd's plan; or

(C) reciprocal or interinsurance exchange.

(V.T.I.C. Art. 1.10, Sec. 5 (part).)

Source Law

> Sec. 5. When a Company's Surplus is Impaired. No impairment of the capital stock of a stock company shall be permitted. No impairment of the surplus of a stock company, or of the minimum required aggregate surplus of a mutual, Lloyd's, or reciprocal insurer, shall be permitted in excess of that provided by this section. . . .

Revisor's Note

Section 5, V.T.I.C. Article 1.10, refers to a

"stock company" and a "mutual, Lloyd's, or reciprocal insurer." For consistency with terminology used in this code, the revised law substitutes "stock insurance company" for "stock company," "mutual company" for "mutual . . . insurer," "Lloyd's plan" for "Lloyd's . . . insurer," and "reciprocal or interinsurance exchange" for "reciprocal insurer."

Revised Law

Sec. 404.052. DETERMINATION OF IMPAIRMENT. (a) When determining under this subchapter whether the surplus or the minimum required aggregate surplus of an insurer is impaired, the commissioner shall charge against the insurer:

(1) the reinsurance reserve required by the laws of this state; and

(2) all other debts and claims against the insurer.

(b) This section does not apply to a life insurance company. (V.T.I.C. Art. 1.10, Sec. 5 (part).)

Source Law

Sec. 5. . . . Having charged against a company other than a life insurance company, the reinsurance reserve, as prescribed by the laws of this State, and adding thereto all other debts and claims against the company, the Commissioner shall . . . [if it is determined that the surplus required by Section 822.054, 822.202, 822.203, 822.205, 822.210, 822.211, or 822.212 . . . is impaired . . . or . . . the required aggregate surplus . . . is impaired . . . the Commissioner shall order the company to remedy the impairment] . . . .

Revised Law

Sec. 404.053. REMEDY FOR IMPAIRMENT. (a) The commissioner shall order an insurer to remedy an impairment of the insurer's surplus, aggregate surplus, or aggregate of guaranty fund and surplus, as applicable, by bringing the surplus to an acceptable level specified by the commissioner, or to cease engaging in business in this state, if the commissioner determines that:

(1) the surplus required by Section 822.054, 822.202, 822.203, 822.205, 822.210, 822.211, or 822.212 of a stock insurance

company engaged in the kind of insurance business described by the company's certificate of authority:

(A) is impaired by more than 50 percent; or

(B) is less than the minimum level of surplus required by risk-based capital and surplus rules adopted by the commissioner; or

(2) the required aggregate of guaranty fund and surplus of a Lloyd's plan, or the required aggregate surplus of a reciprocal or interinsurance exchange or of a mutual company, other than a life insurance company, engaged in the kind of insurance business described by the insurer's certificate of authority:

(A) is impaired by more than 25 percent; or

(B) is less than the minimum level of surplus required by risk-based capital and surplus rules adopted by the commissioner.

(b) After issuing an order described by Subsection (a), the commissioner shall immediately institute any proceeding necessary to determine what further actions the commissioner will take in relation to the matter. (V.T.I.C. Art. 1.10, Sec. 5 (part).)

Source Law

> Sec. 5. . . . the Commissioner shall, (i) if it is determined that the surplus required by Section 822.054, 822.202, 822.203, 822.205, 822.210, 822.211, or 822.212 of this code of a stock company doing the kind or kinds of insurance business set out in its Certificate of Authority is impaired to the extent of more than fifty (50%) per cent of the required surplus for a capital stock insurance company, or is less than the minimum level of surplus required by Commissioner promulgated risk-based capital and surplus regulations, or (ii) if it is determined that the required aggregate surplus of a reciprocal or mutual company, or the required aggregate of guaranty fund and surplus of a Lloyd's company, other than a life insurance company, doing the kind or kinds of insurance business set out in its Certificate of Authority is impaired to the extent of more than twenty-five per cent (25%) of the required aggregate surplus, or is less than the minimum level of surplus required by Commissioner promulgated risk-based capital and surplus regulations, the Commissioner shall order the company to remedy the impairment of surplus to acceptable levels specified by the Commissioner or to cease to do business within this State. The Commissioner shall thereupon immediately institute such proceedings as may be necessary to determine what further actions shall be taken in the

case.

Revisor's Note

(1) Section 5, V.T.I.C. Article 1.10, refers to a "stock company," "reciprocal . . . company," and "Lloyd's company." For consistency with terminology used in this code, the revised law substitutes "stock insurance company" for "stock company," "reciprocal or interinsurance exchange" for "reciprocal . . . company," and "Lloyd's plan" for "Lloyd's company."

(2) Section 5, V.T.I.C. Article 1.10, refers to "regulations." The revised law substitutes "rules" for "regulations" because "rules" is the term more commonly used and is the term used by Chapter 2001, Government Code (Administrative Procedure Act). Also, under Section 311.005(5), Government Code (Code Construction Act), applicable to the revised law, a rule is defined to include a regulation. That definition applies to the revised law.

(3) Section 5(ii), V.T.I.C. Article 1.10, which applies to a reciprocal or interinsurance exchange, a mutual company, and a Lloyd's plan, provides an exemption from the operation of Section 5(ii) for a life insurance company. For clarity, the revised law limits the application of the exemption to a mutual company because neither a reciprocal or interinsurance exchange nor a Lloyd's plan is authorized to engage in the business of life insurance in this state.

[Chapters 405-420 reserved for expansion]

SUBTITLE B. RESERVES AND INVESTMENTS

CHAPTER 421. RESERVES IN GENERAL

Sec. 421.001. RESERVES REQUIRED . . . . . 101
Sec. 421.002. CERTIFICATES FROM OTHER STATES . . . . . 102

## CHAPTER 421. RESERVES IN GENERAL

### Revised Law

Sec. 421.001. RESERVES REQUIRED. (a) An insurer shall maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses or claims for which the insurer may be liable and that are:

(1) incurred on or before the date of statement, whether reported or unreported; and

(2) unpaid as of the date of statement.

(b) In addition to the reserves required by Subsection (a), an insurer shall maintain reserves in an amount estimated to provide for the expenses of adjustment or settlement of the losses or claims described by that subsection.

(c) The commissioner shall adopt each current formula recommended by the National Association of Insurance Commissioners for establishing reserves for each line of insurance. Each insurer writing a line of insurance to which a formula adopted under this subsection applies shall establish reserves in compliance with that formula. (V.T.I.C. Art. 21.39.)

### Source Law

> Art. 21.39. Every insurer shall maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses or claims incurred on or prior to the date of statement, whether reported or unreported, which are unpaid as of such date and for which such insurer may be liable, and also reserves in an amount estimated to provide for the expenses of adjustment or settlement of such claims. The Board of Insurance Commissioners shall adopt each current formula for establishing reserves applicable to each line of insurance recommended by the National Association of Insurance Commissioners and all companies writing the line of insurance to which each such adopted formula is applicable shall establish reserves in compliance therewith.

### Revisor's Note

(1) V.T.I.C. Article 21.39 refers to expenses of adjustment or settlement of "such claims." The revised law substitutes "losses or claims" for "such claims" for consistency with other terminology in the article.

(2) V.T.I.C. Article 21.39 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. Throughout this chapter, references to the Board of Insurance Commissioners or the "Board" have been changed appropriately.

Revised Law

Sec. 421.002. CERTIFICATES FROM OTHER STATES. In computing the reserve liability of an insurer, the commissioner may accept the certificate of the officer of another state charged with the duty of supervising the insurer if:

(1) the insurer is organized under the laws of the other state; and

(2) the certificate shows that the reserve liability has been computed in accordance with Section 421.001. (V.T.I.C. Art. 21.40.)

Source Law

Art. 21.40. The Board, in calculating the reserve liability of any such company, may accept the certificate of the officer of any other state charged with the duty of supervising such company as to any such company organized under the laws of such state; provided, such certificate shows that such liability has been computed in accordance with the provisions of Article 21.39 of this code.

Revisor's Note

V.T.I.C. Article 21.40 refers to "any such company" and "such company." The revised law substitutes "insurer" for those references for clarity and consistency of terminology in this chapter. In

context, it is clear that the quoted text in Article 21.40 is intended to refer to the entities for which reserve requirements are established by V.T.I.C. Article 21.39, revised in this chapter as Section 421.001. Article 21.39, as enacted by Chapter 491, Acts of the 52nd Legislature, Regular Session, 1951, referred to "every insurance company" that provided certain coverage for at least 10 years. The article was amended by Chapter 117, Acts of the 54th Legislature, Regular Session, 1955, to refer to "every insurer" without additional qualification. The revised law in this section is drafted accordingly.

CHAPTER 422. ASSET PROTECTION ACT

SUBCHAPTER A. GENERAL PROVISIONS

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CHAPTER 422. ASSET PROTECTION ACT

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 422.001. SHORT TITLE. This chapter may be cited as the Asset Protection Act. (V.T.I.C. Art. 21.39-A, Sec. 1.)

Source Law

Art. 21.39-A
Sec. 1. This article shall be known and may be cited as the Asset Protection Act.

Revised Law

Sec. 422.002. PURPOSES. (a) The purposes of this chapter are to:

(1) require an insurer to maintain unencumbered assets in an amount equal to the insurer's reserve liabilities;

(2) provide preferential claims against assets in favor of an owner, beneficiary, assignee, certificate holder, or third-party beneficiary of an insurance policy; and

(3) prevent the pledge or encumbrance of assets in excess of certain amounts without a prior written order of the commissioner.

(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. 21.39-A, Secs. 2, 6 (part).)

Source Law

> Sec. 2. This Act is for the purpose of requiring insurers to have and maintain unencumbered assets in an amount equal to reserve liabilities; to provide preferential claims against assets in favor of owners, beneficiaries, assignees, certificate holders, or third party beneficiaries of insurance policies; and to prevent the hypothecation or encumbrance of assets in excess of certain amounts without prior written order of the Commissioner of Insurance.
>
> Sec. 6. The provisions of this Act and the powers and functions authorized by this Act are to be exercised to the end that its purposes be accomplished. . . .

Revisor's Note

(1) Section 2, V.T.I.C. Article 21.39-A, provides that a purpose of the article is to require an insurer to "have and maintain" unencumbered assets in a certain amount. The revised law omits "have" as unnecessary because an insurer that maintains assets must necessarily have the assets.

(2) Section 2, V.T.I.C. Article 21.39-A, provides that a purpose of the article is to prevent the "hypothecation or encumbrance" of certain assets.

"Hypothecation" of an asset is a form of a pledge. Subsequent provisions in the article refer to the "pledge" of assets, clearly indicating that a purpose of the article is to prevent the "pledge" of assets, not just the more narrow "hypothecation" of assets. For clarity and consistency of terminology throughout this chapter, the revised law substitutes "pledge" for "hypothecation."

(3) Section 2, V.T.I.C. Article 21.39-A, refers to the "commissioner of insurance." 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. Throughout this chapter, the revised law is drafted accordingly.

Revised Law

Sec. 422.003. DEFINITIONS. In this chapter:

(1) "Asset" means any property in which an insurer owns a legal or equitable interest.

(2) "Claimant" means an owner, beneficiary, assignee, certificate holder, or third-party beneficiary of an insurance benefit or right arising from the coverage of an insurance policy to which this chapter applies.

(3) "Reserve assets" means the assets of an insurer that are authorized investments for policy reserves under this code.

(4) "Reserve liabilities" means the liabilities that an insurer is required under this code to establish for all of the insurer's outstanding insurance policies. (V.T.I.C. Art. 21.39-A, Sec. 4.)

Source Law

Sec. 4. As used in this Act:

1. "Reserve liabilities" are those liabilities which are required to be established by the insurer for all of its outstanding insurance policies in accordance with the Insurance Code, as amended or as hereafter amended;

2. "Reserve assets" are those assets of an

insurer which are authorized investments for policy reserves in accordance with the Insurance Code, as amended or as hereafter amended;

3. "Assets" are all property, real or personal, tangible or intangible, legal or equitable, owned by an insurer;

4. "Claimants" are any owners, beneficiaries, assignees, certificate holders, or third party beneficiaries of any insurance benefit or right arising out of and within the coverage of an insurance policy covered by this Act.

Revisor's Note

(1) Section 4, V.T.I.C. Article 21.39-A, defines "assets" to include "real or personal, tangible or intangible" 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. The revised law omits the reference to "tangible or intangible" as unnecessary because property may only be tangible or intangible.

(2) Section 4, V.T.I.C. Article 21.39-A, refers to the Insurance Code, "as amended or as hereafter amended." The revised law omits the quoted language 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, or amendments of the statute unless expressly provided otherwise.

Revised Law

Sec. 422.004. APPLICABILITY OF CHAPTER. This chapter applies to:

(1) the following domestic insurers:

(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 title insurance company;

(F) a mutual assessment company;

(G) a local mutual aid association;

(H) a local mutual burial association;

(I) a statewide mutual assessment company;

(J) a stipulated premium company;

(K) a fraternal benefit society;

(L) a group hospital service corporation;

(M) a county mutual insurance company;

(N) a Lloyd's plan;

(O) a reciprocal or interinsurance exchange;

(P) a farm mutual insurance company; and

(Q) a mortgage guaranty insurer; and

(2) all kinds of insurance written by an insurer to which this chapter applies. (V.T.I.C. Art. 21.39-A, Sec. 3 (part).)

Source Law

> Sec. 3. This Act shall apply to all of the following types of domestic insurance companies and to all kinds of insurance written by such companies; and where used herein "insurer" shall mean: all domestic stock and mutual life, health and accident, fire, casualty, fire and casualty and title insurance companies, including mutual assessment companies, local mutual aid associations, local mutual burial associations, Statewide mutual assessment companies, stipulated premium insurance companies, fraternal benefit societies, group hospital service insurance companies, county mutual insurance companies, Lloyd's and reciprocal exchanges, farm mutual companies, and mortgage guaranty insurance companies. . . .

Revisor's Note

(1) Section 3, V.T.I.C. Article 21.39-A, lists insurers to which the article applies and states that "where used herein 'insurer' shall mean" those listed insurers. The revised law omits the quoted language as unnecessary. Because the section specifies the types of insurers to which this chapter applies, the defined term is not helpful to the reader.

(2) Section 3, V.T.I.C. Article 21.39-A, refers to "stipulated premium insurance companies," "group hospital service insurance companies," a "Lloyd's," "reciprocal exchanges," "farm mutual companies," and "mortgage guaranty insurance companies," meaning entities operating under Chapter 884, 842, 941, 942, 911, or 3502, respectively. The terms most frequently used to refer to those entities are "stipulated premium company," "group hospital service corporation," "Lloyd's plan," "reciprocal or interinsurance exchange," "farm mutual insurance company," and "mortgage guaranty insurer." For consistent use of terminology in this code, the revised law substitutes "stipulated premium company," "group hospital service corporation," "Lloyd's plan," "reciprocal or interinsurance exchange," "farm mutual insurance company," and "mortgage guaranty insurer" for "stipulated premium insurance companies," "group hospital service insurance companies," a "Lloyd's," "reciprocal exchanges," "farm mutual companies," and "mortgage guaranty insurance companies," respectively.

Revised Law

Sec. 422.005. EXEMPTIONS. (a) This chapter does not apply to:

(1) variable contracts for which separate accounts are required to be maintained;

(2) a reinsurance agreement or any trust account related to the reinsurance agreement if the agreement and trust account meet the requirements of Chapter 492 or 493;

(3) an assessment-as-needed company or insurance coverage written by an assessment-as-needed company;

(4) an insurer while:

(A) the insurer is subject to a conservatorship

order issued by the commissioner; or

(B) a court-appointed receiver is in charge of the insurer's affairs; or

(5) an insurer's reserve assets that are held, deposited, pledged, or otherwise encumbered to secure, offset, protect, or meet the insurer's reserve liabilities established in a reinsurance agreement under which the insurer reinsures the insurance policy liabilities of a ceding insurer if:

(A) the ceding insurer and the reinsurer are authorized to engage in business in this state; and

(B) in accordance with a written agreement between the ceding insurer and the reinsurer, reserve assets substantially equal to the reserve liabilities the reinsurer must establish on the reinsured business are:

(i) deposited by or withheld from the reinsurer and held in the custody of the ceding insurer, or deposited and held in a trust account with a state or national bank domiciled in this state, as security for the payment of the reinsurer's obligations under the reinsurance agreement;

(ii) held subject to withdrawal by the ceding insurer; and

(iii) held under the separate or joint control of the ceding insurer.

(b) Notwithstanding this section, the commissioner may examine any asset, reinsurance agreement, or deposit arrangement described by Subsection (a)(5) at any time, in accordance with the commissioner's authority under this code to examine an insurer. (V.T.I.C. Art. 21.39-A, Secs. 3 (part), 3A.)

Source Law

> Sec. 3. . . . This Act shall not apply to variable contracts for which separate accounts are required to be maintained and shall not apply to assessment as needed companies nor to insurance coverage written by assessment as needed companies. This Act shall not apply to an insurance company while subject to a conservatorship order issued by the Commissioner of Insurance nor to an insurance company while a court appointed receiver is in charge of its

affairs.

Sec. 3A. (a) This Act shall not apply to those reserve assets of an insurer which are held, deposited, pledged, hypothecated, or otherwise encumbered as provided herein to secure, offset, protect, or meet those reserve liabilities of such insurer which are established, incurred, or required under the provisions of a reinsurance agreement whereby such insurer has reinsured the insurance policy liabilities of a ceding insurer, provided:

(1) the ceding insurer and the reinsurer are both licensed to transact business in this state;

(2) pursuant to a written agreement between the ceding insurer and the reinsurer, reserve assets substantially equal to the reserve liabilities required to be established by the reinsurer on the reinsured business are either (a) deposited by or are withheld from the reinsurer and are in the custody of the ceding insurer as security for the payment of the reinsurer's obligations under the reinsurance agreement, and such assets are held subject to withdrawal by and under the separate or joint control of the ceding insurer, or (b) are deposited and held in a trust account for such purpose and under such conditions with a state or national bank domiciled in this state.

(b) The Commissioner of Insurance shall have the right to examine any of such assets, reinsurance agreements, or deposit arrangements at any time in accordance with the authority to make examinations of insurance companies as conferred by other provisions of this code.

(c) This Act does not apply to a reinsurance agreement or any trust account related to the reinsurance agreement if the agreement and trust account meet the requirements of Article 3.10 or 5.75-1 of this code.

Revisor's Note

(1) Section 3A(a), V.T.I.C. Article 21.39-A, refers to certain assets that are "pledged, hypothecated, or otherwise encumbered." Throughout this chapter, the revised law omits "hypothecated" and variants of that term as unnecessary where the terms are used in conjunction with "pledged" and variants of that term because "hypothecated" is included within the meaning of "pledged."

(2) Section 3A(a), V.T.I.C. Article 21.39-A, refers to reserve liabilities of an insurer "which are established, incurred, or required under the provisions of a reinsurance agreement." The revised law omits the references to "incurred" and "required" because, in context, the terms are included in the

meaning of "established."

(3) Section 3A(a)(1), V.T.I.C. Article 21.39-A, refers to a ceding insurer and a reinsurer "licensed to transact business in this state." The revised law substitutes "authorized" for "licensed" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 422.006. CONFLICT WITH OTHER LAW. If this chapter conflicts with another law relating to the subject matter or application of this chapter, this chapter controls. (V.T.I.C. Art. 21.39-A, Sec. 6 (part).)

Source Law

> Sec. 6. . . . in the event of conflict between this Act and any other law relating to the subject matter of this Act or its application, the provisions of this Act shall control.

Revisor's Note

Section 6, V.T.I.C. Article 21.39-A, 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 Act is cumulative of existing laws, but . . . .

[Sections 422.007-422.050 reserved for expansion]

SUBCHAPTER B. ENCUMBRANCE OF ASSETS

Revised Law

Sec. 422.051. RESTRICTIONS ON ENCUMBRANCE OF ASSETS. (a) An insurer shall at all times maintain unencumbered assets in an amount equal to the insurer's reserve liabilities.

(b) An insurer may not pledge or otherwise encumber:

(1) the insurer's assets in an amount that exceeds the

amount of the insurer's capital and surplus; or

(2) more than 10 percent of the insurer's reserve assets.

(c) Notwithstanding any other provision of this section, on application made to the commissioner, the commissioner may issue a written order approving the pledge or encumbrance of an insurer's asset in any amount if the commissioner determines that the pledge or encumbrance will not adversely affect the insurer's solvency. (V.T.I.C. Art. 21.39-A, Sec. 5 (part).)

Source Law

> Sec. 5. Every insurer subject to the provisions of this Act shall at all times have and maintain free and unencumbered assets in an amount equal to its reserve liabilities, and no such insurer shall pledge, hypothecate, or otherwise encumber its assets in an amount in excess of the amount of its capital and surplus; nor shall such insurer pledge, hypothecate or otherwise encumber more than ten per cent (10%) of its reserve assets as herein defined; provided, however, that the Commissioner of Insurance, upon application made to him, may issue a written order approving the hypothecation or encumbrance of any of the assets of such an insurer in any amount upon a finding that such hypothecation or encumbrance will not adversely affect the solvency of such insurer.
>
> . . .

Revisor's Note

(1) Section 5, V.T.I.C. Article 21.39-A, requires an insurer to "have and maintain" assets in a specified amount. The revised law omits the reference to "have" for the reason stated in Revisor's Note (1) to Section 422.002.

(2) Section 5, V.T.I.C. Article 21.39-A, refers to insurers that are "subject to the provisions of this Act." The revised law omits the quoted language as superfluous because Section 3, V.T.I.C. Article 21.39-A, revised in relevant part in this chapter as Section 422.004(1), specifies the insurers to which the article applies. Similar changes have been made throughout this chapter.

(3) Section 5, V.T.I.C. Article 21.39-A, refers

to the "free and unencumbered" assets of an insurer. The revised law omits the reference to "free" because, in context, "free" and "unencumbered" are synonymous, and the latter is more commonly used.

Revised Law

Sec. 422.052. REPORT TO COMMISSIONER. (a) Not later than the 10th day after the date an insurer pledges or otherwise encumbers an asset, the insurer shall report in writing to the commissioner:

(1) the amount and identity of the pledged or encumbered asset; and

(2) the terms of the transaction.

(b) Annually, or more often as required by the commissioner, the insurer shall file with the commissioner a statement sworn to by the insurer's chief executive officer that:

(1) title to assets that equal the amount of the insurer's reserve liabilities and that are not pledged or otherwise encumbered is vested in the insurer;

(2) the only assets of the insurer that are pledged or otherwise encumbered are those identified and reported in the sworn statement, and no other assets of the insurer are pledged or otherwise encumbered; and

(3) the terms of the transaction pledging or otherwise encumbering the assets are those reported in the sworn statement. (V.T.I.C. Art. 21.39-A, Sec. 5 (part).)

Source Law

Sec. 5. . . . Any such insurer which shall pledge, hypothecate, or otherwise encumber any of its assets shall within (10) days thereafter report in writing to the Commissioner of Insurance the amount and identity of the assets so pledged, hypothecated, or encumbered and the terms and conditions of such transaction. In addition, each such insurer shall annually or more often if required by the Commissioner file with the Commissioner a statement sworn to by the chief executive officer of the insurer that (a) title to assets in an amount equal to the reserve liability of the insurer which are not pledged, hypothecated or otherwise encumbered is vested in the insurer, (b) the only assets of the insurer which are pledged, hypothecated or otherwise encumbered are as identified

and reported in such sworn statement and no other assets of the insurer are pledged, hypothecated or otherwise encumbered, and (c) the terms and provisions of any such transaction of pledge, hypothecation, or encumbrance are as reported in such sworn statement.

. . .

Revisor's Note

Section 5, V.T.I.C. Article 21.39-A, refers to "terms and conditions" and "terms and provisions" of a transaction encumbering assets. The revised law omits the references to "conditions" and "provisions" because "conditions" and "provisions" are included in the meaning of "terms."

Revised Law

Sec. 422.053. CLAIMANT LIEN ON CERTAIN ASSETS. (a) A person, corporation, association, or other legal entity that accepts as security for an insurer's debt or other obligation a pledge or encumbrance of an asset of the insurer that is not made in accordance with this chapter is considered to have accepted the asset subject to a superior, preferential, and automatically perfected lien in favor of a claimant of the insurer.

(b) Subsection (a) does not apply to an asset of an insurer in conservatorship or receivership if the commissioner in the conservatorship proceeding, or the court in which the receivership is pending, approves the pledge or encumbrance of the asset. (V.T.I.C. Art. 21.39-A, Sec. 5 (part).)

Source Law

Sec. 5. . . . Any person, corporation, association or legal entity which accepts a pledge, hypothecation or encumbrance of any asset of an insurer as security for a debt or other obligation of such insurer not in accordance with the terms and limitations of this Act shall be deemed to have accepted such asset subject to a superior, preferential and automatically perfected lien in favor of claimants; provided, however, that such superior, preferential and automatically perfected lien in favor of claimants shall not apply to assets of an insurance company in conservatorship or receivership if the Commissioner of Insurance, in the conservatorship proceeding, or the court in which the receivership is pending, approves the pledge, hypothecation or encumbrance of such assets.

. . .

Revisor's Note

Section 5, V.T.I.C. Article 21.39-A, refers to a superior lien "in favor of claimants." For clarity, the revised law adds that the superior lien is in favor of a claimant of the insurer that encumbers the asset to secure an obligation.

Revised Law

Sec. 422.054. PREFERENTIAL CLAIMS ON LIQUIDATION. If an insurer is involuntarily or voluntarily liquidated, a claimant of the insurer has a prior and preferential claim against all assets of the insurer other than the assets that have been pledged or encumbered in accordance with this chapter. All claimants have equal status, and their prior and preferential claim is superior to any claim or cause of action against the insurer by any other person, corporation, association, or legal entity. (V.T.I.C. Art. 21.39-A, Sec. 5 (part).)

Source Law

> Sec. 5. . . . In the event of involuntary or voluntary liquidation of any insurer subject to this Act, claimants of such insurer shall have a prior and preferential claim against all assets of the insurer except those which have been pledged, hypothecated or encumbered in accordance with the terms and limitations of this Act. All claimants shall have equal status and their prior and preferential claim shall be superior to any claim or cause of action against the insurer by any person, corporation, association or legal entity.

Revisor's Note
(End of Chapter)

(1) Section 7, V.T.I.C. Article 21.39-A, states that the article does not apply to a person to whom it cannot apply under the Texas or United States constitution. Under general principles of constitutional law, a Texas statute could not apply to a person to whom the Texas or United States constitution does not allow the law to apply. Therefore, the revised law omits that provision as unnecessary. The omitted law reads:

Sec. 7. This Act 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.

(2) Section 8, V.T.I.C. Article 21.39-A, states that the article is severable. The section 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. Therefore, the revised law omits the provision as unnecessary. The omitted law reads:

Sec. 8. If any provision of this Act or the application thereof to any person or circumstance is held invalid by any court of competent jurisdiction, such invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are declared to be severable.

CHAPTER 423. TRANSACTIONS WITH MONEY AND OTHER ASSETS

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CHAPTER 423. TRANSACTIONS WITH MONEY AND OTHER ASSETS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 423.001. APPLICABILITY OF CHAPTER. (a) This chapter applies to a domestic insurer regulated under this code, including:

(1) a stock company;

(2) a reciprocal or interinsurance exchange;

(3) a Lloyd's plan;

(4) a fraternal benefit society;

(5) a stipulated premium company;

(6) a mutual insurance company of any kind, including:

(A) a statewide mutual assessment company;

(B) a local mutual aid association;

(C) a burial association;

(D) a county mutual insurance company; and

(E) a farm mutual insurance company; and

(7) any other organization or person engaged in the business of insurance.

(b) A provision of this code limiting the regulation of an insurer under this code does not limit the application of this chapter, except that this chapter does not apply to an insurer that is exempted from its application by another statute that cites this chapter. (V.T.I.C. Art. 21.39-B, Sec. 4 (part).)

Source Law

Sec. 4. The provisions of this article are applicable to all domestic insurance companies subject to regulation by the Insurance Code, as amended, and

any provision of exemption or any provision of inapplicability or applicability limiting such regulation in any chapter of the code are not in limitation of the provisions of this article, . . . . As used herein, the term "insurance companies" includes stock companies, reciprocals or inter-insurance exchanges, Lloyds associations, fraternal benefit societies, stipulated premium companies, and mutual companies of all kinds, including state-wide mutual assessment corporations, local mutual aids, burial associations, and county mutual insurance companies and farm mutual insurance companies and all other organizations, corporations, or persons transacting an insurance business, unless such insurance companies are by statute specifically, by naming this article, exempted from the operation of this article.

Revisor's Note

(1) Section 4, V.T.I.C. Article 21.39-B, refers to "reciprocals or inter-insurance exchanges," "Lloyds associations," "mutual companies," "state-wide mutual assessment corporations," and "local mutual aids." The revised law substitutes "reciprocal or interinsurance exchange," "Lloyd's plan," "mutual insurance company," "statewide mutual assessment company," and "local mutual aid association" for those terms, respectively, for consistent use of terminology within this code.

(2) Section 4, V.T.I.C. Article 21.39-B, refers to "organizations, corporations, or persons." The revised law omits "corporation" as included within the meaning of "organization."

Revised Law

Sec. 423.002. AMBIGUITIES AND CONFLICTS WITH OTHER LAW. This chapter controls to the extent of an ambiguity or a conflict between this chapter and another provision of this code. (V.T.I.C. Art. 21.39-B, Sec. 4 (part).)

Source Law

Sec. 4. . . . and in the event of conflict between this article and any other article of the code or in the event of any ambiguity, the provisions of this article shall govern. . . .

Revised Law

Sec. 423.003. RULES. The commissioner may adopt rules

necessary to implement this chapter. (V.T.I.C. Art. 21.39-B, Sec. 3.)

Source Law

Sec. 3. The State Board of Insurance may promulgate such regulations as may be deemed necessary to carry out the provisions of this article.

Revisor's Note

Section 3, V.T.I.C. Article 21.39-B, authorizes the State Board of Insurance to adopt regulations necessary to implement V.T.I.C. Article 21.39-B. 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. In addition, the revised law substitutes "rules" for "regulations" for consistency of terminology throughout this code 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.

[Sections 423.004-423.050 reserved for expansion]

SUBCHAPTER B. TRANSACTIONS WITH MONEY

Revised Law

Sec. 423.051. DEPOSIT AND INVESTMENT OF MONEY. A director, member of a committee, officer, or clerk of a domestic insurer who has the duty to handle or invest the insurer's money may not:

(1) invest the money other than in the corporate name of the insurer, except as provided by Section 423.102;

(2) deposit the money unless the deposit is:

(A) in the corporate name of the insurer;

(B) in a pooling account with one or more affiliates, as described by Section 823.003; or

(C) in accordance with a reinsurance agreement;

(3) borrow the insurer's money;

(4) have any interest in a loan, pledge, security, or property of the insurer, except as a stockholder; or

(5) take or receive for the individual's use a fee, brokerage, commission, gift, or other consideration for, or on account of, a loan made by or on behalf of the insurer. (V.T.I.C. Art. 21.39-B, Sec. 1 (part).)

Source Law

> Sec. 1. Any director, member of a committee, or officer, or any clerk of a domestic company, who is charged with the duty of handling or investing its funds, shall not:
>
> (1) invest such funds, except in the corporate name of such company, . . . ;
>
> (2) deposit such funds except in the corporate name of such company, or in a pooling account with one or more affiliates, or in accordance with a reinsurance agreement;
>
> (3) borrow the funds of such company;
>
> (4) be interested in any way in any loan, pledge, security, or property of such company, except as stockholder; or
>
> (5) take or receive to his own use any fee, brokerage, commission, gift, or other consideration for, or on account of, a loan made by or on behalf of such company.

Revisor's Note

(1) Section 1, V.T.I.C. Article 21.39-B, refers to an insurer's "funds." 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 1(2), V.T.I.C. Article 21.39-B, refers to "affiliates." Section 2, V.T.I.C. Article 21.39-B, revised in pertinent part in this chapter as Section 423.052(a), refers to an insurer's "affiliate, as defined in Article 21.49-1 of this code." V.T.I.C. Article 21.49-1 was revised in pertinent part in Section 823.003 of this code. For the convenience of the reader, the revised law adds a cross-reference to Section 823.003 of this code because it is clear from the context that the reference to "affiliates" in

Section 1(2) and the reference to an "affiliate" in Section 2 both refer to an affiliate described by Section 823.003 of this code.

Revised Law

Sec. 423.052. MONEY HELD IN POOLING ACCOUNT. (a) Only a domestic insurer and an affiliate, as described by Section 823.003, may hold money in a pooling account.

(b) The accounting and operating records and books of the insurer and affiliate must be adequately detailed to identify specific insurance policies and policyholders with the money from premiums received by the insurer that issues the policies. (V.T.I.C. Art. 21.39-B, Sec. 2 (part).)

Source Law

> Sec. 2. If funds of a domestic company are deposited in a pooling account, only the domestic company and its affiliate, as defined in Article 21.49-1 of this code, may hold funds in a pooling account. The accounting and operational records and books of the companies must be adequately detailed to identify specific insurance policies and policyholders with premium funds received by the particular company issuing the insurance. . . .

Revised Law

Sec. 423.053. AUTHORITY TO DEPOSIT MONEY IN ACCOUNT OF REINSURER. A reinsurance agreement between a domestic insurer and an affiliate, as described by Section 823.003, must specifically authorize the deposit of money from premiums to the account of the affiliate that assumes the reinsurance. (V.T.I.C. Art. 21.39-B, Sec. 2 (part).)

Source Law

> Sec. 2. . . . A reinsurance agreement between the domestic company and one or more affiliates must specifically authorize the deposit of premium funds to the account of the affiliate which is assuming the reinsurance.

[Sections 423.054-423.100 reserved for expansion]

SUBCHAPTER C. TRANSACTIONS WITH OTHER ASSETS

Revised Law

Sec. 423.101. DEFINITION. In this subchapter, "clearing corporation" means:

(1) a clearing corporation as defined by Section 8.102(a), Business & Commerce Code; or

(2) a clearance system that:

(A) is organized or operating under the laws of at least one foreign country;

(B) provides for book-entry settlement and custody of internationally traded securities; and

(C) has been organized and in operation for not less than 15 consecutive years. (V.T.I.C. Art. 21.39-B, Sec. 5(b).)

Source Law

(b) As used in this article, a clearing corporation is:

(1) a corporation defined in Section 8.102(c) of the Business & Commerce Code; or

(2) a clearance system that:

(A) is organized or operating under the law of one or more foreign countries;

(B) provides for the book entry settlement and custody of internationally traded securities; and

(C) has been organized and in operation for a period of not less than 15 consecutive years.

Revisor's Note

Section 5(b), V.T.I.C. Article 21.39-B, refers to a clearing corporation defined by "Section 8.102(c) of the Business & Commerce Code." Section 5(b), V.T.I.C. Article 21.39-B, was added by Chapter 267, Acts of the 68th Legislature, Regular Session, 1983. At that time, Section 8.102(c), Business & Commerce Code, defined "clearing corporation." Section 8.102, Business & Commerce Code, was reorganized by Chapter 962, Acts of the 74th Legislature, Regular Session, 1995, and the definition of "clearing corporation" was moved to Section 8.102(a). The revised law is drafted accordingly.

Revised Law

Sec. 423.102. DEPOSIT AND HOLDING OF SECURITIES. (a) A domestic insurer that has securities held in or purchased for the

insurer's general account or separate accounts may deposit the securities or arrange through an agent, broker, or dealer for deposit of the securities with a clearing corporation or in the Federal Reserve book-entry system.

(b) If securities are deposited directly with a clearing corporation or deposited indirectly through a participating custodian bank, certificates representing securities of the same class of the same issuer may be merged and held in bulk, in the name of a nominee of the clearing corporation, with any other securities deposited with the clearing corporation by any person, regardless of the ownership of the securities.

(c) Certificates under Subsection (b) that represent securities of small denominations may be merged into one or more certificates of larger denominations.

(d) The records of an agent, broker, dealer, or member bank through which an insurer holds securities in the Federal Reserve book-entry system and the records of a custodian bank through which an insurer holds securities with a clearing corporation must show that the securities are held for the insurer and show the accounts for which the securities are held.

(e) A bank must enter into a custodial agreement with an insurer to be eligible to act as a participating custodian bank for the insurer under this section. (V.T.I.C. Art. 21.39-B, Sec. 5(a) (part).)

Source Law

> Sec. 5. (a) [A domestic insurance company may . . .] The insurance company may deposit or arrange through its agents, brokers, or dealers for the deposit of securities held in or purchased for its general account or its separate accounts in either a clearing corporation or the Federal Reserve Book Entry System. When securities are deposited with a clearing corporation directly or deposited indirectly through a participating custodian bank, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of nominee of such clearing corporation with any other securities deposited with such clearing corporation by any person, regardless of the ownership of such securities, and certificates representing securities of small denominations may be merged into one or more certificates of larger denominations. The records of

any agent, broker, dealer, or member banks through which an insurance company holds securities in the Federal Reserve Book Entry System and the record of any custodian banks through which an insurance company holds securities in a clearing corporation shall at all times show that such securities are held for such insurance company and for which accounts thereof. To be eligible to act as a participating custodian bank under this subsection, a bank must enter a custodial agreement with the insurance company for which it is to act as a participating custodian bank.

Revisor's Note

Section 5(a), V.T.I.C. Article 21.39-B, states that certain records must "at all times" reflect that certain securities are held for an insurer and reflect the accounts for which the securities are held. The revised law omits "at all times" as unnecessary because, without an express limitation, a requirement that the records reflect the specified information includes the requirement that the records do so at all times.

Revised Law

Sec. 423.103. SECURITIES HELD UNDER CUSTODIAL OR TRUST AGREEMENT. A domestic insurer's securities that are held under a custodial agreement or trust agreement with a bank, Federal Home Loan Bank, or trust company may be issued in the name of a nominee of the bank, Federal Home Loan Bank, or trust company only if the bank, Federal Home Loan Bank, or trust company:

(1) has corporate trust powers;

(2) is authorized to act as a custodian or trustee;

(3) is organized under the laws of the United States or any state of the United States; and

(4) meets one of the following requirements:

(A) is a member of the Federal Reserve System;

(B) is a member of or is eligible to receive deposits that are insured by the Federal Deposit Insurance Corporation;

(C) maintains an account with a Federal Reserve Bank and is subject to supervision and examination by the Board of

Governors of the Federal Reserve System; or

(D) is subject to supervision and examination by the Federal Housing Finance Board. (V.T.I.C. Art. 21.39-B, Sec. 1 (part).)

Source Law

> Sec. 1. [Any director, member of a committee, or officer, or any clerk of a domestic company . . . shall not . . . invest such funds . . .] provided, however, that securities kept under a custodial agreement or trust agreement with a bank, federal home loan bank, or trust company may be issued in the name of a nominee of such bank, federal home loan bank, or trust company if such bank, federal home loan bank, or trust company has corporate trust powers and is duly authorized to act as a custodian or trustee and is organized under the laws of the United States of America or any state thereof and either (i) is a member of the Federal Reserve System, (ii) is a member of or is eligible to receive deposits which are insured by the Federal Deposit Insurance Corporation, (iii) maintains an account with a Federal Reserve Bank and is subject to supervision and examination by the Board of Governors of the Federal Reserve System, or (iv) is subject to supervision and examination by the Federal Housing Finance Board; . . . .

Revisor's Note

Section 1, V.T.I.C. Article 21.39-B, requires certain banks and trust companies to be "duly authorized" to act as custodians or trustees of securities. The revised law omits "duly" as unnecessary because a bank or trust company is authorized to act as a custodian only if the bank or trust company is duly authorized.

Revised Law

Sec. 423.104. PROOF OF OWNERSHIP OF SECURITIES. (a) A domestic insurer may demonstrate ownership of a security through a definitive certificate or in accordance with rules adopted under this section.

(b) The commissioner shall adopt rules under which a domestic insurer may demonstrate ownership of an uncertificated security, as defined by Section 8.102(a), Business & Commerce Code, consistent with common practices of securities exchanges and markets. The rules must establish:

(1) standards for the types of uncertificated securities the insurer may hold;

(2) the manner in which the insurer may demonstrate ownership of the security; and

(3) adequate financial safeguards relating to the ownership of uncertificated securities. (V.T.I.C. Art. 21.39-B, Secs. 5(a) (part), 6.)

Source Law

> Sec. 5. (a) A domestic insurance company may evidence its ownership of securities either through definitive certificates or through uncertificated securities as defined by the Business & Commerce Code and as provided by Section 6 of this article. . . .
>
> Sec. 6. The State Board of Insurance shall adopt rules authorizing a domestic insurance company to demonstrate ownership of an uncertificated security consistent with common practices of securities exchanges and markets. The rules shall establish:
>
> (1) standards for the types of uncertificated securities that may be held;
>
> (2) the manner in which ownership of the security may be demonstrated; and
>
> (3) adequate financial safeguards relating to the ownership of uncertificated securities.

Revised Law

Sec. 423.105. MANDATORY DEPOSIT OF SECURITIES; COMMISSIONER CONTROL. (a) An insurer that is required to deposit securities as a condition of engaging in the business of insurance in this state may deposit the securities with a clearing corporation or in the Federal Reserve book-entry system.

(b) Securities under Subsection (a) are under the commissioner's control and may not be withdrawn by the insurer without the commissioner's approval. (V.T.I.C. Art. 21.39-B, Sec. 5(c) (part).)

Source Law

> (c) Whenever an insurance company is required to deposit securities as a condition of commencing or continuing to do an insurance business in this state, such deposit may be made through the use of a clearing corporation or the Federal Reserve Book Entry System. Securities deposited with a clearing corporation or held in the Federal Reserve Book Entry System and used to meet the deposit requirements under the insurance laws of this state shall be under the control of the commissioner and shall not be withdrawn by the

insurance company without the approval of the commissioner. . . .

Revised Law

Sec. 423.106. REQUIRED EVIDENCE FOR SECURITIES. (a) An insurer that deposits securities under Section 423.105 shall provide evidence to the commissioner to establish that:

(1) the securities are recorded in an account in the name of:

(A) the participating custodian bank or member bank through which the insurer deposits the securities with a clearing corporation or in the Federal Reserve book-entry system; or

(B) the insurer, if the insurer makes the deposit directly with the clearing corporation as a direct participant; and

(2) the records of the participating custodian bank, direct participant, or member bank and of the clearing corporation show that the securities are under the commissioner's control.

(b) Evidence under Subsection (a)(1) must be issued, as applicable, by:

(1) the participating custodian bank;

(2) the member bank; or

(3) the insurer, when the insurer makes the deposit directly with the clearing corporation as a direct participant. (V.T.I.C. Art. 21.39-B, Sec. 5(c) (part).)

Source Law

(c) [Whenever an insurance company is required to deposit securities as a condition of commencing or continuing to do an insurance business in this state, such deposit may be made through the use of a clearing corporation or the Federal Reserve Book Entry System. . . .] Any insurance company making a deposit in this manner shall provide to the commissioner evidence issued by its custodian or member bank through which such insurance company has deposited securities with a clearing corporation or in the Federal Reserve Book Entry System or when making the deposit directly with the clearing corporation as a participant, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian or direct participant or member bank, and shall also provide to the commissioner evidence that the records of the custodian, participant, or member bank and clearing corporation reflect that such securities are held subject to the

order of the commissioner.

Revisor's Note

Section 5(c), V.T.I.C. Article 21.39-B, refers to securities "held subject to the order of the commissioner." The revised law substitutes "under the commissioner's control" for "held subject to the order of the commissioner" for consistency with other terminology used in Section 5(c), revised in this chapter as Section 423.105(b), to describe the securities.

Revised Law

Sec. 423.107. ASSETS DEPOSITED WITH CLEARING CORPORATION. A domestic insurer may deposit assets with a clearing corporation only if:

(1) the insurer is a member of an insurance holding company system that has assets of at least $5 billion, as shown by annual statements of member insurers for the preceding year;

(2) the insurer uses the clearing corporation only as a depository for investments in internationally traded securities;

(3) the insurer's total investment in internationally traded securities under Subdivision (2) does not exceed the insurer's policyholders' surplus; and

(4) the insurer does not use securities deposited with the clearing corporation as security for reinsurance. (V.T.I.C. Art. 21.39-B, Sec. 5(e).)

Source Law

(e) A domestic insurance company may deposit assets in a clearing corporation defined by Subsection (b)(2) of this section only if the insurance company:

(1) is a member of an insurance company holding company system with total assets of at least $5 billion as reflected by annual statements of member companies for the preceding year;

(2) uses that clearing corporation only as a depository for investments in internationally traded securities;

(3) has a total investment in those internationally traded securities that does not exceed the company's policyholders' surplus; and

(4) does not use those securities deposited with that clearing corporation as security for reinsurance.

Revisor's Note

Section 5(e), V.T.I.C. Article 21.39-B, refers to an "insurance company holding company system." The revised law substitutes "insurance holding company system" for the quoted language for consistent use of terminology with Chapter 823 of this code, which regulates that type of system.

Revised Law

Sec. 423.108. LIMITATION ON ASSETS DEPOSITED WITH CLEARING CORPORATION. The commissioner by rule may adopt a reasonable limit on the percentage of a domestic insurer's assets that may be deposited with a clearing corporation. The limit may not exceed five percent of the insurer's total assets, as shown by the insurer's annual statement filed with the department for the year preceding the year for which the limit is adopted. (V.T.I.C. Art. 21.39-B, Sec. 5(d).)

Source Law

(d) The State Board of Insurance by rule may prescribe a reasonable maximum limit on the percentage of a domestic insurance company's assets that may be deposited in a clearing corporation as defined by Subsection (b)(2) of this section, but the maximum limit may not exceed five percent of a company's total assets as reflected by its annual statement filed with the State Board of Insurance for the year preceding the year for which the limit is prescribed.

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## CHAPTER 424. INVESTMENTS FOR CERTAIN INSURERS

### SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 424.001. DEFINITIONS. In this chapter:

(1) "Insurer" means any insurer organized under the laws of this state other than an insurer writing life, health, and accident insurance.

(2) "Minimum capital and surplus" means the minimum amount of capital stock and minimum amount of surplus required of an insurer under Section 822.054 or 822.210.

(3) "Securities valuation office" means the Securities Valuation Office of the National Association of Insurance Commissioners. (V.T.I.C. Art. 2.10, Sec. (e) (part); Art. 2.10-5, Sec. 1(10).)

Source Law

[Art. 2.10]
(e) No company except any writing life, health and accident insurance, organized under the laws of this state, [shall invest its funds over and above its minimum capital and its minimum surplus], as provided in Article 2.02, [except as otherwise provided in this Code, in any other manner than as follows:]
. . . .

[Art. 2.10-5]
Sec. 1. In this article:
. . .
(10) "Securities valuation office" means the Securities Valuation Office of the National Association of Insurance Commissioners.

Revisor's Note

(1) The definition of "insurer" is derived from Section (e), V.T.I.C. Article 2.10, which was part of former V.T.I.C. Chapter 2, as are the other provisions revised in this chapter. It is clear from former

V.T.I.C. Article 2.01, revised in Chapter 822 of this code, that former Chapter 2, including the provisions revised in this chapter, applied to insurers organized under the laws of this state, other than life, health, and accident insurance companies. As a result, it is appropriate to apply the definition of "insurer" derived from Section (e), Article 2.10, throughout this chapter. The revised law is drafted accordingly.

(2) Section (e), V.T.I.C. Article 2.10, refers to "[an insurer's] minimum capital and its minimum surplus, as provided in Article 2.02." The revised law adds a definition of "minimum capital and surplus" for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition. The revised law also substitutes a reference to "Section 822.054 or 822.210" for the reference to "Article 2.02" because the provisions of that article governing minimum capital and surplus are codified in those sections.

Revised Law

Sec. 424.002. INAPPLICABILITY OF CERTAIN LAW. The definition of "state" assigned by Section 311.005, Government Code, does not apply to this chapter. (New.)

Revisor's Note

Section 311.005(7), Government Code (Code Construction Act), defines "state" to include a district, commonwealth, territory, and insular possession of the United States. That definition generally applies to the revised law. However, it is clear that in the provisions of V.T.I.C. Chapter 2, revised in this chapter, the term "state" has a narrower meaning. For example, Section (e), V.T.I.C. Article 2.10, revised in this chapter as Section 424.068, permits an insurer to invest in

"commonwealths, territories or possessions of the United States," but provides additional limitations on those investments that are not provided for investments in states of the United States. The revised law provides that the Code Construction Act definition does not apply in this chapter to ensure that no substantive change is made by the revision of the phrase "state of the United States" in the context of this chapter.

[Sections 424.003-424.050 reserved for expansion]

SUBCHAPTER B. INVESTMENT OF FUNDS IN EXCESS OF MINIMUM CAPITAL AND SURPLUS

Revised Law

Sec. 424.051. GENERAL INVESTMENT AUTHORITY SPECIFIED BY LAW. An insurer may not invest the insurer's funds in excess of minimum capital and surplus, except that an insurer may invest as otherwise authorized by this code. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

> (e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . except as otherwise provided in this Code, in any other manner than as follows:
>
> . . . .

Revised Law

Sec. 424.052. ADDITIONAL GENERAL INVESTMENT AUTHORITY. An insurer may make investments that are not otherwise authorized by this chapter or otherwise authorized by this code for the insurer if:

(1) the investment is not specifically prohibited by law and does not exceed the limits prescribed by this code;

(2) the amount of a single investment under this section does not exceed five percent of the insurer's capital and surplus in excess of the insurer's minimum capital and surplus; and

(3) the aggregate amount of all investments made by the insurer under this section does not exceed five percent of the

insurer's assets. (V.T.I.C. Art. 2.10-1, Sec. (2).)

Source Law

(2) Insurers may make additional investments which are not otherwise permitted by Article 2.08, Article 2.10, or Article 2.10-1 of this code, or which are not otherwise authorized by this code for such insurers, and which investments are not otherwise specifically prohibited by law, or which investments exceed the limits otherwise specified in this code, provided:

(a) The amount of any one such investment may not exceed five percent of the insurer's capital and surplus in excess of the insurer's statutory minimum capital and surplus; and

(b) The aggregate of the investments made under this Subsection (2) may not exceed five per cent of the insurer's assets.

Revisor's Note

(1) Section (2), V.T.I.C. Article 2.10-1, refers to certain investments authorized by "Article 2.08, Article 2.10, or Article 2.10-1 . . . , or . . . otherwise authorized by this code." The revised law substitutes a reference to an investment "otherwise authorized by this chapter or otherwise authorized by this code" and does not specifically reference investments authorized by V.T.I.C. Articles 2.10 and 2.10-1, which are revised in this chapter, or by V.T.I.C. Article 2.08, revised as Section 822.204 of this code, because those references are included within the substituted language. In addition, the provisions revised in this chapter that are not specifically referenced in Section (2) are included in the reference in Section (2) to investments "otherwise authorized by this code."

(2) Section (2)(a), V.T.I.C. Article 2.10-1, refers to an insurer's "statutory minimum capital and surplus." The revised law omits the reference to "statutory" as unnecessary because "minimum capital and surplus" is defined in Section 424.001, for the purposes of this chapter, as the minimum amount of capital stock and minimum amount of surplus required

of an insurer under the relevant statutes.

Revised Law

Sec. 424.053. LIMITATION AS TO SINGLE ISSUER OR BORROWER. (a) Notwithstanding Sections 424.051, 424.056-424.071, and 424.074, the aggregate amount of an insurer's investments in all or any type of securities, loans, obligations, or evidences of indebtedness of a single issuer or borrower, other than investments described by Subsection (c), may not exceed five percent of the insurer's total assets.

(b) For purposes of this section, a single issuer or borrower includes:

(1) the issuer's or borrower's majority-owned subsidiaries;

(2) the issuer's or borrower's parent; or

(3) the majority-owned subsidiaries of the issuer's or borrower's parent.

(c) This section does not apply to:

(1) an authorized investment that:

(A) is a direct obligation of or guaranteed by the full faith and credit of the United States, this state, or a political subdivision of this state; or

(B) is insured by an agency of the United States or this state; or

(2) an investment described by Section 424.061 or 424.063. (V.T.I.C. Art. 2.10, Sec. (g) (part).)

Source Law

(g) Notwithstanding Subsections (a)-(e) of this article:

(1) investment in all or any types of securities, loans, obligations, or evidences of indebtedness of a single issuer or borrower, including the issuer's or borrower's majority-owned subsidiaries or parent or the majority-owned subsidiaries of that parent, other than those authorized investments that either are direct obligations of or are guaranteed by the full faith and credit of the United States of America, this state, or a political subdivision of this state, or are insured by any agency of the United States of America or this state, may not in the aggregate exceed five percent of the insurer's total assets, other than investments described by Subsection

(e)(5) or (e)(7) of this article; and

. . . .

Revisor's Note

Section (g), V.T.I.C. Article 2.10, refers to Section (e), Article 2.10. Section (e) is revised as various sections in this chapter, including as Sections 424.001(1) and (2). Throughout this subchapter, however, the revised law does not include in the revision of references to Section (e) or to Article 2.10 a reference to Sections 424.001(1) and (2) because those sections are definitional provisions that apply by their own terms throughout this chapter, and a reference to those sections is therefore unnecessary.

Revised Law

Sec. 424.054. APPLICABILITY OF PERCENTAGE AUTHORIZATIONS AND LIMITATIONS. (a) The percentage authorizations and limitations established by Sections 424.051, 424.053-424.071, and 424.074 apply only at the time an investment is originally acquired or a transaction is entered into and do not apply to the insurer or the investment or transaction after that time.

(b) An investment, once qualified under a law described by Subsection (a), remains qualified notwithstanding any refinancing, restructuring, or modification of the investment, except that an insurer may not refinance, restructure, or modify an investment solely to circumvent the requirements or limitations of a law described by Subsection (a). (V.T.I.C. Art. 2.10, Sec. (f).)

Source Law

(f) The percentage authorizations and limitations set forth in this article apply only at the time of the original acquisition of an investment or at the time a transaction is entered into and do not thereafter apply to the insurer or the investment or transaction except as provided by this subsection. An investment, once qualified under this article, remains qualified notwithstanding any refinancing, restructuring, or modification of the investment; however, the insurer may not engage in that refinancing, restructuring, or modification solely to circumvent the requirements or limitations of this article.

Revised Law

Sec. 424.055. WAIVER BY COMMISSIONER OF QUANTITATIVE LIMITATIONS. (a) Notwithstanding Sections 424.051, 424.056-424.071, and 424.074, the commissioner may waive a quantitative limitation on any investment authorized by those laws if:

(1) the insurer seeks the waiver before making the investment;

(2) a hearing is held to determine whether the waiver should be granted;

(3) the applicant seeking the waiver establishes that unreasonable or unnecessary loss or harm will result to the insurer if the commissioner denies the waiver;

(4) the excess investment will not have a material adverse effect on the insurer; and

(5) the size of the investment is reasonable in relation to the insurer's assets, capital, surplus, and liabilities.

(b) The commissioner's waiver must be in writing and may treat the resulting excess investment as a nonadmitted asset. (V.T.I.C. Art. 2.10, Sec. (g) (part).)

Source Law

(g) Notwithstanding Subsections (a)-(e) of this article:

. . .

(2) the quantitative limitations regarding any investment authorized by this article may be waived by prior written approval of the commissioner if:

(A) a hearing is held to determine whether approval should be granted;

(B) the applicant seeking approval establishes that unreasonable or unnecessary loss or harm to the insurer will result if approval is withheld;

(C) the excessive investment will not have a material adverse effect on the insurer;

(D) the size of the investment is reasonable in relation to the insurer's assets, capital, surplus, and liabilities; and

(E) the commissioner's prior authorization may treat the resulting excessive investment as an asset not admitted.

Revisor's Note

Section (g)(2), V.T.I.C. Article 2.10, states that the commissioner of insurance may waive the quantitative limitations for certain investments under that article by prior written approval if certain listed conditions are met, including a condition that "the commissioner's prior authorization may treat the resulting excessive investment as an asset not admitted." It is clear from the context that the quoted language is not a condition for granting prior written approval, but rather is a separate grant of authority to the commissioner that results from granting that approval. The revised law is drafted accordingly.

Revised Law

Sec. 424.056. WRITTEN INVESTMENT PLAN. (a) Each insurer's board of directors, or, if the insurer does not have a board of directors, the corresponding authority designated by the insurer's charter, bylaws, or plan of operation, shall adopt a written investment plan consistent with the requirements of:

(1) this chapter;

(2) Sections 822.204, 822.209, 861.258, and 862.002; and

(3) other statutes governing investments by the insurer.

(b) The investment plan must:

(1) specify the diversification of the insurer's investments designed to reduce the risk of large losses, by:

(A) broad categories, such as bonds and real property loans;

(B) kinds, such as government obligations, obligations of business entities, mortgage-backed securities, and real property loans on office, retail, industrial, or residential properties;

(C) quality;

(D) maturity;

(E) type of industry; and

(F) geographical areas, as to both domestic and foreign investments;

(2) balance safety of principal with yield and growth;

(3) seek a reasonable relationship of assets and liabilities as to term and nature; and

(4) be appropriate considering the capital and surplus and the business conducted by the insurer.

(c) At least annually, the board of directors or corresponding authority shall review the adequacy of the investment plan and the implementation of the plan.

(d) An insurer shall maintain the insurer's investment plan in the insurer's principal office and provide the plan to the commissioner or the commissioner's designee on request. The commissioner or the commissioner's designee shall maintain the plan as a privileged and confidential document. The plan is not subject to public disclosure. (V.T.I.C. Art. 2.10, Secs. (a), (b), (c).)

Source Law

Art. 2.10. (a) The board of directors of each insurer, or the corresponding authority designated by the charter, bylaws, or plan of operations of an insurer that does not have a board of directors, shall adopt a written investment plan consistent with the requirements of this article and Articles 2.08, 2.09, 2.10-1, 2.10-2, 2.10-3, 2.10-4, 2.10-5, 6.08, 8.18, and 8.19 of this code and the other applicable statutes governing investments by the insurer. The investment plan must:

(1) specify the diversification of the insurer's investments designed to reduce the risk of large losses, by:

(A) broad categories of investments, such as bonds and real estate loans;

(B) kinds of investments, such as:

(i) obligations of governments or business entities;

(ii) mortgage-backed securities; and

(iii) real estate loans on office, retail, industrial, or residential properties;

(C) quality;

(D) maturity;

(E) type of industry; and

(F) geographical areas, as to both

domestic and foreign investments;

(2) balance the safety of principal with yield and growth;

(3) seek a reasonable relationship of assets and liabilities as to term and nature; and

(4) be appropriate considering the capital and surplus and the business conducted by the insurer.

(b) At least annually, the board of directors or other authority shall review the adequacy of the investment plan and the implementation of the plan.

(c) The insurer shall maintain the investment plan in its principal office and shall provide the plan to the commissioner or the commissioner's designee on request. The commissioner or the commissioner's designee shall maintain the investment plan as a privileged and confidential document, and the plan is not subject to public disclosure.

Revisor's Note

Section (a), V.T.I.C. Article 2.10, refers to the requirements of "this article and Articles 2.08, 2.09, 2.10-1, 2.10-2, 2.10-3, 2.10-4, 2.10-5, 6.08, 8.18, and 8.19 of this code and the other applicable statutes governing investments by the insurer." The revised law substitutes a reference to "this chapter" for the references to Articles 2.10-1, 2.10-2, 2.10-4, and 2.10-5, which are revised in this chapter. Although V.T.I.C. Article 2.10-3A, which is also revised in this chapter, is not referenced in the quoted language, it was enacted by Chapter 1040, Acts of the 76th Legislature, Regular Session, 1999, to regulate transactions previously regulated under Article 2.10-3, which was repealed by that act. Furthermore, Article 2.10-3A is included within the meaning of the reference to "other . . . statutes governing investments by the insurer," and it is therefore appropriate to include a reference to the revision of that article. In addition, the revised law omits the reference to "applicable" with respect to other statutes governing investments by the insurer because a statute governs an investment only if the statute is applicable.

Revised Law

Sec. 424.057. INVESTMENT RECORDS. An insurer shall maintain investment records covering each transaction. The insurer must be able to demonstrate at all times to the department that the insurer's investments are within the limitations imposed by the statutes listed in Section 424.056(a). (V.T.I.C. Art. 2.10, Sec. (d).)

Source Law

> (d) The insurer shall maintain investment records covering each transaction. At all times, the insurer must be able to demonstrate to the department that its investments are within the limitations prescribed by the statutes described by Subsection (a) of this article.

Revised Law

Sec. 424.058. AUTHORIZED INVESTMENTS: FORM OF MINIMUM CAPITAL AND SURPLUS. An insurer may invest the insurer's funds in excess of minimum capital and surplus in any manner authorized by Section 822.204 for investment of the insurer's minimum capital and surplus. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

> (e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:
>
> (1) as provided for the investment of its minimum capital and its minimum surplus in Article 2.08;
>
> . . . .

Revised Law

Sec. 424.059. AUTHORIZED INVESTMENTS: GOVERNMENT OBLIGATIONS. An insurer may invest the insurer's funds in excess of minimum capital and surplus in a bond or other evidence of indebtedness of any state or of Canada or a province of Canada that:

(1) is issued by the authority of law; and

(2) at the time of purchase:

(A) bears interest; and

(B) is not in default as to principal or interest. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

(e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:

. . .

(2) in bonds or other evidences of debt which at the time of purchase are interest-bearing and are issued by authority of law and are not in default as to principal or interest, of any state, Canada, or province of Canada, . . . .

Revised Law

Sec. 424.060. AUTHORIZED INVESTMENTS: STOCK OF NATIONAL OR STATE BANK. (a) An insurer may invest the insurer's funds in excess of minimum capital and surplus in the stock of:

(1) a national bank; or

(2) a state bank of this state whose deposits are insured by the Federal Deposit Insurance Corporation.

(b) Notwithstanding Subsection (a)(2):

(1) not more than 35 percent of the total outstanding stock of a single state bank may be purchased by a single insurer; and

(2) if an insurer has invested the insurer's funds in 35 percent of a state bank's stock under this section, no other insurer may invest funds in the bank's remaining stock. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

(e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:

. . .

(2) . . . or in the stock of any National Bank, in stock of any State Bank of Texas whose deposits are insured by the Federal Deposit Insurance Corporation; provided, however, that if said funds are invested in the stock of a State Bank of Texas that not more than thirty-five per cent (35%) of the total outstanding stock of any one (1) State Bank of Texas may be so purchased by any one (1) insurance company; and provided further, that neither the insurance company whose funds are invested in said bank stock nor any other insurance company may invest its funds in the remaining stock of any such State Bank;

. . . .

Revised Law

Sec. 424.061. AUTHORIZED INVESTMENTS: DEPOSITS IN CERTAIN FINANCIAL INSTITUTIONS. (a) Subject to this section, an insurer

may invest in any type of savings deposit, time deposit, certificate of deposit, NOW account, or money market account in a solvent bank, savings and loan association, or credit union that is organized under the laws of the United States or a state, or in a branch of one of those financial institutions.

(b) An investment under this section must be made in accordance with the laws or regulations applicable to the bank, savings and loan association, or credit union.

(c) The amount of an insurer's deposits in a single bank, savings and loan association, or credit union may not exceed the greater of:

(1) 20 percent of the insurer's capital and surplus;

(2) the amount of federal or state deposit insurance coverage that applies to the deposits; or

(3) 10 percent of the amount of capital, surplus, and undivided profits of the financial institution receiving the deposits. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

> (e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:
>
> . . .
>
> (5) in any type or form of savings deposits, time deposits, certificates of deposit, NOW accounts, and money market accounts in solvent banks, savings and loan associations, credit unions, and branches of those financial institutions, organized under the laws of the United States or of a state, if made in accordance with the laws or regulations applicable to those entities, provided that the amount of the deposits in any one bank, savings and loan association, or credit union may not exceed the greater of:
>
> (A) 20 percent of the insurer's capital and surplus;
>
> (B) the amount of federal or state deposit insurance coverage relating to that deposit; or
>
> (C) 10 percent of the amount of capital, surplus, and undivided profits of the entity receiving the deposits;
>
> . . . .

Revisor's Note

Section (e)(5), V.T.I.C. Article 2.10, refers to any "type or form" of deposit in a financial

institution. The revised law omits the reference to "form" because, in this context, the term is included in the meaning of "type."

Revised Law

Sec. 424.062. AUTHORIZED INVESTMENTS: CERTAIN OBLIGATIONS OF PARTNERSHIP OR CORPORATION. (a) Except as provided by this section, an insurer may invest the insurer's funds in excess of minimum capital and surplus in a stock, bond, debenture, bill of exchange, evidence of indebtedness, other commercial note or bill, or security of any partnership or dividend-paying corporation that:

(1) is incorporated under the laws of the United States, this state, another state, Canada, or a province of Canada;

(2) is solvent at the time of the investment; and

(3) has not defaulted in the payment of any of the partnership's or corporation's obligations during the five years preceding the date of the investment.

(b) Except as provided by Subsection (d), an insurer may invest the insurer's funds in excess of minimum capital and surplus, and all reserves required by law, in a stock, bond, or debenture of any solvent corporation that is incorporated under the laws of the United States, this state, another state, Canada, or a province of Canada.

(c) Funds invested under Subsection (a) may not be invested in the stock of an oil, manufacturing, or mercantile corporation unless the corporation has, at the time of the investment:

(1) a net worth of at least $250,000, if the corporation is organized under the laws of this state; or

(2) a combined capital, surplus, and undivided profits of at least $2.5 million, if the corporation is not organized under the laws of this state.

(d) An insurer may not invest the insurer's funds in:

(1) the insurer's own stock or in any stock on account of which the holders or owners of the stock may be liable for an assessment other than taxes; or

(2) any stock, bond, or other security issued by a corporation with respect to which a majority of the stock having voting powers is directly or indirectly owned by or for the benefit of an officer or director of the insurer, unless the insurer has been in continuous operation for at least five years. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

> (e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:
>
> . . .
>
> (6) in the stocks, bonds, debentures, bills of exchange, evidence of indebtedness, or other commercial notes or bills and securities of any solvent partnership or solvent dividend paying corporation at time of purchase, incorporated under the laws of this state, any other state, the United States, Canada, or any province of Canada, which has not defaulted in the payment of any of its obligations for a period of five (5) years, immediately preceding the date of the investment; provided that:
>
> (A) such funds may not be invested in the stock of any oil, manufacturing or mercantile corporation organized under the laws of this state, unless such corporation has at the time of investment a net worth of not less than $250,000.00 nor in the stock of any oil, manufacturing or mercantile corporation not organized under the laws of this state, unless such corporation has a combined capital, surplus and undivided profits of not less than $2,500,000.00;
>
> (B) any such insurance company may invest its funds over and above its minimum capital stock, its minimum surplus, and all reserves required by law, in the stocks, bonds or debentures of any solvent corporation organized under the laws of this state, any other state, the United States, Canada, or any province of Canada;
>
> (C) no such insurance company shall invest any of its funds in its own stock or in any stock on account of which the holders or owners thereof may, in any event, be or become liable to any assessment, except for taxes; and
>
> (D) no such insurance company shall invest any of its funds in stocks, bonds or other securities issued by a corporation if a majority of the stock having voting powers of such issuing corporation is owned, directly or indirectly, by or for the benefit of one or more officers or directors of such insurance company; provided, however, that this paragraph shall not apply to any insurance company which has been in continuous operation for five (5) years;
>
> . . . .

Revisor's Note

(1) Section (e)(6), V.T.I.C. Article 2.10, authorizes an insurer to invest in certain partnerships or corporations that have not defaulted

in the payment of any obligation during the five years "immediately preceding" the date of the investment. The revised law omits the term "immediately" before "preceding" as unnecessary because in this context, "preceding" means "immediately preceding."

(2) Section (e)(6)(C), V.T.I.C. Article 2.10, refers to investment in stock on account of which the holders or owners of the stock "may, in any event, be or become liable" for any assessment. The revised law substitutes "may be liable" for the quoted language because the meaning of the quoted language is included within the meaning of "may be liable."

Revised Law

Sec. 424.063. AUTHORIZED INVESTMENTS: MUTUAL FUNDS. An insurer may invest the insurer's funds in excess of minimum capital and surplus in shares of a mutual fund engaged in business under the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), as amended, if:

(1) the mutual fund is solvent and has at least $1 million of net assets as of the date of the mutual fund's latest annual or more recent certified audited financial statement; and

(2) the amount of the insurer's investment in a single mutual fund does not exceed 15 percent of the insurer's capital and surplus. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

(e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:

. . .

(7) in shares of mutual funds doing business under the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), as amended, provided that:

(A) mutual funds must be solvent with at least $1,000,000 of net assets as of the date of its latest annual or more recent certified audited financial statement; and

(B) investment in any one mutual fund may not exceed 15 percent of the insurer's capital and surplus;

. . . .

Revised Law

Sec. 424.064. AUTHORIZED INVESTMENTS: REAL PROPERTY. (a) Subject to this section, an insurer may invest the insurer's funds in excess of minimum capital and surplus in real property to the extent authorized by other provisions of this code.

(b) An insurer with admitted assets of more than $500 million may own investment real property other than real property authorized by another provision of this code, or participations in that other investment real property, if the property is materially enhanced in value by:

(1) the construction of durable, permanent-type buildings and other improvements that cost an amount at least equal to the cost of the real property, excluding buildings and improvements at the time the property is acquired; or

(2) the construction, commenced before the second anniversary of the date the real property is acquired, of buildings and improvements described by Subdivision (1).

(c) The amount invested by an insurer in a single investment real property and improvements, or in any interest in real property and improvements, may not exceed five percent of the insurer's admitted assets in excess of $500 million. The total amount invested by an insurer in investment real property and improvements may not exceed 15 percent of the insurer's admitted assets in excess of $500 million.

(d) Except as provided by Section 862.002, an insurer may not own, develop, or hold an equity interest in any residential property or subdivision, single or multiunit family dwelling property, or undeveloped real property to subdivide for or develop residential, single or multiunit family dwellings.

(e) The investment authority granted by this section is in addition to and separate from the investment authority granted by Section 862.002, except that an insurer may not invest in any real property that, when added to properties acquired by the insurer under Section 862.002, would exceed the limitations prescribed by

that section.

(f) An insurer's admitted assets are determined from the insurer's annual statements that are made as of the December 31 that precedes the date of the determination and are filed with the department as required by law. The value of any investment made under this section is subject to the appraisal requirement of Section 862.002. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

(e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:

. . .

(11) in real estate to the extent as elsewhere authorized by this Code; provided that:

(A) any such company with admitted assets in excess of $500,000,000.00 may own other investment real property or participations therein, which must be materially enhanced in value by the construction of durable, permanent type buildings and other improvements costing an amount at least equal to the cost of such real property, exclusive of buildings and improvements at the time of acquisition, or by the construction of such buildings and improvements which must be commenced within two years of the date of acquisition of such real property; however, nothing in this Article shall allow ownership of, development of, or equity interest in any residential property or subdivision, single or multiunit family dwelling property, or undeveloped real estate for the purpose of subdivision for or development of residential, single or multiunit family dwellings, except those properties acquired as provided in Article 6.08 of this Code, and such ownership, development, or equity interests shall be specifically prohibited;

(B) the total amount invested by any such company in all such investment real property and improvements thereof shall not exceed fifteen per cent (15%) of its admitted assets which are in excess of $500,000,000.00; however, the amount invested in any one such property and its improvements or interest therein shall not exceed five per cent (5%) of its admitted assets which are in excess of $500,000,000.00. The admitted assets of the company at any time shall be determined from its annual statements made as of the last preceding December 31 and filed with the department as required by law. The value of any investment made under this Article shall be subject to the appraisal provision set forth in Article 6.08 of this Code;

(C) the investment authority granted by Paragraphs (A) and (B) of this subdivision is in addition to and separate and apart from that granted by Article 6.08 of this Code; however, no such company shall make any investment in such real estate which, when added to those properties described in Article 6.08 of this Code, would be in excess of the limitations provided by Article 6.08 of this Code; and

. . . .

Revisor's Note

(1) Section (e)(11)(B), V.T.I.C. Article 2.10, states that the value of an investment made under "this Article" is subject to the appraisal provision in V.T.I.C. Article 6.08, which is revised as Section 862.002 of this code. The revised law substitutes "this section" for "this Article" because Section 862.002 deals with the appraisal of real property only, and the only part of V.T.I.C. Article 2.10 that relates to investments in real property is revised in this section.

(2) Section (e)(11)(B), V.T.I.C. Article 2.10, provides that the admitted assets of certain insurers "at any time" are determined from the insurer's annual statements that are made as of the December 31 that precedes the date of the determination. The revised law omits the reference to "at any time" because, in the context in which it is used, that reference does not add any substantive effect to the law.

(3) Section (e)(11)(C), V.T.I.C. Article 2.10, refers to investment authority that is "separate and apart" from other investment authority. The revised law omits the reference to "apart" because, in this context, the meaning of that term is included in the meaning of "separate."

Revised Law

Sec. 424.065. ACTING AS REAL ESTATE BROKER OR SALESPERSON PROHIBITED. An insurer defined in Section 822.001 or 822.201 or another insurer specifically made subject to Sections 424.051, 424.053-424.071, and 424.074 may not engage in the business of a broker or salesperson as defined by Chapter 1101, Occupations Code, except that the insurer may hold, improve, maintain, manage, rent, lease, sell, exchange, or convey any of the real property interests legally owned as investments under this code. (V.T.I.C. Art. 2.10,

Sec. (e) (part).)

Source Law

(e) . . .

(11) . . .

(D) the insurance companies defined in Article 2.01 of this Code and other insurers specifically made subject to the provisions of this Article shall not engage in the business of a real estate broker or a real estate salesperson as defined by The Real Estate License Act (Article 6573a, Vernon's Texas Civil Statutes), except that such insurers may hold, improve, maintain, manage, rent, lease, sell, exchange, or convey any of the real property interests legally owned as investments under this Code;

. . . .

Revisor's Note

Section (e)(11)(D), V.T.I.C. Article 2.10, refers to "a real estate broker or a real estate salesperson as defined by The Real Estate License Act (Article 6573a, Vernon's Texas Civil Statutes)." That statute was codified in 2001 as Chapter 1101, Occupations Code. Section 1101.002, Occupations Code, defines the terms "broker" and "salesperson" rather than "real estate broker" and "real estate salesperson." The revised law is drafted accordingly.

Revised Law

Sec. 424.066. AUTHORIZED INVESTMENTS: OBLIGATIONS SECURED BY REAL PROPERTY LOANS. (a) Subject to this section, an insurer may invest the insurer's funds in excess of minimum capital and surplus in a bond, note, or evidence of indebtedness, or a participation in a bond, note, or evidence of indebtedness, that is secured by a valid first lien on real property or a leasehold estate in real property located in the United States or in any state, commonwealth, territory, or possession of the United States.

(b) The amount of an obligation secured by a first lien on real property or a leasehold estate in real property may exceed 90 percent of the value of the real property or leasehold estate only if:

(1) the amount does not exceed 100 percent of the value of the real property or leasehold estate and the insurer or one or

more wholly owned subsidiaries of the insurer owns, in the aggregate, a 10 percent or greater equity interest in the real property or leasehold estate;

(2) the amount does not exceed 95 percent of the value of the real property and:

(A) the property contains only a dwelling designed exclusively for occupancy by not more than four families for residential purposes; and

(B) the portion of the unpaid balance of the obligation that exceeds 90 percent of the value of the real property is guaranteed or insured by a mortgage guaranty insurer authorized to engage in business in this state; or

(3) the amount exceeds 90 percent of the value of the real property only to the extent the obligation is insured or guaranteed by:

(A) this state;

(B) the United States;

(C) the Federal Housing Administration under the National Housing Act (12 U.S.C. Section 1701 et seq.), as amended; or

(D) any other agency or instrumentality of the United States.

(c) The term of an obligation secured by a first lien on a leasehold estate in real property and improvements located on the property may not exceed a period equal to four-fifths of the unexpired term of the leasehold estate, and the obligation must fully amortize during that period. The term of the leasehold estate may not expire sooner than the 10th anniversary of the expiration date of the term of the obligation.

(d) An obligation secured by a first lien on a leasehold estate in real property and improvements located on the property must be payable in equal monthly, quarterly, semiannual, or annual payments of principal plus accrued interest to the date of the principal payment.

(e) An insurer's investment in a single obligation under this section may not exceed 10 percent of the insurer's capital and surplus. An insurer's aggregate investments under this section may not exceed 30 percent of the insurer's assets. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

> (e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:
>
> . . .
>
> (3) in bonds, notes, evidences of indebtedness or participations therein secured by a valid first lien upon real property or leasehold estate therein located in the United States of America, its states, commonwealths, territories, or possessions, provided that:
>
> (A) the amount of any such obligation secured by a first lien upon real property or leasehold estate therein shall not exceed ninety per cent (90%) of the value of such real property or leasehold estate therein, but the amount of such obligation may:
>
> (i) exceed ninety per cent (90%) but shall not exceed one hundred per cent (100%) of the value of such real property or leasehold estate therein if the insurer or one or more wholly owned subsidiaries of the insurer own in the aggregate a ten per cent (10%) or greater equity interest in such real property or leasehold estate therein;
>
> (ii) be ninety-five per cent (95%) of the value of such real property if it contains only a dwelling designed exclusively for occupancy by not more than four families for residential purposes, and the portion of the unpaid balance of such obligation which is in excess of an amount equal to ninety per cent (90%) of such value is guaranteed or insured by a mortgage insurance company licensed to do business in the State of Texas; or
>
> (iii) be greater than ninety per cent (90%) of the value of such real property to the extent the obligation is insured or guaranteed by the United States of America, or an agency or instrumentality thereof, the Federal Housing Administration pursuant to the National Housing Act of 1934, as amended (12 U.S.C. Sec. 1701 et seq.), or the State of Texas; and
>
> (B) the term of an obligation secured by a first lien upon a leasehold estate in real property and improvements situated thereon shall not exceed a period equal to four-fifths (4/5) of the then unexpired term of such leasehold estate, provided that:
>
> (i) the unexpired term of the leasehold estate must extend at least ten (10) years beyond the term of the obligation; and
>
> (ii) each obligation shall be payable in equal monthly, quarterly, semi-annual, or annual payments of principal plus accrued interest to the date of such principal payment, so that under either method of repayment such obligation will fully amortize during a period of time not to exceed four-fifths (4/5) of the then unexpired term of the

security leasehold estate;

(C) the amount of any one such obligation may not exceed ten per cent (10%) of the insurer's capital and surplus; and

(D) the aggregate of investments made under this Subdivision (3) may not exceed thirty per cent (30%) of the insurer's assets;

. . . .

Revisor's Note

Section (e)(3)(A)(ii), V.T.I.C. Article 2.10, refers to a "mortgage insurance company" that is "licensed" to engage in business in this state. The revised law substitutes "mortgage guaranty insurer" for "mortgage insurance company" for consistency with V.T.I.C. Article 21.50, revised as Chapter 3502, which regulates mortgage guaranty insurance. The revised law also substitutes "authorized" for "licensed" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 424.067. AUTHORIZED INVESTMENTS: TRANSPORTATION EQUIPMENT. An insurer may invest the insurer's funds in excess of minimum capital and surplus in:

(1) an adequately secured equipment trust obligation, certificate, or other instrument evidencing an interest in transportation equipment wholly or partly located in the United States; and

(2) a right to receive determined portions of rental, purchase, or other fixed obligatory payments for the use or purchase of the equipment. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

(e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:

. . .

(12) in equipment trust obligations or certificates that are adequately secured or in other adequately secured instruments evidencing an interest in transportation equipment in whole or in part within the United States and a right to receive determined portions of rental, purchase, or other fixed obligatory payments for the use or purchase of the

transportation equipment; and

. . . .

Revised Law

Sec. 424.068. AUTHORIZED INVESTMENTS: INVESTMENT IN FOREIGN JURISDICTION. (a) In addition to the investments in Canada authorized by Sections 424.051, 424.058-424.071, and 424.074 and subject to this section, an insurer may invest the insurer's funds in excess of minimum capital and surplus in an investment in a foreign commonwealth, territory, or possession of the United States, a foreign country other than Canada, or a foreign security originating in one of those commonwealths, territories, possessions, or countries, if:

(1) the investment is similar to investments the insurer is authorized by Sections 424.051, 424.058-424.071, and 424.074 to make within the United States or Canada; and

(2) if a debt obligation, the investment is rated one or two by the securities valuation office.

(b) The aggregate amount of an insurer's investments under Sections 424.051, 424.058-424.071, and 424.074 in a single foreign jurisdiction may not exceed:

(1) as to a foreign jurisdiction that is given a sovereign debt rating of one by the securities valuation office, 10 percent of the insurer's admitted assets; or

(2) as to any other foreign jurisdiction, five percent of the insurer's admitted assets.

(c) The amount of investments made under this section may not exceed the sum of:

(1) the amounts authorized by Section 424.073; and

(2) 20 percent of the insurer's assets.

(d) The combined total of the amount of investments made under this section, the amount of similar investments made within the United States and Canada, and any amounts of investments authorized by Section 424.073 may not exceed any limitation prescribed by Sections 424.051, 424.058-424.071, and 424.074. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

(e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:

. . .

(8) in addition to the investments in Canada authorized in other subdivisions of this subsection, investments in other foreign countries, commonwealths, territories or possessions of the United States, or foreign securities originating in such foreign countries, commonwealths, territories or possessions of the United States, provided that:

(A) such investments are similar to those authorized for investment within the United States or Canada by other provisions of this subsection and, if debt obligations, are rated one or two by the Securities Valuation Office of the National Association of Insurance Commissioners;

(B) the aggregate amount of foreign investments held by the insurer under this subsection in a single foreign jurisdiction does not exceed either 10 percent of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of Securities Valuation Office 1 by the Securities Valuation Office of the National Association of Insurance Commissioners or five percent of its admitted assets as to any other foreign jurisdiction;

(C) such investments when added to the amount of similar investments made within the United States and Canada and any amounts authorized by Article 2.10-2 of this Code do not result in the combined total of such investments exceeding the limitations specified elsewhere in this subsection; and

(D) such investments may not exceed the sum of:

(i) the amounts authorized by Article 2.10-2 of this Code; and

(ii) 20 percent of the insurer's assets;

. . . .

Revised Law

Sec. 424.069. AUTHORIZED INVESTMENTS: CERTAIN LOANS. An insurer may invest the insurer's funds in excess of minimum capital and surplus in a loan on the pledge of any mortgage, stock, bond, or other evidence of indebtedness acceptable as an investment under Sections 424.051, 424.053-424.071, and 424.074, if the current value of the mortgage, stock, bond, or other evidence of indebtedness is at least 25 percent more than the amount of the loan. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

(e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:

. . .

(9) in loans upon the pledge of any mortgage, stock, bonds or other evidence of indebtedness acceptable as investments under the terms of this Article, if the current value of such mortgage, stock, bonds or other evidence of indebtedness is at least twenty-five per cent (25%) more than the amount loaned thereon;

. . . .

Revised Law

Sec. 424.070. AUTHORIZED INVESTMENTS: OBLIGATIONS OF LOCAL GOVERNMENTAL ENTITIES. (a) Subject to this section, an insurer may invest the insurer's funds in excess of minimum capital and surplus in a bond or other interest-bearing evidence of indebtedness of a:

(1) county or subdivision of a county;

(2) municipality;

(3) road district;

(4) turnpike district or authority;

(5) water district;

(6) school district;

(7) sanitary or navigation district; or

(8) municipally owned revenue water system, sewer system, or electric utility company with respect to which the municipality has appropriated, pledged, or otherwise provided for special revenues to meet the principal and interest payments of the bond or other evidence of indebtedness.

(b) A bond or other evidence of indebtedness of a navigation district is an authorized investment under this section only if:

(1) the navigation district is located wholly or partly in a county that has a population of at least 100,000; and

(2) the interest due on the bond or other evidence of indebtedness has never been in default. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

(e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:

. . .

(4) in bonds or other interest-bearing evidences of debt of any county, municipality, road district, turnpike district or authority, water district, any subdivision of a county, incorporated city, town, school district, sanitary or navigation

district, any municipally owned revenue water system, sewer system or electric utility company where special revenues to meet the principal and interest payments of such municipally owned revenue water system, sewer system or electric utility company bonds or other evidences of debt shall have been appropriated, pledged or otherwise provided for by such municipality, provided that:

(A) before bonds or other evidences of debt of navigation districts shall be eligible investments such navigation district shall be located in whole or in part in a county containing a population of not less than 100,000 according to the last preceding Federal Census; and

(B) the interest due on such navigation bonds or other evidences of debt of navigation districts must never have been defaulted;

. . . .

Revisor's Note

(1) Section (e)(4), V.T.I.C. Article 2.10, lists certain entities, including a "municipality, . . . incorporated city, [or] town." The revised law omits the references to "incorporated city" and "town" as included within the meaning of "municipality."

(2) Section (e)(4), V.T.I.C. Article 2.10, describes a population number that is to be determined according to the most recent federal census. The revised law omits the reference to the federal census as unnecessary because Section 311.005(3), Government Code (Code Construction Act), applicable to the revised law, and Section 312.011(20), Government Code, define "population" as population according to the most recent federal decennial census.

Revised Law

Sec. 424.071. AUTHORIZED INVESTMENTS: THE UNIVERSITY OF TEXAS. An insurer may invest the insurer's funds in excess of minimum capital and surplus in an interest-bearing note or bond of The University of Texas issued under the laws of this state. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

(e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:

. . .

(10) in interest-bearing notes or bonds of

The University of Texas issued under the laws of this state;

. . . .

Revised Law

Sec. 424.072. AUTHORIZED INVESTMENTS: BONDS ISSUED, ASSUMED, OR GUARANTEED IN INTERNATIONAL MARKET. An insurer may invest the insurer's funds in excess of minimum capital and surplus in bonds issued, assumed, or guaranteed by any of the following international financial institutions in which the United States is a member:

(1) the Inter-American Development Bank;

(2) the International Bank for Reconstruction and Development (the World Bank);

(3) the African Development Bank;

(4) the Asian Development Bank; or

(5) the International Finance Corporation. (V.T.I.C. Art. 2.10-1, Sec. (1).)

Source Law

Art. 2.10-1. (1) In addition to the securities authorized as investments in Article 2.10, a company may also invest its funds over and above its minimum capital and minimum surplus, as provided in Article 2.02, in bonds, issued, assumed, or guaranteed by certain international financial institutions in which the United States is a member, to wit: the Inter-American Development Bank, the International Bank for Reconstruction and Development (the World Bank), the African Development Bank, the Asian Development Bank, and the International Finance Corporation.

Revisor's Note

(1) Section (1), V.T.I.C. Article 2.10-1, authorizes an insurer to make certain investments "[i]n addition to the securities authorized as investments in Article 2.10." The revised law omits the quoted language as unnecessary 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.

(2) Section (1), V.T.I.C. Article 2.10-1, authorizes an insurer to invest its funds in excess of its minimum capital and surplus "as provided in Article 2.02," the relevant parts of which are codified as Sections 822.054 and 822.210 of this code. The revised law omits the reference to Article 2.02 as unnecessary because Section 424.001 defines "minimum capital and surplus" for purposes of this chapter to mean the minimum amount of capital stock and minimum amount of surplus required of an insurer under those sections.

Revised Law

Sec. 424.073. AUTHORIZED INVESTMENTS: INSURER ENGAGED IN BUSINESS IN FOREIGN COUNTRY. (a) Subject to this section, an insurer authorized by the law of a foreign country to engage in a line of insurance in which the insurer is authorized to engage in this state may invest in foreign securities originating in the foreign country of the same kind as the domestic securities originating in the United States in which the insurer is authorized to invest under Sections 424.051, 424.053-424.071, and 424.074.

(b) The aggregate amount of an insurer's investments made under this section in a single country may not exceed by more than 10 percent at any time the lesser of:

(1) the amount of funds required by the law of the foreign country to be maintained in securities originating in that country; or

(2) the amount of total unearned premium reserves, reinsurance reserves, loss reserves, and any other liabilities required by the law of this state to be carried by the insurer that are directly attributable to the particular insurance policies or contracts on residents or property located in the foreign country.

(c) This section does not authorize an insurer to invest in a foreign security originating in a foreign country with respect to which the president of the United States or other federal authority

has refused to exercise the authority to issue guarantees on projects in the country to citizens or corporations of the United States against loss by reason of inconvertibility of currency, expropriation, confiscation, war, revolution, or insurrection because the foreign country has failed to enter into arrangements for the security of American property as required by the president or other federal authority for the issuance of those guarantees. (V.T.I.C. Art. 2.10-2.)

Source Law

> Art. 2.10-2. In addition to the securities authorized as investments by Article 2.10 of the Insurance Code, any insurer subject to the provisions of Article 2.10 of the Insurance Code that is authorized by the law of a foreign country to engage in a line or lines of insurance which the insurer is authorized to transact in this state may invest in the same kinds of foreign securities originating in such foreign country as would be authorized by Article 2.10 of the Insurance Code (as the same now exists or may be amended in the future) for domestic securities originating in the United States of America; provided, however, that the aggregate investment made under the provisions of this Article in any one country shall not exceed by more than 10% at any time the lesser of the following amounts:
>
> (a) The funds required by the law of the foreign country to be maintained in securities originating in such country.
>
> (b) The total unearned premium reserves, reinsurance reserves, loss reserves and other liabilities, if any, required by the law of this state to be carried by the insurer that are directly attributable to the particular policies or contracts of insurance on residents or property located in the foreign country.
>
> Provided, however, this Article shall not constitute authority to invest in foreign securities originating in any foreign country where the President of the United States or other federal authority is authorized but has refused to issue on projects in the country guarantees to citizens or corporations of the United States of America guaranteeing against loss by reason of inconvertibility of currency, expropriation, confiscation, war, revolution or insurrection because of the omission or failure of such foreign country to enter into arrangements for the security of American property required by the federal authority for the issuance of such guarantees.

Revisor's Note

(1) V.T.I.C. Article 2.10-2 authorizes an insurer to make certain investments "[i]n addition to the securities authorized as investments by Article 2.10 of the Insurance Code." The revised law omits the

quoted language as unnecessary for the reason stated in Revisor's Note (1) to Section 424.072.

(2) V.T.I.C. Article 2.10-2 refers to V.T.I.C. Article 2.10 "as the same now exists or may be amended in the future." The revised law omits this language as unnecessary because Section 311.027, Government Code (Code Construction Act), applicable to the revised law, provides that "[u]nless expressly provided otherwise, a reference to any portion of a statute or rule applies to all reenactments, revisions, or amendments of the statute or rule."

(3) V.T.I.C. Article 2.10-2 refers to the "omission or failure" of a foreign country to enter into arrangements for the security of American property. The revised law omits the reference to "omission" because in the context in which the term is used, its meaning is included within the meaning of "failure."

Revised Law

Sec. 424.074. OTHER SPECIFICALLY AUTHORIZED INVESTMENTS. An insurer may invest the insurer's funds in excess of minimum capital and surplus in:

(1) a savings account as authorized by Chapter 65, Finance Code;

(2) a bond or other indebtedness as authorized by Sections 435.045 and 435.046, Government Code;

(3) a bond issued under Subchapter B, Chapter 1505, Government Code;

(4) a bond as authorized by Subchapter B, Chapter 284, Transportation Code;

(5) a municipal bond issued under Sections 51.038 and 51.039, Water Code;

(6) an insured account or evidence of indebtedness as authorized by Section 1, Chapter 160, General Laws, Acts of the 43rd

Legislature, Regular Session, 1933 (Article 842a, Vernon's Texas Civil Statutes);

(7) an insured or guaranteed obligation as authorized by Chapter 230, Acts of the 49th Legislature, Regular Session, 1945 (Article 842a-1, Vernon's Texas Civil Statutes);

(8) a bond issued under Section 1, Chapter 1, page 427, General Laws, Acts of the 46th Legislature, Regular Session, 1939 (Article 1269k-1, Vernon's Texas Civil Statutes);

(9) a bond as authorized by Section 24, Chapter 110, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-133, Vernon's Texas Civil Statutes);

(10) a bond as authorized by Section 19, Chapter 340, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-137, Vernon's Texas Civil Statutes);

(11) a bond as authorized by Section 10, Chapter 398, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-138, Vernon's Texas Civil Statutes);

(12) a bond as authorized by Section 18, Chapter 465, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-139, Vernon's Texas Civil Statutes); or

(13) another investment specifically authorized by law. (V.T.I.C. Art. 2.10, Sec. (e) (part).)

Source Law

(e) No company . . . shall invest its funds over and above its minimum capital and its minimum surplus . . . in any other manner than as follows:

. . .

(13) in:

(A) insured accounts and evidences of indebtedness as defined and limited by Section 1, Chapter 618, page 1356, Acts of the 47th Legislature;

(B) shares or share accounts as authorized by Chapter 65, Finance Code;

(C) insured or guaranteed obligations as authorized in Chapter 230, Acts of the 49th Legislature, Regular Session, 1945 (Article 842a-1, Vernon's Texas Civil Statutes);

(D) bonds issued under the provisions authorized by Section 9, Chapter 231, General Laws, Acts of the 43rd Legislature, Regular Session, 1933 (Article 1187a, Vernon's Texas Civil Statutes);

(E) bonds issued under the authority of Section 1, Chapter 1, page 427, General Laws, Acts of the 46th Legislature, Regular Session, 1939

(Article 1269k-1, Vernon's Texas Civil Statutes);

(F) bonds and other indebtedness as authorized by Sections 435.045 and 435.046, Government Code;

(G) "Municipal Bonds" issued under Sections 51.038 and 51.039, Water Code;

(H) bonds as authorized by Subchapter B, Chapter 284, Transportation Code;

(I) bonds as authorized by Section 19, Chapter 340, Acts of the 51st Legislature, Regular Session, 1949;

(J) bonds as authorized by Section 10, Chapter 398, Acts of the 51st Legislature, Regular Session, 1949;

(K) bonds as authorized by Section 18, Chapter 465, Acts of the 51st Legislature, Regular Session, 1949;

(L) bonds as authorized by Section 24, Chapter 110, Acts of the 51st Legislature, Regular Session, 1949; and

(M) such other investments as are now or may hereafter be specifically authorized by law.

Revisor's Note

(1) Section (e)(13)(A), V.T.I.C. Article 2.10, refers to an insured account or evidence of indebtedness "as defined and limited by Section 1, Chapter 618, page 1356, Acts of the 47th Legislature." The revised law substitutes a reference to an insured account or evidence of indebtedness "as authorized by Section 1, Chapter 160, General Laws, Acts of the 43rd Legislature, Regular Session, 1933 (Article 842a, Vernon's Texas Civil Statutes)" for the following reasons. Section 1, Chapter 618, page 1356, Acts of the 47th Legislature, includes provisions that amend statutes originally enacted by Section 1, Chapter 160, General Laws, Acts of the 43rd Legislature, Regular Session, 1933 (Article 842a, Vernon's Texas Civil Statutes). A cite to the original enactment includes any subsequent revision of the cited statutes and clarifies in which articles those statutes are found in Vernon's Texas Civil Statutes.

(2) Section (e)(13)(B), V.T.I.C. Article 2.10, refers to "shares or share accounts" as authorized by Chapter 65, Finance Code. The revised law substitutes a reference to a "savings account" because that is the

term currently used by Chapter 65, Finance Code.

(3) Section (e)(13)(D), V.T.I.C. Article 2.10, refers to a bond "issued under the provisions authorized by Section 9, Chapter 231, General Laws, Acts of the 43rd Legislature, Regular Session, 1933 (Article 1187a, Vernon's Texas Civil Statutes)." That statute was codified in 1999 as Subchapter B, Chapter 1505, Government Code. The revised law is drafted accordingly.

(4) Sections (e)(13)(I)-(L), V.T.I.C. Article 2.10, refer to certain bonds as authorized by various provisions adopted during the Regular Session of the 51st Legislature in 1949. The revised law adds cites to the articles in which those laws are found in Vernon's Texas Civil Statutes.

(5) Section (e)(13)(M), V.T.I.C. Article 2.10, refers to "such other investments as are now or may hereafter be specifically authorized by law." The revised law omits "as are now or may hereafter be" as unnecessary. 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. Consequently, for purposes of the law revised in this section, an investment will be considered "authorized by law" regardless of whether the investment is authorized at the time this revision takes effect or is authorized by subsequent legislation.

[Sections 424.075-424.100 reserved for expansion]

SUBCHAPTER C. INVESTMENT POOLS

Revised Law

Sec. 424.101. DEFINITIONS. In this subchapter:

(1) "Business entity" means an association,

corporation, joint stock company, joint venture, limited liability company, mutual fund trust, partnership, or other similar form of business organization, regardless of whether organized for profit.

(2) "Obligation" means:

(A) a bond, note, debenture, trust certificate, including an equipment certificate, or production payment;

(B) a negotiable bank certificate of deposit, bankers' acceptance, credit tenant loan, or other loan secured by financing net leases; or

(C) any other evidence of indebtedness for the payment of money or participation certificates or other evidences of an interest in an obligation otherwise described by this subdivision, whether constituting a general obligation of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment.

(3) "Qualified bank" means a national bank, state bank, or trust company that:

(A) is at all times adequately capitalized as determined by the standards adopted by the United States banking regulators; and

(B) is either a member of the Federal Reserve System or regulated by state banking laws.

(4) "Repurchase transaction," "reverse repurchase transaction," and "securities lending transaction" have the meanings assigned by Section 424.151. (V.T.I.C. Art. 2.10-5, Secs. 1(1), (5), (6), (7), (8), (9).)

Source Law

Art. 2.10-5
Sec. 1. In this article:
(1) "Business entity" means a corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund trust, or other similar form of business organization, whether organized as for-profit or not-for-profit.

(5) "Obligation" means:
(A) a bond, note, debenture, trust certificate (including an equipment certificate), or production payment;
(B) a negotiable bank certificate of

deposit, bankers' acceptance, credit tenant loan, or other loan secured by financing net leases; or

(C) any other evidence of indebtedness for the payment of money or participation certificates or other evidences of an interest in an obligation described by this subdivision, whether constituting a general obligation of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment.

(6) "Qualified bank" means a national bank, state bank, or trust company that at all times is adequately capitalized as determined by the standards adopted by the United States banking regulators and that is either regulated by state banking laws or a member of the Federal Reserve System.

(7) "Repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period or on demand.

(8) "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the securities sold or equivalent securities from the business entity at a specified price, either within a specified period or on demand.

(9) "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period or on demand.

Revisor's Note

Sections 1(7), (8), and (9), V.T.I.C. Article 2.10-5, define the terms "repurchase transaction," "reverse repurchase transaction," and "securities lending transaction." V.T.I.C. Article 2.10-3A, which regulates those activities, provides substantively identical definitions for those terms in Sections 1(2), (3), and (4), revised in this chapter in Section 424.151. Consequently, for clarity and consistency, the revised law simply states that in this subchapter, the defined terms have the meanings assigned by Section 424.151.

Revised Law

Sec. 424.102. AUTHORITY TO INVEST IN POOL. An insurer may acquire investments and participate in an investment pool that is qualified under Section 424.103(b) and the investments of which are limited to investments authorized for:

(1) a short-term investment pool under Section 424.104; or

(2) an authorized investment pool under Section 424.107. (V.T.I.C. Art. 2.10-5, Sec. 2.)

Source Law

Sec. 2. An insurer may acquire investments and participate in an investment pool that is qualified under Section 5 of this article and the investments of which are limited to investments authorized for a short-term investment pool under Section 3 of this article or for an authorized investment pool under Section 4 of this article.

Revisor's Note

(1) Section 2, V.T.I.C. Article 2.10-5, refers to an investment pool "qualified under Section 5" of that article. Section 5 is revised in various sections in this subchapter. Section 424.103(b) lists the requirements for an investment pool to be qualified and includes requirements that the pool manager and pooling agreement comply with this subchapter, the provisions of which are derived from the remaining portions of Section 5 and specify requirements for serving as the pool manager and for terms of the pooling agreement. Therefore, the revised law substitutes a reference to "Section 424.103(b)" for the reference to "Section 5."

(2) Section 2, V.T.I.C. Article 2.10-5, refers to investments authorized for a short-term investment pool under "Section 3" of that article. Section 3 of that article is revised in Sections 424.104, 424.105, and 424.106. However, Section 424.104 requires compliance with Sections 424.105 and 424.106. Therefore, the revised law substitutes a reference to "Section 424.104" for the reference to "Section 3."

Revised Law

Sec. 424.103. INVESTMENT POOL REQUIREMENTS AND QUALIFICATIONS. (a) An investment pool must be a business entity.

(b) To be qualified, an investment pool must:

(1) have a written pooling agreement and a pool manager that comply with the requirements of this subchapter; and

(2) comply with Subsection (c).

(c) The investment pool may not:

(1) acquire securities issued, assumed, guaranteed, or insured by the investing insurer or an affiliate of the investing insurer;

(2) borrow or incur indebtedness for borrowed money, except for securities lending and reverse repurchase transactions that meet the requirements of this subchapter; or

(3) permit the aggregate value of securities loaned or sold to, purchased from, or invested in a single business entity at the time of the loan, sale, purchase, or investment to exceed 10 percent of the pool's total assets. (V.T.I.C. Art. 2.10-5, Secs. 5(a), (b), (c), 6(a).)

Source Law

Sec. 5. (a) To be qualified, an investment pool must comply with the requirements established under this section.

(b) The investment pool may not:

(1) acquire securities issued, assumed, guaranteed, or insured by the investing insurer or an affiliate of the investing insurer;

(2) borrow or incur an indebtedness for borrowed money, except for securities lending and reverse repurchase transactions that meet the requirements of this article; or

(3) permit the aggregate value of securities then loaned or sold to, purchased from, or invested in any one business entity under this section to exceed 10 percent of the total assets of the investment pool.

(c) The investment pool shall have a written pooling agreement.

Sec. 6. (a) An investment pool must be a business entity.

Revisor's Note

Section 5(a), V.T.I.C. Article 2.10-5, requires an investment pool to "comply with the requirements established under this section." Those requirements are revised in part in provisions of this subchapter that pertain to pooling agreement and pool manager

requirements and in part in Subsections (b) and (c) of this section. The revised law is drafted accordingly.

Revised Law

Sec. 424.104. AUTHORIZED INVESTMENTS FOR SHORT-TERM INVESTMENT POOL. A short-term investment pool may contain only:

(1) obligations described by Section 424.105;

(2) money market funds described by Section 424.106; or

(3) repurchase, reverse repurchase, and securities lending transactions that meet the requirements of Subchapter D. (V.T.I.C. Art. 2.10-5, Sec. 3(a) (part).)

Source Law

> Sec. 3. (a) A short-term investment pool may contain only:
>
> (1) . . . obligations that are rated one or two by the securities valuation office . . . and that have a remaining maturity of:
>
> . . .
>
> (2) government money market mutual funds or class one money market mutual funds; or
>
> (3) securities lending, repurchase, and reverse repurchase transactions that meet the requirements imposed under Article 2.10-3 of this code.

Revisor's Note

Section 3(a)(3), V.T.I.C. Article 2.10-5, refers to certain transactions that meet the requirements of "Article 2.10-3 of this code." V.T.I.C. Article 2.10-3 was repealed by Chapter 1040, Acts of the 76th Legislature, Regular Session, 1999. That legislation also added V.T.I.C. Article 2.10-3A to regulate the transactions previously regulated under Article 2.10-3. Consequently, the revised law substitutes a reference to the subchapter in which V.T.I.C. Article 2.10-3A is revised for the reference to V.T.I.C. Article 2.10-3.

Revised Law

Sec. 424.105. SHORT-TERM INVESTMENT POOL: CERTAIN SHORT-TERM OBLIGATIONS. (a) Obligations contained in a short-term

investment pool must meet the requirements of this section.

(b) The obligations must:

(1) have a rating by the securities valuation office of one or two, or an equivalent rating issued by a nationally recognized statistical rating organization recognized by the securities valuation office; or

(2) be issued by an issuer with outstanding obligations that have a rating described by Subdivision (1).

(c) The obligations must have:

(1) a remaining maturity of 397 days or less or a put that:

(A) entitles the holder to receive the principal amount of the obligation; and

(B) may be exercised through maturity at specified intervals not exceeding 397 days; or

(2) a remaining maturity of three years or less and a floating interest rate that resets at least quarterly on the basis of a current short-term index and is not subject to a maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes.

(d) For purposes of this section, a current short-term index is:

(1) a federal funds rate;

(2) the prime rate;

(3) the rate for treasury bills;

(4) the London InterBank Offered Rate; or

(5) the rate for commercial paper. (V.T.I.C. Art. 2.10-5, Secs. 3(a) (part), (b), (c).)

Source Law

Sec. 3. (a) A short-term investment pool may contain only:

(1) except as provided by Subsection (b) of this section, obligations that are rated one or two by the securities valuation office or that have a rating equivalent to a securities valuation office rating of one or two made by a statistical rating organization that is nationally recognized and recognized by the securities valuation office and that

have a remaining maturity of:

(A) 397 days or less or a put that entitles the holder to receive the principal amount of the obligation and that may be exercised through maturity at specified intervals not exceeding 397 days; or

(B) three years or less and a floating interest rate that resets not less frequently than quarterly on the basis of a current short-term index acceptable under Subsection (c) of this section and is not subject to a maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes;

. . . .

(b) In the absence of a one or two rating or equivalent rating, the issuer of an obligation under Subsection (a)(1) of this section must have outstanding obligations rated one or two by the securities valuation office or that have a rating equivalent to a securities valuation office rating of one or two made by a nationally recognized statistical rating organization recognized by the securities valuation office.

(c) For purposes of this section, a current short-term index is:

(1) a federal funds rate;

(2) the prime rate;

(3) the rate for treasury bills;

(4) the London InterBank Offered Rate; or

(5) the rate for commercial paper.

Revised Law

Sec. 424.106. SHORT-TERM INVESTMENT POOL: CERTAIN MONEY MARKET FUNDS. A short-term investment pool may contain a money market fund as described by 17 C.F.R. Section 270.2a-7 under the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), as amended, that is:

(1) a government money market fund that at all times:

(A) invests only in obligations issued, guaranteed, or insured by the United States or collateralized repurchase agreements composed of those obligations; and

(B) qualifies for investment without a reserve under the Purposes and Procedures Manual of the securities valuation office or a successor publication; or

(2) a class one money market fund that at all times qualifies for investment using the bond class one reserve factor described by the Purposes and Procedures Manual of the securities valuation office. (V.T.I.C. Art. 2.10-5, Secs. 1(2), (3), (4), 3(a) (part).)

Source Law

[Sec. 1]

(2) "Class one money market mutual fund" means a mutual fund that at all times qualifies for investment using the bond class one reserve factor described by the purposes and procedures of the securities valuation office.

(3) "Government money market mutual fund" means a money market mutual fund that at all times:

(A) invests only in obligations issued, guaranteed, or insured by the United States or collateralized repurchase agreements composed of those obligations; and

(B) is qualified for investment without a reserve under the purposes and procedures publication of the securities valuation office or any successor publication.

(4) "Money market mutual fund" means a mutual fund that qualifies under 17 C.F.R. Part 270.2a-7, as authorized by the Investment Company Act of 1940 (15 U.S.C. Sections 80a-1 et seq.), as amended.

Sec. 3. (a) A short-term investment pool may contain only:

. . .

(2) government money market mutual funds or class one money market mutual funds; or

. . . .

Revisor's Note

(1) Section 1(2), V.T.I.C. Article 2.10-5, refers to "the purposes and procedures of the securities valuation office." Other provisions revised in this chapter contain similar references. Throughout this chapter, the revised law substitutes "Purposes and Procedures Manual of the securities valuation office" for the quoted language because that is the correct name of the publication.

(2) Section 1(4), V.T.I.C. Article 2.10-5, defines "money market mutual fund" as a "mutual fund" that qualifies under "17 C.F.R. Part 270.2a-7, as authorized by the Investment Company Act of 1940 (15 U.S.C. Sections 80a-1 et seq.), as amended." Because 17 C.F.R. Section 270.2a-7 does not define or use the term "money market mutual fund," but does prescribe requirements for a registered investment company that holds itself out as a "money market fund," the revised law substitutes "money market fund" for "money market

mutual fund."

Revised Law

Sec. 424.107. AUTHORIZED INVESTMENTS FOR AUTHORIZED INVESTMENT POOL; LIMITATION. (a) An authorized investment pool may contain only investments that a participating insurer is authorized to acquire by provisions of this code other than this subchapter.

(b) The insurer's total of proportionate ownership interests in a single authorized investment held by an authorized investment pool and the insurer's direct investments in that authorized investment may not exceed the limit prescribed by the applicable authorizing provision.

(c) In addition to the limitation described by Subsection (b), an insurer is subject to the limitations described by Section 424.108. (V.T.I.C. Art. 2.10-5, Sec. 4.)

Source Law

> Sec. 4. Authorized investment pools are limited to investments that a participating insurer is authorized to acquire by other articles of this code. The insurer's total of proportionate ownership interests in any one authorized investment held by an authorized investment pool, and direct investments in the same authorized investment, may not exceed the limit provided by the applicable authorizing article. In addition to that limitation, an insurer is also subject to the overall limitations contained in Section 6(c) of this article.

Revised Law

Sec. 424.108. GENERAL INSURER INVESTMENT LIMITATIONS. An insurer may not acquire an investment in an investment pool if, as a result of and after making the investment, the aggregate amount of investments held by the insurer under this subchapter at the time of the investment:

(1) in a single investment pool would exceed 10 percent of the insurer's admitted assets;

(2) in all investment pools investing in investments authorized under Section 424.107 would exceed 25 percent of the insurer's admitted assets; or

(3) in all investment pools would exceed 35 percent of

the insurer's admitted assets. (V.T.I.C. Art. 2.10-5, Sec. 6(c).)

Source Law

(c) An insurer shall not acquire an investment in an investment pool under this section if, as a result of and after giving effect to that investment, the aggregate amount of investments then held by the insurer under this article:

(1) in any one investment pool would exceed 10 percent of its admitted assets;

(2) in all investment pools investing in investments permitted under Section 4 of this article would exceed 25 percent of its admitted assets; or

(3) in all investment pools would exceed 35 percent of its admitted assets.

Revised Law

Sec. 424.109. DESIGNATION OF POOL MANAGER; QUALIFICATIONS. (a) The pooling agreement for an investment pool must designate a pool manager.

(b) The pool manager must be organized under the laws of the United States or a state and must be:

(1) the investing insurer, an affiliated insurer, or a business entity affiliated with the insurer;

(2) a qualified bank;

(3) a business entity registered under the Investment Advisers Act of 1940 (15 U.S.C. Section 80b-1 et seq.), as amended;

(4) the attorney-in-fact of a reciprocal or interinsurance exchange; or

(5) the United States manager or an affiliate or subsidiary of the United States manager of a United States branch of an alien insurer. (V.T.I.C. Art. 2.10-5, Sec. 5(d).)

Source Law

(d) The pooling agreement must designate a pool manager. The pool manager must be organized under the laws of the United States or a state and must be:

(1) the investing insurer, an affiliated insurer, or a business entity affiliated with the insurer;

(2) a qualified bank;

(3) a business entity registered under the Investment Advisers Act of 1940 (15 U.S.C. Sec. 80b-1 et seq.), as amended;

(4) if a reciprocal insurer or interinsurance exchange, its attorney-in-fact; or

(5) if a United States branch of an alien insurer, its United States manager or an affiliate or subsidiary of its United States manager.

Revisor's Note

Section 5(d), V.T.I.C. Article 2.10-5, refers to a "reciprocal insurer or interinsurance exchange." For consistency with terminology used throughout this code, the revised law substitutes "reciprocal or interinsurance exchange" for "reciprocal insurer or interinsurance exchange."

Revised Law

Sec. 424.110. POOL MANAGER TO MAINTAIN ASSETS; CUSTODY AGREEMENT. (a) The pool manager shall maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the pool, under a custody agreement with a qualified bank.

(b) The custody agreement must:

(1) state and recognize the claims and rights of each participant;

(2) acknowledge that the investment pool's underlying assets are held solely for the benefit of each participant in proportion to the aggregate amount of the participant's investments in the pool; and

(3) contain an agreement that the pool's underlying assets may not be commingled with the general assets of the custodian qualified bank or any other person. (V.T.I.C. Art. 2.10-5, Sec. 5(f).)

Source Law

(f) The pool manager shall maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the investment pool, under a custody agreement with a qualified bank. The custody agreement must:

(1) state and recognize the claims and rights of each participant;

(2) acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its investments in the investment pool; and

(3) contain an agreement that the underlying assets of the investment pool may not be commingled with the general assets of the custodian qualified bank or any other person.

Revised Law

Sec. 424.111. POOLING AGREEMENT PROVISIONS. The pooling

agreement for an investment pool must provide that:

(1) 100 percent of the ownership interests in the pool must at all times be held by:

(A) an insurer and the insurer's affiliated insurers;

(B) for a pool investing solely in investments authorized under Section 424.104, the insurer and the insurer's subsidiaries and affiliates or any pension or profit-sharing plan of the insurer and the insurer's subsidiaries and affiliates; or

(C) for a United States branch of an alien insurer, subsidiaries or affiliates of the insurer's United States manager;

(2) the pool's underlying assets are held solely for the benefit of each participant and may not be commingled with the general assets of the pool manager or any other person;

(3) each participant owns an undivided interest in the pool's underlying assets in proportion to the aggregate amount of the participant's interest in the pool; and

(4) a pool participant or, if a pool participant is insolvent, bankrupt, or in receivership, the participant's trustee, receiver, conservator, or other successor-in-interest may withdraw all or any portion of the participant's investment from the pool under the terms of the pooling agreement. (V.T.I.C. Art. 2.10-5, Sec. 5(g).)

Source Law

(g) The pooling agreement for the investment pool must also provide that:

(1) 100 percent of the ownership interests in the investment pool must at all times be held by:

(A) an insurer and its affiliated insurers;

(B) in the case of an investment pool investing solely in investments permitted under Section 3 of this article, the insurer and its subsidiaries and affiliates or any pension or profit-sharing plan of the insurer, its subsidiaries, and affiliates; or

(C) in the case of a United States branch of an alien insurer, affiliates or subsidiaries of its United States manager;

(2) the underlying assets of the investment pool may not be commingled with the general

assets of the pool manager or any other person;

(3) each participant owns an undivided interest in the underlying assets of the investment pool in proportion to the aggregate amount of each pool participant's interest in the investment pool and the underlying assets of the investment pool are held solely for the benefit of each participant; and

(4) a pool participant or, in the event of the pool participant's insolvency, bankruptcy, or receivership, its trustee, receiver, conservator, or other successor-in-interest may withdraw all or any portion of its investment from the pool under the terms of the pooling agreement.

Revisor's Note

Section 5(g)(1)(B), V.T.I.C. Article 2.10-5, refers to investments permitted under "Section 3" of that article. The revised law substitutes a reference to "Section 424.104" for the reason stated in Revisor's Note (2) to Section 424.102.

Revised Law

Sec. 424.112. WITHDRAWALS AND DISTRIBUTIONS. (a) A pool participant must be able to make withdrawals on demand without penalty or other assessment on any business day, and settlement of funds must occur within a reasonable and customary period that does not exceed five business days after a withdrawal.

(b) The pooling agreement must provide that the pool manager shall make a distribution to a pool participant, at the manager's discretion:

(1) in cash in an amount equal to the fair market value at the time of the distribution of the participant's pro rata share of each of the pool's underlying assets;

(2) in kind in an amount equal to a pro rata share of each underlying asset; or

(3) in a combination of cash and in-kind distributions in an amount equal to a pro rata share of each underlying asset.

(c) A distribution under Subsection (b) must be computed after subtracting all the investment pool's applicable fees and expenses. (V.T.I.C. Art. 2.10-5, Secs. 6(d), (e), (f).)

Source Law

(d) A pool participant must be able to make withdrawals on demand without penalty or other

assessment on any business day, and settlement of funds must occur within a reasonable and customary period after a withdrawal not to exceed five business days.

(e) The pooling agreement must provide that the pool manager shall make a distribution to a pool participant, at the discretion of the pool manager:

(1) in cash the fair market value at the time of the distribution of the participant's pro rata share of each underlying asset of the investment pool;

(2) in kind a pro rata share of each underlying asset; or

(3) in a combination of cash and in-kind distributions a pro rata share in each underlying asset.

(f) A distribution under Subsection (e) of this section is computed in each case after subtracting all applicable fees and expenses of the investment pool.

Revised Law

Sec. 424.113. INVESTMENT POOL RECORDS. The pool manager shall compile and maintain:

(1) detailed accounting records that show:

(A) the cash receipts and disbursements reflecting each pool participant's proportionate investment in the investment pool; and

(B) a complete description of all the pool's underlying assets, including the amount, interest rate, and maturity date, if any, of each of those assets and other appropriate designations; and

(2) other records that, on a daily basis, allow third parties to verify each participant's investment in the pool. (V.T.I.C. Art. 2.10-5, Sec. 5(e).)

Source Law

(e) The pool manager shall compile and maintain:

(1) detailed accounting records that set forth:

(A) the cash receipts and disbursements reflecting each pool participant's proportionate investment in the investment pool; and

(B) a complete description of all underlying assets of the investment pool, including the amount, interest rate, and maturity date, if any, of each of those assets and other appropriate designations; and

(2) other records that, on a daily basis, allow third parties to verify each pool participant's investment in the investment pool.

Revised Law

Sec. 424.114. INSPECTION OF RECORDS. The pool manager

shall make records of the investment pool available for inspection by the commissioner. (V.T.I.C. Art. 2.10-5, Sec. 6(g).)

Source Law

(g) The pool manager must make the records of the investment pool available for inspection by the commissioner.

Revised Law

Sec. 424.115. REPORTS OF TRANSACTIONS BETWEEN POOL AND PARTICIPANT. (a) A transaction between an investment pool and a pool participant is not subject to Subchapter C, Chapter 823, except that before entering into a pool, an insurer subject to Chapter 823 shall give the commissioner the written notice required under Section 823.103.

(b) The investment pool's investment activities and the transactions between the pool and a pool participant must be reported in the registration statement required by Subchapter B, Chapter 823. (V.T.I.C. Art. 2.10-5, Sec. 6(b).)

Source Law

(b) A transaction between the pool and a participant in the pool is not subject to Section 4, Article 21.49-1 of this code, except that, before entering into a pool, an insurer subject to Article 21.49-1 of this code shall file the notice required under Section 4(d)(2), Article 21.49-1 of this code. Investment activities of the pool and transactions between pools and participants shall be reported annually in the registration statement required by Section 3, Article 21.49-1 of this code.

Revisor's Note

(1) Section 6(b), V.T.I.C. Article 2.10-5, provides that a transaction between an investment pool and a pool participant is not subject to Section 4, V.T.I.C. Article 21.49-1, with certain exceptions. Section 4, Article 21.49-1, is revised in various places in Chapter 823 of this code. The provisions of that section that apply to transactions are revised as Subchapter C, Chapter 823. The revised law is drafted accordingly.

(2) Section 6(b), V.T.I.C. Article 2.10-5,

refers to the registration statement required by Section 3, V.T.I.C. Article 21.49-1. Section 3, Article 21.49-1, is revised in various places in Chapter 823 of this code. The provisions of that section that contained registration requirements are revised as Subchapter B, Chapter 823. The revised law is drafted accordingly.

[Sections 424.116-424.150 reserved for expansion]

SUBCHAPTER D. DOLLAR ROLL, REPURCHASE, REVERSE REPURCHASE, AND SECURITIES LENDING TRANSACTIONS

Revised Law

Sec. 424.151. DEFINITIONS. In this subchapter:

(1) "Dollar roll transaction" means two simultaneous transactions with settlement dates not more than 96 days apart, in one of which an insurer sells to a business entity, and in the other of which the insurer is obligated to purchase from the same business entity, substantially similar securities that are:

(A) mortgage-backed securities issued, assumed, or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, or a successor to one of those organizations; or

(B) other mortgage-backed securities referred to in 15 U.S.C. Section 77r-1 et seq., as amended.

(2) "Repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period or on demand.

(3) "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period or on demand.

(4) "Securities lending transaction" means a transaction in which an insurer lends securities to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period or on demand. (V.T.I.C. Art. 2.10-3A, Sec. 1.)

Source Law

Art. 2.10-3A

Sec. 1. In this article:

(1) "Dollar roll transaction" means two simultaneous transactions, with settlement dates not more than 96 days apart, in one of which an insurer sells to a business entity and in the other the insurer is obligated to purchase from the same business entity substantially similar securities of the following types:

(A) mortgage-backed securities issued, assumed, or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association, or the Federal Home Loan Mortgage Corporation or their successor organizations; or

(B) other mortgage-backed securities described under Section 106, Title I, Secondary Mortgage Market Enhancement Act of 1984 (15 U.S.C. Section 77r-1), as amended.

(2) "Repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period or on demand.

(3) "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period or on demand.

(4) "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period or on demand.

Revisor's Note

Section 1(1)(B), V.T.I.C. Article 2.10-3A, refers to "Section 106, Title I, Secondary Mortgage Market Enhancement Act of 1984 (15 U.S.C. Section 77r-1)." The revised law omits the reference to "Section 106, Title I, Secondary Mortgage Market Enhancement Act of 1984" as unnecessary because it is simply a cite to the provisions in which 15 U.S.C. Section 77r-1 was originally enacted and does not add

any meaning to the substance of the law.

Revised Law

Sec. 424.152. TRANSACTIONS AUTHORIZED. An insurer may engage in dollar roll, repurchase, reverse repurchase, and securities lending transactions as provided by this subchapter. (V.T.I.C. Art. 2.10-3A, Sec. 2(a).)

Source Law

Sec. 2. (a) An insurer may engage in securities lending, repurchase, reverse repurchase, and dollar roll transactions as provided by this article.

Revised Law

Sec. 424.153. PERIOD OF TRANSACTION. An insurer must enter into a written agreement for each transaction under this subchapter, other than a dollar roll transaction. The agreement must require that the transaction terminate on or before the first anniversary of the transaction's inception. (V.T.I.C. Art. 2.10-3A, Sec. 2(b).)

Source Law

(b) The insurer shall enter into a written agreement for each transaction, other than a dollar roll transaction, that requires each transaction to terminate not later than the first anniversary of the inception of the transaction.

Revised Law

Sec. 424.154. CASH REQUIREMENTS. With respect to cash received in a transaction under this subchapter, an insurer shall:

(1) invest the cash in accordance with this subchapter and in a manner that recognizes the liquidity needs of the transaction; or

(2) use the cash for the insurer's general corporate purposes. (V.T.I.C. Art. 2.10-3A, Sec. 3(a).)

Source Law

Sec. 3. (a) Cash received in a transaction under this article must be:

(1) invested in accordance with this article and in a manner that recognizes the liquidity needs of the transaction; or

(2) used by the insurer for the insurer's general corporate purposes.

Revised Law

Sec. 424.155. COLLATERAL REQUIREMENTS. (a) While a transaction under this subchapter is outstanding, the insurer or the insurer's agent or custodian shall maintain, as to acceptable collateral received in the transaction, either physically or through the book-entry system of the Federal Reserve, Depository Trust Company, Participants Trust Company, or another securities depository approved by the commissioner:

(1) possession of the collateral;

(2) a perfected security interest in the collateral; or

(3) in the case of a jurisdiction outside of the United States, title to, or the rights of a secured creditor to, the collateral.

(b) The amount of collateral required for repurchase, reverse repurchase, and securities lending transactions is the amount required under the Purposes and Procedures Manual of the securities valuation office or a successor publication. (V.T.I.C. Art. 2.10-3A, Secs. 3(b), (e).)

Source Law

(b) While the transaction is outstanding, the insurer, or the insurer's agent or custodian, shall maintain, as to acceptable collateral received in a transaction under this section, either physically or through the book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company, or other securities depositories approved by the commissioner:

(1) possession of the acceptable collateral;

(2) a perfected security interest in the acceptable collateral; or

(3) in the case of a jurisdiction outside of the United States, title to, or rights of a secured creditor to, the acceptable collateral.

(e) The amount of collateral required for a securities lending, repurchase, or reverse repurchase transaction is the amount required under the Purposes and Procedures Manual of the Securities Valuation Office or a successor publication.

Revisor's Note

Section 3(b), V.T.I.C. Article 2.10-3A, establishes certain requirements with respect to

collateral received in a transaction under "this section." The revised law applies those requirements to collateral received in a transaction under "this subchapter" because it is clear from the context in which "this section" appears that it is intended to refer to transactions authorized by Article 2.10-3A, revised as this subchapter.

Revised Law

Sec. 424.156. PERCENTAGE LIMITATIONS. (a) An insurer may not enter into a transaction under this subchapter if, as a result of and after making the transaction, the aggregate amount of securities loaned or sold to or purchased from:

(1) a single business entity counterparty under this subchapter would exceed five percent of the insurer's assets; or

(2) all business entities under this subchapter would exceed 40 percent of the insurer's assets.

(b) In computing the amount sold to or purchased from a business entity counterparty under a repurchase or reverse repurchase transaction, effect may be given to netting provisions under a master written agreement. (V.T.I.C. Art. 2.10-3A, Secs. 3(c), (d).)

Source Law

(c) An insurer may not enter into a transaction under this article if, as a result of and after giving effect to the transaction, the aggregate amount of securities loaned, sold to, or purchased from:

(1) any one business entity counterparty under this article would exceed five percent of the insurer's assets; or

(2) all business entities under this article would exceed 40 percent of the insurer's assets.

(d) In computing the amount sold to or purchased from a business entity counterparty under a repurchase or reverse repurchase transaction, effect may be given to netting provisions under a master written agreement.

Revised Law

Sec. 424.157. RULES. The commissioner may adopt reasonable rules and issue reasonable orders as necessary to implement this subchapter. (V.T.I.C. Art. 2.10-3A, Sec. 3(f).)

Source Law

(f) The commissioner may adopt reasonable rules and orders consistent with, and as necessary to implement, this article.

Revisor's Note

(1) Section 3(f), V.T.I.C. Article 2.10-3A, authorizes the commissioner of insurance to adopt rules and orders consistent with and as necessary to implement Article 2.10-3A. For consistency with the terminology used in this code, the revised law substitutes "issue" for "adopt" in relation to orders.

(2) Section 3(f), V.T.I.C. Article 2.10-3A, authorizes the commissioner of insurance to adopt reasonable rules and orders "consistent with" and as necessary to implement Article 2.10-3A. A rule or order must be consistent with the law under which the rule is adopted or the order is issued. The revised law, therefore, omits the quoted language as unnecessary.

[Sections 424.158-424.200 reserved for expansion]

SUBCHAPTER E. RISK CONTROL TRANSACTIONS

Revised Law

Sec. 424.201. DEFINITIONS. In this subchapter:

(1) "Acceptable collateral" means:

(A) cash;

(B) cash equivalents;

(C) letters of credit and direct obligations; or

(D) securities that are fully guaranteed as to principal and interest by the United States.

(2) "Business entity" includes an association, bank, corporation, joint stock company, joint tenancy, joint venture, limited liability company, mutual fund, partnership, sole proprietorship, trust, or other similar form of business organization, regardless of whether organized for profit.

(3) "Cap" means an agreement obligating the seller to

make payments to the buyer, with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number that is sometimes called the strike rate or strike price.

(4) "Cash equivalent" means an investment or security that is short-term, highly rated, highly liquid, and readily marketable. The term includes a money market fund described by Section 424.106. For purposes of this subdivision, an investment or security is:

(A) short-term if it has a remaining term to maturity of one year or less; and

(B) highly rated if it has:

(i) a rating of "P-1" by Moody's Investors Service, Inc.;

(ii) a rating of "A-1" by the Standard and Poor's Division of the McGraw Hill Companies, Inc.; or

(iii) an equivalent rating by a nationally recognized statistical rating organization recognized by the securities valuation office.

(5) "Collar" means an agreement to receive payments as the buyer of a cap, floor, or option and to make payments as the seller of a different cap, floor, or option.

(6)(A) "Counterparty exposure amount" means:

(i) for an over-the-counter derivative instrument not entered into under a written master agreement that provides for netting of payments owed by the respective parties, the market value of the over-the-counter derivative instrument, if the liquidation of the derivative instrument would result in a final cash payment to the insurer, or zero, if the liquidation of the derivative instrument would not result in a final cash payment to the insurer; or

(ii) for an over-the-counter derivative instrument entered into under a written master agreement that provides for netting of payments owed by the respective parties and

for which the counterparty's domiciliary jurisdiction is within the United States or a foreign jurisdiction listed in the Purposes and Procedures Manual of the securities valuation office as eligible for netting, the greater of zero or the net sum payable to the insurer in connection with all derivative instruments subject to the written master agreement on the liquidation of the instruments in the event of the counterparty's default under the master agreement, if there is no condition precedent to the counterparty's obligation to make the payment and if there is no setoff of amounts payable under another instrument or agreement.

(B) For purposes of this subdivision, market value or the net sum payable, as applicable, must be determined at the end of the most recent quarter of the insurer's fiscal year and must be reduced by the market value of acceptable collateral held by the insurer or a custodian on the insurer's behalf.

(7) "Derivative instrument":

(A) means an agreement, option, or instrument, or a series or combination of agreements, options, or instruments:

(i) to make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement instead of making or taking delivery of, or assuming or relinquishing, a specified amount of an underlying interest; or

(ii) that has a price, performance, value, or cash flow based primarily on the actual or expected price, yield, level, performance, value, or cash flow of one or more underlying interests;

(B) includes an option, a warrant not otherwise permitted to be held by the insurer under this subchapter, a cap, a floor, a collar, a swap, a swaption, a forward, a future, any other substantially similar agreement, option, or instrument, and a series or combination of those agreements, options, or instruments; and

(C) does not include a collateralized mortgage

obligation, another asset-backed security, a principal-protected structured security, a floating rate security, an instrument that an insurer would otherwise be authorized to invest in or receive under a provision of this subchapter other than this subdivision, or a debt obligation of the insurer.

(8) "Derivative transaction" means a transaction involving the use of one or more derivative instruments. The term does not include a dollar roll transaction, repurchase transaction, reverse repurchase transaction, or securities lending transaction.

(9) "Floor" means an agreement obligating the seller to make payments to the buyer, each of which is based on the amount by which a predetermined number that is sometimes called the floor price or floor rate exceeds a reference level, performance, price, or value of one or more underlying interests.

(10) "Forward" means an agreement to make or take delivery in the future of one or more underlying interests, or to effect a cash settlement, based on the actual or expected level, performance, price, or value of those interests. The term does not include a future or a spot transaction effected within a customary settlement period, a when-issued purchase, or another similar cash market transaction.

(11) "Future" means an agreement traded on a futures exchange to make or take delivery of one or more underlying interests, or to effect a cash settlement, based on the actual or expected level, performance, price, or value of those interests.

(12) "Futures exchange" means a foreign or domestic exchange, contract market, or board of trade on which trading in futures is conducted and that, in the United States, is authorized to conduct that trading by the Commodity Futures Trading Commission or a successor to that agency.

(13) "Hedging transaction" means a derivative transaction entered into and maintained to manage, with respect to an asset, liability, or portfolio of assets or liabilities, that an insurer has acquired or incurred or anticipates acquiring or

incurring:

(A) the risk of a change in value, yield, price, cash flow, or quantity; or

(B) the currency exchange rate risk.

(14) "Income generation transaction" means a derivative transaction entered into to generate income. The term does not include a hedging transaction or a replication transaction.

(15) "Market value" means the price for a security or derivative instrument obtained from a generally recognized source, the most recent quotation from a generally recognized source, or if a generally recognized source does not exist, the price determined under the terms of the instrument or in good faith by the insurer, as can be reasonably demonstrated to the commissioner on request, plus the amount of accrued but unpaid income on the security or instrument to the extent that amount is not included in the price as of the date the security or instrument is valued.

(16) "Option" means an agreement giving the buyer the right to buy or receive, referred to as a "call option," to sell or deliver, referred to as a "put option," to enter into, extend, or terminate, or to effect a cash settlement based on the actual or expected level, performance, price, spread, or value of, one or more underlying interests.

(17) "Over-the-counter derivative instrument" means a derivative instrument entered into with a business entity in a manner other than through a securities exchange or futures exchange or cleared through a qualified clearinghouse.

(18) "Potential exposure" means:

(A) as to a futures position, the amount of initial margin required for that position; or

(B) as to a swap, collar, or forward, one-half of one percent multiplied by the notional amount multiplied by the square root of the remaining years to maturity.

(19) "Qualified clearinghouse" means a clearinghouse

that:

(A) is subject to the rules of a securities exchange or a futures exchange; and

(B) provides clearing services, including acting as a counterparty to each of the parties to a transaction in a manner that eliminates the parties' credit risk to each other.

(20) "Replication transaction" means a derivative transaction or a combination of derivative transactions effected separately or in conjunction with cash market investments included in the insurer's investment portfolio to replicate the risks and returns of another authorized transaction, investment, or instrument or to operate as a substitute for cash market transactions. The term does not include a hedging transaction.

(21) "Securities exchange" means:

(A) an exchange registered as a national securities exchange or a securities market registered under the Securities Exchange Act of 1934 (15 U.S.C. Section 78a et seq.), as amended;

(B) the Private Offerings, Resales and Trading through Automated Linkages system; or

(C) a designated offshore securities market as defined by 17 C.F.R. Section 230.902, as amended.

(22) "Swap" means an agreement to exchange or to net payments at one or more times based on the actual or expected price, yield, level, performance, or value of one or more underlying interests.

(23) "Swaption" means an option to purchase or sell a swap at a given price and time or at a series of prices and times. The term does not include a swap with an embedded option.

(24) "Underlying interest" means an asset, liability, or other interest underlying a derivative instrument or a combination of those assets, liabilities, or interests. The term includes a security, currency, rate, index, commodity, or derivative instrument.

(25) "Warrant" means an instrument under which the holder has the right to purchase or sell the underlying interest at a given price and time or at a series of prices and times stated in the warrant. (V.T.I.C. Art. 2.10-4, Sec. 1.)

Source Law

Art. 2.10-4

Sec. 1. In this article:

(1) "Acceptable collateral" means:

(A) cash;

(B) cash equivalents;

(C) letters of credit and direct obligations; and

(D) securities that are fully guaranteed as to principal and interest by the United States.

(2) "Business entity" includes a sole proprietorship, corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund, bank, trust, joint tenancy, or other similar form of business organization, whether organized for profit or not for profit.

(3) "Cap" means an agreement under which a seller is obligated to make payments to the buyer with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number, sometimes called the strike rate or strike price.

(4) "Cash equivalent" means an investment or security that is short-term, highly rated, highly liquid, and readily marketable. The term includes money market funds as described by Article 2.10 of this code. For purposes of this subdivision:

(A) a short-term investment is an investment with a remaining term to maturity of one year or less; and

(B) a highly rated investment is an investment rated:

(i) "P-1" by Moody's Investors Service, Inc.;

(ii) "A-1" by the Standard and Poor's Division of the McGraw Hill Companies, Inc.; or

(iii) an equivalent rating by a nationally recognized statistical rating organization recognized by the Securities Valuation Office.

(5) "Collar" means an agreement to receive payments as the buyer of an option, cap, or floor and to make payments as the seller of a different option, cap, or floor.

(6)(A) "Counterparty exposure amount" means:

(i) for an over-the-counter derivative instrument that is not entered into under a written master agreement that provides for netting of payments owed by the respective parties:

(a) the market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

(b) zero if the liquidation of the derivative instrument would not

result in a final cash payment to the insurer; or

(ii) for an over-the-counter derivative instrument that is entered into under a written master agreement that provides for netting of payments owed by the respective parties and in which the domiciliary jurisdiction of the counterparty is either in the United States or in a foreign jurisdiction listed in the Purposes and Procedures Manual of the Securities Valuation Office as eligible for netting, the greater of:

(a) zero; or

(b) the net sum payable to the insurer in connection with all derivative instruments subject to the written master agreement on their liquidation in the event of default by the counterparty under the master agreement, if there are no conditions precedent to the obligations of the counterparty to make such a payment and no setoff of amounts payable under any other instrument or agreement.

(B) For purposes of this subdivision, the market value or the net sum payable, as applicable, is determined at the end of the most recent quarter of the insurer's fiscal year and is reduced by the market value of acceptable collateral held by the insurer or a custodian on the insurer's behalf.

(7) "Derivative instrument" means an agreement, option, or instrument, or any series or combination of agreements, options, or instruments, to make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or instead to make a cash settlement, or that has a price, performance, value, or cash flow based primarily on the actual or expected price, yield, level, performance, value, or cash flow of one or more underlying interests. The term includes an option, a warrant not otherwise permitted to be held by the insurer under this article, a cap, a floor, a collar, a swap, a swaption, a forward, a future, and any other substantially similar agreement, option, or instrument or series or combinations of those agreements, options, or instruments. The term does not include a collateralized mortgage obligation, another asset-backed security, a principal-protected structured security, a floating rate security, an instrument that an insurer is otherwise permitted to invest in or receive under this article other than under this definition, or any debt obligation of the insurer.

(8) "Derivative transaction" means a transaction that involves the use of one or more derivative instruments. The term does not include a dollar roll transaction, repurchase transaction, reverse repurchase transaction, or securities lending transaction.

(9) "Floor" means an agreement under which the seller is obligated to make payments to the buyer and in which each payment is based on the amount by which a predetermined number, sometimes called the floor rate or price, exceeds a reference price, level, performance, or value of one or more underlying interests.

(10) "Forward" means an agreement to make or take delivery in the future of one or more underlying interests, or effect a cash settlement, based on the actual or expected price, level, performance, or value of those underlying interests. The term does not include a future or a spot

transaction effected within customary settlement periods, when-issued purchases, or other similar cash market transactions.

(11) "Future" means an agreement that is traded on a futures exchange to make or take delivery of, or effect a cash settlement, based on the actual or expected price, level, performance, or value of, one or more underlying interests.

(12) "Futures exchange" means a foreign or domestic exchange, contract market, or board of trade on which trading in futures is conducted and that, in the United States, is authorized to conduct that trading by the Commodities Futures Trading Commission or any successor organization.

(13) "Hedging transaction" means a derivative transaction that is entered into and maintained to manage:

(A) the risk of a change in the value, yield, price, cash flow, or quantity of assets or liabilities, or a portfolio of assets or liabilities, that the insurer has acquired or incurred or anticipates acquiring or incurring; or

(B) the currency exchange rate risk related to assets or liabilities, or a portfolio of assets or liabilities, that an insurer has acquired or incurred or anticipates acquiring or incurring.

(14) "Income generation transaction" means a derivative transaction that is entered into to generate income. The term does not include a derivative transaction entered into as a hedging transaction or a replication transaction.

(15) "Market value" means the price for a security or derivative instrument obtained from a generally recognized source or the most recent quotation from such a source or, if a generally recognized source does not exist, the price for the security or derivative instrument as determined under the terms of the instrument or in good faith by the insurer, as can be reasonably demonstrated to the commissioner on request, plus accrued but unpaid income on the security or derivative instrument to the extent not included in the price as of the applicable date.

(16) "Option" means an agreement under which the buyer has the right to buy or receive, referred to as a "call option," sell or deliver, referred to as a "put option," enter into, extend or terminate, or effect a cash settlement based on the actual or expected price, spread, level, performance, or value of one or more underlying interests.

(17) "Over-the-counter derivative instrument" means a derivative instrument entered into with a business entity other than through a securities exchange or futures exchange or cleared through a qualified clearinghouse.

(18) "Potential exposure" means:

(A) as to a futures position, the amount of initial margin required for that position; or

(B) as to swaps, collars, and forwards, one-half percent times the notional amount times the square root of the remaining years to maturity.

(19) "Qualified clearinghouse" means a clearinghouse that is subject to the rules of a securities exchange or a futures exchange and provides clearing services, including acting as a counterparty to each of the parties to a transaction in such a

manner that the parties no longer have credit risk to each other.

(20) "Replication transaction" means a derivative transaction or combination of derivative transactions effected either separately or in conjunction with cash market investments included in the insurer's investment portfolio to replicate the risks and returns of another authorized transaction, investment, or instrument or to operate as a substitute for a cash market transaction. The term does not include a derivative transaction entered into by the insurer as a hedging transaction.

(21) "Securities exchange" means:

(A) an exchange registered as a national securities exchange or a securities market registered under the Securities Exchange Act of 1934 (15 U.S.C. Section 78a et seq.), as amended;

(B) the Private Offerings Resales and Trading through Automated Linkages (PORTAL); or

(C) a designated offshore securities market as defined by Securities Exchange Commission Regulation S, 17 C.F.R. Part 230, as amended.

(22) "Swap" means an agreement to exchange or to net payments at one or more times based on the actual or expected price, yield, level, performance, or value of one or more underlying interests.

(23) "Swaption" means an option to purchase or sell a swap at a given price and time or at a series of prices and times. The term does not include a swap with an embedded option.

(24) "Underlying interest" means the assets, liabilities, or other interests, or a combination of those assets, liabilities, or other interests, that underlie a derivative instrument. The term includes securities, currencies, rates, indices, commodities, or derivative instruments.

(25) "Warrant" means an instrument under which the holder has the right to purchase or sell the underlying interest at a given price and time or at a series of prices and times stated in the warrant.

Revisor's Note

Section (1)(21)(C), V.T.I.C. Article 2.10-4, refers to a designated offshore securities market as defined by "Securities Exchange Commission Regulation S, 17 C.F.R. Part 230, as amended." For the reader's convenience, the revised law substitutes for the quoted language a more specific reference to 17 C.F.R. Section 230.902, which contains the definition of "designated offshore securities market."

Revised Law

Sec. 424.202. RISK CONTROL TRANSACTIONS AUTHORIZED. (a) Except as provided by Subsection (b), an insurer may engage in a risk control transaction authorized by this subchapter to:

(1) protect the insurer's assets against the risk of

changing asset values or interest rates;

(2) reduce risk; and

(3) generate income.

(b) An insurer with a statutory net capital and surplus as determined by the insurer's most recent financial statement required to be filed with the department that is less than the minimum amount of capital and surplus required for a new charter and certificate of authority for the same type of insurer may not engage in a transaction authorized under this subchapter. (V.T.I.C. Art. 2.10-4, Secs. 2(a), 8(b), (c).)

Source Law

Sec. 2. (a) Except as provided by Section 8 of this article, an insurer may, for purposes of protecting the assets owned by the insurer against the risk of changing asset values or interest rates and for risk reduction and income generation, engage in risk control transactions authorized under this article.

[Sec. 8]

(b) An insurer with a statutory net capital and surplus less than the minimum amount of capital and surplus required for a new charter and certificate of authority for the same type of insurer may not engage in the transactions authorized under this article.

(c) For purposes of this section, net capital and surplus are determined by the most recent financial statement of the insurer required to be filed with the department.

Revised Law

Sec. 424.203. NOTICE OF INTENT TO ENGAGE IN RISK CONTROL TRANSACTIONS REQUIRED. (a) Before an insurer with a statutory net capital and surplus of less than $10 million engages in a transaction authorized under this subchapter, the insurer shall file a written notice with the commissioner describing:

(1) the need to engage in the transaction;

(2) the lack of acceptable alternatives; and

(3) the insurer's plan to engage in the transaction.

(b) If the commissioner does not issue an order prohibiting an insurer who files a notice under Subsection (a) from engaging in the transaction on or before the 90th day after the date the commissioner receives the notice, the insurer may engage in the transaction described in the notice.

(c) For purposes of this section, an insurer's net capital and surplus are determined by the insurer's most recent financial statement required to be filed with the department. (V.T.I.C. Art. 2.10-4, Secs. 8(a), (c).)

Source Law

> Sec. 8. (a) Before engaging in a transaction authorized under this article, an insurer that has a statutory net capital and surplus of less than $10 million shall file a written notice with the commissioner describing the need to engage in the transaction, the lack of acceptable alternatives, and the insurer's plan to engage in the transaction. If the commissioner does not issue an order prohibiting the insurer from engaging in the transaction within 90 days after the date of receipt of the insurer's notice, the insurer may engage in the transaction described in the notice.
>
> (c) For purposes of this section, net capital and surplus are determined by the most recent financial statement of the insurer required to be filed with the department.

Revised Law

Sec. 424.204. TRADING REQUIREMENTS FOR DERIVATIVE INSTRUMENTS. Each derivative instrument must be:

(1) traded on a securities exchange;

(2) entered into with, or guaranteed by, a business entity;

(3) issued or written by, or entered into with, the issuer of the underlying interest on which the derivative instrument is based; or

(4) in the case of futures, traded through a broker who is:

(A) registered as a futures commission merchant under the Commodity Exchange Act (7 U.S.C. Section 1 et seq.), as amended; or

(B) exempt from that registration under 17 C.F.R. Section 30.10, adopted under the Commodity Exchange Act (7 U.S.C. Section 1 et seq.), as amended. (V.T.I.C. Art. 2.10-4, Sec. 6.)

Source Law

> Sec. 6. Each derivative instrument must be:
> (1) traded on a securities exchange;
> (2) entered into with, or guaranteed by, a

business entity;

(3) issued or written by, or entered into with, the issuer of the underlying interest on which the derivative instrument is based; or

(4) in the case of futures, traded through a broker who is registered as a futures commission merchant under the Commodity Exchange Act (7 U.S.C. Section 1 et seq.), as amended, or who is exempt from that registration under 17 C.F.R. Rule 30.10, adopted under the Commodity Exchange Act (7 U.S.C. Section 1 et seq.), as amended.

Revised Law

Sec. 424.205. DERIVATIVE USE PLAN. (a) Before an insurer enters into a derivative transaction, the insurer's board of directors must approve a derivative use plan as part of the insurer's investment plan otherwise required by law.

(b) The derivative use plan must:

(1) describe investment objectives and risk constraints, such as counterparty exposure amounts;

(2) define permissible transactions, identifying the risks to be hedged and the assets or liabilities being replicated; and

(3) require compliance with the insurer's internal control procedures established under Section 424.206. (V.T.I.C. Art. 2.10-4, Sec. 2(b).)

Source Law

(b) Before entering into a derivative transaction, the board of directors of the insurer must approve a derivative use plan as part of the insurer's investment plan otherwise required by law. The derivative use plan must:

(1) describe investment objectives and risk constraints, such as counterparty exposure amounts;

(2) define permissible transactions, identifying the risks to be hedged and the assets or liabilities being replicated; and

(3) require compliance with the insurer's internal control procedures established under Subsection (c) of this section.

Revised Law

Sec. 424.206. INTERNAL CONTROL PROCEDURES. An insurer that enters into a derivative transaction shall establish written internal control procedures that require:

(1) a quarterly report to the board of directors that reviews:

(A) each derivative transaction entered into, outstanding, or closed out;

(B) the results and effectiveness of the derivatives program; and

(C) the credit risk exposure to each counterparty for over-the-counter derivative transactions based on the counterparty exposure amount;

(2) a system for determining whether hedging or replication strategies used by the insurer have been effective;

(3) a system of reports, at least as frequent as monthly, to the insurer's management, that include:

(A) a description of each derivative transaction entered into, outstanding, or closed out during the period since the last report;

(B) the purpose of each outstanding derivative transaction;

(C) a performance review of the derivative instrument program; and

(D) the counterparty exposure amount for each over-the-counter derivative transaction;

(4) a written authorization that identifies the responsibilities and limitations of authority of each person authorized to effect and maintain derivative transactions; and

(5) appropriate documentation for each transaction, including:

(A) the purpose of the transaction;

(B) the assets or liabilities to which the transaction relates;

(C) the specific derivative instrument used in the transaction;

(D) for an over-the-counter derivative transaction, the name of the counterparty and the counterparty exposure amount; and

(E) for an exchange-traded derivative

instrument, the name of the exchange and the name of the firm that handled the transaction. (V.T.I.C. Art. 2.10-4, Sec. 2(c).)

Source Law

(c) The insurer shall establish written internal control procedures that require:

(1) a quarterly report to be made to the board of directors that reviews:

(A) all derivative transactions entered into, outstanding, or closed out;

(B) the results and effectiveness of the derivatives program; and

(C) the credit risk exposure to each counterparty for over-the-counter derivative transactions based on the counterparty exposure amount;

(2) a system for determining whether hedging or replication strategies used by the insurer have been effective;

(3) a system of reports, at least as frequent as monthly, to the insurer's management, that include:

(A) a description of each derivative transaction entered into, outstanding, or closed out during the period since the last report;

(B) the purpose of each outstanding derivative transaction;

(C) a performance review of the derivative instrument program; and

(D) the counterparty exposure amount for over-the-counter derivative transactions;

(4) written authorizations that identify the responsibilities and limitations of authority of persons authorized to effect and maintain derivative transactions; and

(5) appropriate documentation for each transaction, including:

(A) the purpose of the transaction;

(B) the assets or liabilities to which the transaction relates;

(C) the specific derivative instrument used in the transaction;

(D) for over-the-counter derivative instrument transactions, the name of the counterparty and the counterparty exposure amount; and

(E) for exchange-traded derivative instruments, the name of the exchange and the name of the firm that handled the transaction.

Revisor's Note

Section 2(c)(5)(D), V.T.I.C. Article 2.10-4, refers to "over-the-counter derivative instrument transactions." For consistent use of the terminology, the revised law substitutes "over-the-counter derivative transaction" for "over-the-counter derivative instrument transactions."

Revised Law

Sec. 424.207. ABILITY TO DEMONSTRATE HEDGING CHARACTERISTICS AND EFFECTIVENESS. An insurer must be able to demonstrate to the commissioner on request the intended hedging characteristics and continuing effectiveness of a derivative transaction or combination of transactions through:

(1) cash flow testing;

(2) duration analysis; or

(3) other appropriate analysis. (V.T.I.C. Art. 2.10-4, Sec. 2(d).)

Source Law

(d) The insurer must be able to demonstrate to the commissioner, on request, the intended hedging characteristics and ongoing effectiveness of the derivative transaction or combination of transactions through cash flow testing, duration analysis, or any other appropriate analysis.

Revised Law

Sec. 424.208. OFFSETTING TRANSACTIONS. (a) Subject to this section, an insurer may purchase or sell one or more derivative instruments to wholly or partly offset a derivative instrument previously purchased or sold, without regard to the quantitative limitations of this subchapter.

(b) An offsetting transaction under this section must use the same type of derivative instrument as the derivative instrument being offset. (V.T.I.C. Art. 2.10-4, Sec. 2(f).)

Source Law

(f) An insurer may purchase or sell one or more derivative instruments to offset, in whole or in part, a derivative instrument previously purchased or sold without regard to the quantitative limitations of this article if the offsetting transaction uses the same type of derivative instrument as the derivative instrument being offset.

Revised Law

Sec. 424.209. INCLUSION OF COUNTERPARTY EXPOSURE AMOUNTS. The insurer shall include all counterparty exposure amounts in determining compliance with the limitations of this subchapter. (V.T.I.C. Art. 2.10-4, Sec. 2(e).)

Source Law

(e) The insurer shall include all counterparty exposure amounts in determining compliance with the limitations of this article.

Revised Law

Sec. 424.210. OVERSIGHT BY COMMISSIONER. (a) Not later than the 10th day before the date an insurer is scheduled to enter into an initial hedging transaction, the insurer shall notify the commissioner in writing that:

(1) the insurer's board of directors has adopted an investment plan that authorizes hedging transactions; and

(2) each hedging transaction will comply with this subchapter.

(b) If a hedging transaction does not comply with this subchapter or if continuing the transaction may create a hazardous financial condition for the insurer that affects the insurer's policyholders or creditors or the public, the commissioner may, after notice and an opportunity for a hearing, order the insurer to take action that the commissioner determines is reasonably necessary to:

(1) remedy a hazardous financial condition; or

(2) prevent an impending hazardous financial condition from occurring. (V.T.I.C. Art. 2.10-4, Secs. 3(a), (d).)

Source Law

Sec. 3. (a) Not later than the 10th day before the date on which an insurer is scheduled to enter into an initial hedging transaction, the insurer shall notify the commissioner in writing that:

(1) the insurer's board of directors has adopted an investment plan that authorizes hedging transactions; and

(2) all hedging transactions will comply with this article.

(d) If a hedging transaction entered into under this section is not in compliance with this article or, if continued, may create a hazardous financial condition to the insurer that affects the insurer's policyholders or creditors or the public, the commissioner may, after notice and an opportunity for a hearing, order the insurer to take action that the commissioner determines is reasonably necessary to:

(1) rectify a hazardous financial condition; or

(2) prevent an impending hazardous

financial condition from occurring.

Revised Law

Sec. 424.211. AUTHORITY TO ENTER INTO HEDGING TRANSACTION. After providing notice under Section 424.210, an insurer may enter into a hedging transaction under this subchapter if as a result of and after making the transaction:

(1) the aggregate statement value of all outstanding caps, floors, options, swaptions, and warrants not attached to another financial instrument purchased by the insurer under this subchapter, other than a collar, does not exceed 7.5 percent of the insurer's assets;

(2) the aggregate statement value of all outstanding caps, floors, options, swaptions, and warrants written by the insurer under this subchapter, other than a collar, does not exceed three percent of the insurer's assets; and

(3) the aggregate potential exposure of all outstanding collars, forwards, futures, and swaps entered into or acquired by the insurer under this subchapter does not exceed 6.5 percent of the insurer's assets. (V.T.I.C. Art. 2.10-4, Sec. 3(c).)

Source Law

(c) After the notice under Subsection (a) or (b), the insurer may enter into hedging transactions under this article, if as a result of and after giving effect to each hedging transaction:

(1) the aggregate statement value of all outstanding options, caps, floors, swaptions, and warrants that are not attached to another financial instrument purchased by the insurer, but not including collars, under this article does not exceed seven and one-half percent of the insurer's assets;

(2) the aggregate statement value of all outstanding options, swaptions, warrants, caps, and floors, but not including collars, written by the insurer under this article does not exceed three percent of the insurer's assets; and

(3) the aggregate potential exposure of all outstanding collars, swaps, forwards, and futures entered into or acquired by the insurer under this article does not exceed six and one-half percent of the insurer's assets.

Revisor's Note

Section 3(c), V.T.I.C. Article 2.10-4, refers to providing notice under "Subsection (a) or (b)." The

revised law omits the reference to Subsection (b) because that provision is omitted from this revision for the reason stated in the revisor's note to the end of this subchapter.

Revised Law

Sec. 424.212. AUTHORITY TO ENTER INTO INCOME GENERATION TRANSACTION. An insurer may enter into an income generation transaction only if:

(1) as a result of and after making the transaction, the sum of the following amounts does not exceed 10 percent of the insurer's assets:

(A) the aggregate statement value of admitted assets that at the time of the transaction are subject to call or that generate the cash flows for payments the insurer is required to make under caps and floors sold by the insurer and that at the time of the transaction are outstanding under this subchapter;

(B) the statement value of admitted assets underlying derivative instruments that at the time of the transaction are subject to calls sold by the insurer and outstanding under this subchapter; and

(C) the purchase price of assets subject to puts that at the time of the transaction are outstanding under this subchapter; and

(2) the transaction is a sale of:

(A) a call option on assets that meets the requirements of Section 424.213;

(B) a put option on assets that meets the requirements of Section 424.214;

(C) a call option on a derivative instrument, including a swaption, that meets the requirements of Section 424.215; or

(D) a cap or floor that meets the requirements of Section 424.216. (V.T.I.C. Art. 2.10-4, Secs. 4(a), (b), (c).)

Source Law

Sec. 4. (a) An insurer may enter into an income generation transaction only as provided by this section.

(b) An insurer may enter into an income generation transaction only if, as a result of and after giving effect to the transaction, the aggregate statement value of admitted assets that are then subject to call or that generate the cash flows for payments required to be made by the insurer under caps and floors sold by the insurer and then outstanding under this article, plus the statement value of admitted assets underlying derivative instruments then subject to calls sold by the insurer and outstanding under this article, plus the purchase price of assets subject to puts then outstanding under this article, does not exceed 10 percent of the insurer's assets.

(c) The transaction must be a sale of:

(1) a call option on assets that meets the requirements of Subsection (d);

(2) a put option on assets that meets the requirements of Subsection (e);

(3) a call option on a derivative instrument, including a swaption that meets the requirements of Subsection (f); or

(4) a cap or floor that meets the requirements of Subsection (g).

Revised Law

Sec. 424.213. LIMITATION ON SALE OF CALL OPTION ON ASSETS. If an income generation transaction is a sale of a call option on assets, the insurer must, during the entire period the option is outstanding, hold, or have a currently exercisable right to acquire, the underlying assets. (V.T.I.C. Art. 2.10-4, Sec. 4(d).)

Source Law

(d) If the transaction is a sale of a call option on assets, the insurer must hold or have a currently exercisable right to acquire the underlying assets during the entire period that the option is outstanding.

Revised Law

Sec. 424.214. LIMITATION ON SALE OF PUT OPTION ON ASSETS. (a) If an income generation transaction is a sale of a put option on assets, the insurer must:

(1) during the entire period the option is outstanding, hold sufficient cash, cash equivalents, or interests in a short-term investment pool to purchase the underlying assets on exercise of the option; and

(2) have the ability to hold the underlying assets in the insurer's portfolio.

(b) If during the entire period the put option is outstanding the total market value of all put options sold by the insurer exceeds two percent of the insurer's assets, the insurer shall set aside, under a custodial or escrow agreement, cash or cash equivalents that have a market value equal to the amount of the insurer's put option obligations in excess of two percent of the insurer's assets. (V.T.I.C. Art. 2.10-4, Sec. 4(e).)

Source Law

> (e) If the transaction is a sale of a put option on assets, the insurer must hold sufficient cash, cash equivalents, or interests in a short-term investment pool to be able to purchase the underlying assets on exercise of the option during the entire period that the option is outstanding, and must be able to hold the underlying assets in the insurer's portfolio. If the total market value of all put options sold by the insurer exceeds two percent of the insurer's assets, the insurer shall set aside, under a custodial or escrow agreement, cash or cash equivalents that have a market value equal to the amount of the insurer's put option obligations in excess of two percent of the insurer's assets during the entire period the option is outstanding.

Revised Law

Sec. 424.215. LIMITATION ON SALE OF CALL OPTION ON DERIVATIVE INSTRUMENT. If an income generation transaction is a sale of a call option on a derivative instrument, including a swaption, the insurer must:

(1) during the entire period the call option is outstanding, hold, or have a currently exercisable right to acquire, assets generating the cash flow necessary to make any payment for which the insurer is liable under the underlying derivative instrument; and

(2) have the ability to enter into the underlying derivative transaction for the insurer's portfolio. (V.T.I.C. Art. 2.10-4, Sec. 4(f).)

Source Law

> (f) If the transaction is a sale of a call option on a derivative instrument, including a swaption, the insurer must hold or have a currently exercisable

right to acquire assets generating the cash flow necessary to make any payments for which the insurer is liable under the underlying derivative instrument during the entire period that the call option is outstanding, and must be able to enter into the underlying derivative transaction for the insurer's portfolio.

Revised Law

Sec. 424.216. LIMITATION ON SALE OF CAP OR FLOOR. If an income generation transaction is a sale of a cap or a floor, the insurer must, during the entire period the cap or floor is outstanding, hold, or have a currently exercisable right to acquire, assets generating the cash flow necessary to make any payment for which the insurer is liable under the cap or floor. (V.T.I.C. Art. 2.10-4, Sec. 4(g).)

Source Law

(g) If the transaction is a sale of a cap or a floor, the insurer must hold or have a currently exercisable right to acquire assets generating the cash flow necessary to make any payments for which the insurer is liable under the cap or floor during the entire period that the cap or floor is outstanding.

Revised Law

Sec. 424.217. AUTHORITY TO ENTER REPLICATION TRANSACTION. (a) An insurer may enter into a replication transaction only with the prior written approval of the commissioner.

(b) To be eligible for approval by the commissioner:

(1) the insurer must be otherwise authorized to invest the insurer's funds under this chapter in the asset being replicated; and

(2) the asset being replicated must be subject to all the provisions of this subchapter relating to the making of the transaction by the insurer with respect to that kind of asset as if the transaction constituted a direct investment by the insurer in the replicated asset.

(c) The commissioner may adopt rules regarding replication transactions as necessary to implement this section. (V.T.I.C. Art. 2.10-4, Sec. 5.)

Source Law

Sec. 5. (a) An insurer may enter into a replication transaction only with the prior written approval of the commissioner. To be eligible for approval by the commissioner:

(1) the insurer must be otherwise authorized to invest its funds under this chapter in the asset being replicated; and

(2) the asset being replicated must be subject to all the provisions and limitations on the making of the transaction specified by this article relating to investments by the insurer as if the transaction constituted a direct investment by the insurer in the replicated asset.

(b) The commissioner may adopt rules regarding replication transactions as necessary to implement this section.

Revisor's Note

(1) Section 5(a)(1), V.T.I.C. Article 2.10-4, refers to an insurer authorized to invest its funds under "this chapter," meaning V.T.I.C. Chapter 2. Chapter 2 is revised in various places throughout this code. The parts of that chapter that authorize an insurer to invest its funds are revised in this chapter. The revised law is drafted accordingly.

(2) Section 5(a)(2), V.T.I.C. Article 2.10-4, refers to certain "provisions and limitations" of that article. The revised law omits the reference to "limitations" as unnecessary because the meaning of that term is included within the meaning of "provisions."

Revised Law

Sec. 424.218. RULES. The commissioner may adopt rules consistent with this subchapter that prescribe reasonable limits, standards, and guidelines for:

(1) the risk control transactions authorized under this subchapter; and

(2) plans related to those transactions. (V.T.I.C. Art. 2.10-4, Sec. 7.)

Source Law

Sec. 7. The commissioner may adopt rules consistent with this article that prescribe reasonable

limits, standards, and guidelines with respect to the risk-limiting transactions authorized under this article and plans related to those transactions.

Revisor's Note

Section 7, V.T.I.C. Article 2.10-4, refers to "risk-limiting transactions" authorized under this subchapter. To be consistent with the terminology used in other provisions revised in this subchapter, the revised law substitutes a reference to "risk control transactions."

Revisor's Note
(End of Subchapter)

Section 3(b), V.T.I.C. Article 2.10-4, requires certain insurers to send notice to the commissioner of insurance by a date that has now passed. Consequently, the revised law omits the requirement as executed. The omitted law reads:

> (b) An insurer engaged in hedging transactions on September 1, 1999, shall send to the commissioner a notice containing the statements required by Subsection (a) of this section not later than October 1, 1999.

CHAPTER 425. RESERVES AND INVESTMENTS FOR LIFE INSURANCE COMPANIES AND RELATED ENTITIES

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CHAPTER 425. RESERVES AND INVESTMENTS FOR LIFE INSURANCE COMPANIES AND RELATED ENTITIES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 425.001. SECURITIES IN AMOUNT OF RESERVES REQUIRED. The commissioner, after determining the amount of the reserves required on all of a life insurance company's policies in force, shall ensure that the company has at least that amount in securities of the class and character required by the law of this state, after all debts and claims against the company and the minimum capital required by Chapter 841 or 982, as applicable, have been provided for. (V.T.I.C. Art. 3.32.)

Source Law

> Art. 3.32. Having determined the required reserves on all the policies in force, the Board shall see that the company has in securities of the class and character required by the laws of this State the amount of said reserves on all its policies, after all the debts and claims against it and the minimum capital required by this chapter have been provided for.

Revisor's Note

(1) V.T.I.C. Article 3.32 refers to "the Board," meaning 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. Throughout this chapter, references to either board have been changed

appropriately.

(2) V.T.I.C. Article 3.32 refers to "the company," apparently referring back to an insurance company described by former V.T.I.C. Article 3.28, as it existed at the time Article 3.32 was enacted by Chapter 491, Acts of the 52nd Legislature, Regular Session, 1951, which refers to "every company organized under the laws of this State, or authorized to transact business in this State . . . on the lives or persons of citizens of this State." Accordingly, the revised law substitutes "life insurance company" for "company."

(3) V.T.I.C. Article 3.32 refers to the minimum capital required by "this chapter," meaning V.T.I.C. Chapter 3. The applicable minimum capital requirements formerly provided by Chapter 3 were revised in 2001 in Chapters 841 and 982 of this code, and the revised law is drafted accordingly.

Revised Law

Sec. 425.002. CERTAIN INSURERS: DEPOSIT OF SECURITIES, MONEY, OR PROPERTY IN AMOUNT OF LEGAL RESERVES. (a) Except as provided by Subsection (b), a life insurance company incorporated under the laws of this state may deposit with the department, for the common benefit of all the holders of the company's policies and annuity contracts and in an amount equal to the legal reserve on all the company's outstanding policies and contracts in force, securities of the character in which the law of this state permits the company to invest, or against which the law of this state permits the company to loan, the company's capital, surplus, or reserves.

(b) A life insurance company may not make a new deposit of securities after August 28, 1961, except to the extent expressly required by Section 425.003.

(c) For purposes of this section, securities may be

physically delivered to the department without being accompanied by a written transfer of a lien securing the securities. A life insurance company may deposit registered or unregistered United States government securities under this section.

(d) A life insurance company may deposit lawful money of the United States instead of all or part of the securities described by Subsection (a). A company may, for the purposes of the deposit described by Subsection (a), convey to the department in trust the real property in which any part of the company's reserve is lawfully invested. If the company conveys the property, the department shall hold the title to the property in trust until the company deposits with the department securities to take the place of the property, at which time the department shall reconvey the property to the company.

(e) The department may have any securities or real property appraised and valued before the securities or real property may be deposited with or conveyed to the department under this section. The life insurance company shall pay the reasonable expense of the appraisal or valuation.

(f) For purposes of state, county, and municipal taxation, the situs of the deposited securities is the municipality and county in which the life insurance company's charter requires the principal business office of the company making the deposit to be located. (V.T.I.C. Art. 3.16, Secs. 1 (part), 2, 3.)

Source Law

Art. 3.16

Sec. 1. Any life insurance company now or which may hereafter be incorporated under the laws of this State may deposit with the State Board of Insurance for the common benefit of all the holders of its policies and annuity bonds, securities of the kinds in which, by the laws of this State, it is permitted to invest or loan its capital, surplus and/or reserves, equal to the legal reserve on all its outstanding policies in force, . . . . The physical delivery of such securities to the State Board of Insurance shall be sufficient without being accompanied by a written transfer of any lien securing them. Any such company may deposit lawful money of the United States in lieu of the securities above referred to, or any portion thereof, and may also, for the purposes of such deposit, convey to said State Board of Insurance in

trust the real estate in which any portion of its said reserve may be lawfully invested. In such case, the State Board of Insurance shall hold the title thereto in trust until other securities in lieu thereof shall be deposited with it, whereupon it shall reconvey the same to such company. Said State Board of Insurance may cause any such securities or real estate to be appraised and valued prior to their being deposited with or conveyed to it, in trust as aforesaid; the reasonable expense of such appraisement or valuation to be paid by the company. Under the provisions of this Article, registered as well as unregistered United States Government securities may be deposited.

Sec. 2. Notwithstanding the provisions of Section 1, of this Article, no new deposit of securities will be lawful after the effective date of this Section, except to the extent expressly required by Article 3.17.

Sec. 3. For the purpose of state, county, and municipal taxation the situs of securities deposited with the State Board of Insurance shall be in the city and county where the principal business office of such company is fixed by its charter.

Revisor's Note

(1) Section 1, V.T.I.C. Article 3.16, provides that "[a]ny life insurance company now or which may hereafter be incorporated under the laws of this state" may deposit securities in the amount of the company's legal reserves. The revised law substitutes "a life insurance company incorporated under the laws of this state" for the quoted language. Section 311.022, Government Code (Code Construction Act), which applies to the revised law, provides that a statute is presumed to operate prospectively unless expressly made retroactive. Therefore, the law as revised refers to a life insurance company that is incorporated at any time without the necessity of an express reference to companies incorporated in the future.

(2) Section 1, V.T.I.C. Article 3.16, refers to "annuity bonds." Throughout this subchapter, the revised law substitutes "annuity contract" for "annuity bond" for consistency with other provisions of this code and because "annuity contract" is the more accurate term.

(3) Section 1, V.T.I.C. Article 3.16, refers to "securities of the kinds in which" the laws of this state permit a life insurance company to invest. For consistency throughout this chapter, the revised law throughout this chapter substitutes "character" for "kind" in this context.

(4) Section 1, V.T.I.C. Article 3.16, refers to a deposit being equal to "the legal reserve on all [a life insurance company's] outstanding policies in force." Because of the preceding reference in Section 1 to the deposit being for the benefit of "all the holders of [the company's] policies and annuity bonds," it is clear from the context that the amount of the deposit is intended to be equal to the reserves on outstanding policies and on outstanding annuity contracts. The revised law is drafted accordingly.

(5) Section 2, V.T.I.C. Article 3.16, refers to "the effective date of this Section," meaning Section 2, V.T.I.C. Article 3.16. Section 2 was added by Chapter 469, Acts of the 57th Legislature, Regular Session, 1961. That act took effect August 28, 1961. Accordingly, the revised law substitutes "August 28, 1961," for "the effective date of this Section."

(6) Section 3, V.T.I.C. Article 3.16, refers to a "city." The revised law substitutes "municipality" for "city" because that is the term used in the Local Government Code.

Revised Law

Sec. 425.003. CERTAIN INSURERS: REQUIRED DEPOSITS OF SECURITIES; ADDITIONAL DEPOSITS AND WITHDRAWALS. (a) A life insurance company that, before August 28, 1961, issued or assumed the obligations of policies or annuity contracts that were registered as provided by Article 3.18, as that article existed before August 28, 1961, shall have on deposit with the department

securities of the character described by Section 425.002 in an amount equal to or greater than the aggregate net value of the company's outstanding registered policies and annuity contracts in force.

(b) To comply with Subsection (a), a life insurance company shall periodically make additional deposits of securities in amounts of not less than $5,000. A company whose deposits exceed the aggregate net value of the company's outstanding registered policies and annuity contracts in force may periodically withdraw the excess in amounts of not less than $5,000. A company may at any time withdraw any of the company's deposited securities by depositing in their place securities of equal value to the securities replaced and of a character authorized by this chapter.

(c) A life insurance company may at any time collect the interest, rents, and other income from the company's securities on deposit.

(d) The net value of each policy or annuity contract subject to this section is the policy's or contract's value according to the standard prescribed by state law when the first premium on the policy or contract is paid, minus the amount of any liens the life insurance company has against the policy or contract not to exceed the policy's or contract's value.

(e) The department shall hold a life insurance company's securities on deposit with the department under this section in trust for the benefit of all holders of the company's outstanding policies and annuity contracts that were registered as provided by Article 3.18, as that article existed before August 28, 1961.

(f) A life insurance company that has outstanding registered policies or annuity contracts in force may not reinsure all or any part of that outstanding business, other than in a company authorized to engage in business in this state. (V.T.I.C. Art. 3.16, Sec. 1 (part); Art. 3.17.)

Source Law

[Art. 3.16]

Sec. 1. [Any life insurance company now or which may hereafter be incorporated under the laws of this State may deposit with the State Board of Insurance for the common benefit of all the holders of its policies and annuity bonds, securities of the kinds in which, by the laws of this State, it is permitted to invest or loan its capital, surplus and/or reserves, equal to the legal reserve on all its outstanding policies in force,] which securities shall be held by said State Board of Insurance in trust for the purpose and objects herein specified. . . .

Art. 3.17

Sec. 1. Any life insurance company which has heretofore issued or assumed the obligations of policies or annuity bonds which have been registered in the manner at any time authorized by this Chapter, shall at all times hereafter have on deposit with the State Board of Insurance securities of the character described in Article 3.16 in amounts equal to or in excess of the aggregate net value of such outstanding registered policies and annuity bonds in force, and for such purpose new and additional deposits of securities shall be made from time to time and in amounts of not less than Five Thousand Dollars ($5,000). Any such company whose deposits exceed such aggregate net value of its outstanding registered policies and annuity bonds in force may from time to time withdraw such excess by withdrawals of not less than Five Thousand Dollars ($5,000). Any such company may at any time withdraw any of its deposited securities by depositing in their stead others of equal value and of the character authorized by this Chapter, and may collect the interest, rents and other income from its securities on deposit. The net value of every policy or annuity bond subject to this Act shall be its value according to the standard prescribed by the laws of this State, when the first premium thereon has been paid, less the amount of such liens as the company may have against it not in excess of such value.

Sec. 2. The securities of any such company on deposit with the State Board of Insurance shall be held in trust by said board for the benefit of all of the holders of the outstanding policies and annuity bonds of such company which have been registered pursuant to this Chapter.

Sec. 3. No company which has outstanding registered policies or annuity bonds in force shall reinsure its outstanding registered business, or the whole of any one or more of its registered policies or annuity bonds, except in a company or companies incorporated and organized under the laws of this State or having permission to do business in this State.

Revisor's Note

(1) Section 1, V.T.I.C. Article 3.17, refers to policies and annuities that have "heretofore" been issued or assumed and have been registered in the manner that was at any time authorized by "this Chapter," meaning V.T.I.C. Chapter 3. Under V.T.I.C.

Article 3.18 as enacted by Chapter 491, Acts of the 52nd Legislature, Regular Session, 1951, certain life insurance policies and annuity contracts were required to be registered with the Board of Insurance Commissioners. Article 3.18 was amended by Chapter 469, Acts of the 57th Legislature, Regular Session, 1961; Section 1, V.T.I.C. Article 3.18, was added to provide that, after the effective date of that section, "no policy or annuity bond shall be registered in the manner heretofore authorized by this Chapter." Chapter 469 took effect August 28, 1961. Accordingly, the revised law substitutes "before August 28, 1961," for "heretofore," and refers to registration as provided by Article 3.18 "as that article existed before August 28, 1961."

(2) Section 1, V.T.I.C. Article 3.17, requires certain life insurance companies to have "at all times hereafter" certain securities on deposit. The revised law omits "at all times" because, absent a limitation on the requirement to have securities on deposit, the requirement applies at all times without an express statement to that effect. In addition, the revised law omits the reference to "hereafter" as unnecessary because Section 311.022, Government Code (Code Construction Act), applicable to the revised law, provides that a statute operates prospectively unless expressly made retrospective.

(3) Section 1, V.T.I.C. Article 3.17, refers to securities "authorized by this Chapter," meaning V.T.I.C. Chapter 3. Although Chapter 3 is revised in several titles throughout this code, the revised law refers to this chapter of the revised law because this chapter revises V.T.I.C. Articles 3.33 and 3.39, which are the applicable provisions of V.T.I.C. Chapter 3

governing authorized securities for a life insurance company.

(4) Section 3, V.T.I.C. Article 3.17, refers to an insurance company "incorporated and organized under the laws of this State" or authorized to engage in business in this state. The revised law omits the quoted language as unnecessary because a company that is authorized to engage in business in this state includes a company that is incorporated and organized under the laws of this state.

Revised Law

Sec. 425.004. RECORDS OF SECURITIES DEPOSITED WITH DEPARTMENT; REPORT OF VALUE. Each life insurance company that is required by Section 425.003 to have securities on deposit with the department shall:

(1) keep records of:

(A) all of the company's outstanding registered policies and annuity contracts in force; and

(B) the net value of those policies and contracts; and

(2) not later than the 15th day after the last day of each calendar month, file with the department a report stating whether the value of the company's securities on deposit is equal to or greater than the aggregate net value of the company's registered policies and annuity contracts outstanding and in force at the end of the preceding calendar month. (V.T.I.C. Art. 3.18, Secs. 2, 3.)

Source Law

Sec. 2. Every life insurance company which is required by this Chapter to have securities on deposit with the State Board of Insurance shall keep records of all of its outstanding registered policies and annuity bonds in force, and of the net value thereof.

Sec. 3. Each life insurance company which is required by this Chapter to have securities on deposit with the State Board of Insurance shall, within fifteen (15) days after the termination of each calendar month, file with said Board a report stating whether or not the value of its securities on deposit is equal to or in excess of the aggregate value of its registered policies and annuity bonds outstanding and

in force at the end of such preceding calendar month.

Revisor's Note

(1) Section 2, V.T.I.C. Article 3.18, refers to a life insurance company that is required by "this Chapter," meaning V.T.I.C. Chapter 3, to have securities on deposit. Although Chapter 3 is revised in several titles throughout this code, the revised law refers to Section 425.003 because that section revises Article 3.17, the part of V.T.I.C. Chapter 3 that requires a life insurance company to have securities on deposit.

(2) Section 3, V.T.I.C. Article 3.18, requires a life insurance company to report whether the securities the company has on deposit equal or exceed the "aggregate value" of the company's registered policies and annuity bonds. The revised law substitutes "aggregate net value" for "aggregate value" because it is clear from the context that "net value" in Section 2, Article 3.18, is a reference to "aggregate net value" as used in Section 1, V.T.I.C. Article 3.17, revised in this chapter in Section 425.003, which contains the substantive requirement that a company deposit securities.

Revised Law

Sec. 425.005. DEPARTMENT DUTIES REGARDING DEPOSITED SECURITIES; INSURANCE COMPANY ACCESS. (a) The department shall keep securities deposited by a life insurance company under Sections 425.002 and 425.003 in a secure safe-deposit, fireproof box or vault in the municipality of, or a municipality near the location of, the company's home office.

(b) The life insurance company's officers may, in accordance with reasonable rules adopted by the commissioner, have access to the securities to detach interest coupons, credit payment, and exchange securities as provided by Section 425.003.

(V.T.I.C. Art. 3.18, Sec. 4.)

Source Law

Sec. 4. The securities deposited under this Chapter by each company shall be placed and kept by the State Board of Insurance in some secure safe-deposit, fireproof box or vault in the city or town in or near where the home office of the company is located. The officers of the company shall have access to such securities for the purpose of detaching interest coupons and crediting payment and exchanging securities as above provided, under such reasonable rules and regulations as the State Board of Insurance may establish.

Revisor's Note

(1) Section 4, V.T.I.C. Article 3.18, requires certain securities to be "placed and kept" in certain places. The revised law omits the reference to "placed" as unnecessary because a security cannot be "kept" somewhere unless it is first placed there.

(2) Section 4, V.T.I.C. Article 3.18, refers to a "city or town." The revised law substitutes "municipality" for "city or town" for the reason stated in Revisor's Note (6) to Section 425.002.

(3) Section 4, V.T.I.C. Article 3.18, refers to "rules and regulations." Other provisions revised in this chapter refer only to "regulations" with respect to state law. Throughout this chapter, the revised law, as applicable, omits "regulation," or substitutes "rule" for "regulation," 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. 425.006. ADDITIONAL RESERVES REQUIRED: SUBSTANDARD OR EXTRA HAZARDOUS POLICIES. (a) If a life insurance company engaged in business under the laws of this state has written or assumed risks that are substandard or extra hazardous and has charged more for the policies under which those risks are written or assumed than

the company's published premium rates, the commissioner shall, in valuing those policies, compute and charge extra reserves on the policies as necessary because of the extra hazard assumed and the extra premium charged.

(b) If the commissioner determines, after notice and hearing, that a particular risk or class of risks is substandard or extra hazardous, a life insurance company may not, after the determination is made, write or assume the particular risk or class of risks unless the company charges an extra premium as necessary because of the extra hazard assumed. (V.T.I.C. Art. 3.29.)

Source Law

> Art. 3.29. If any life insurance company doing business under the laws of this State has written or assumed risks that are sub-standard or extra hazardous and has charged therefor more than its published rates of premium, the Board of Insurance Commissioners shall in valuing such policies compute and charge such extra reserves thereon as is warranted by reason of the extra hazard assumed and the extra premium charged. If the Board of Insurance Commissioners shall find, after notice and hearing, that a particular risk or class of risks is sub-standard or extra hazardous, then and in that event no such company shall thereafter write or assume any such risks unless they charge therefor such extra premium as is warranted by reason of the extra hazard assumed.

Revised Law

Sec. 425.007. SUBSCRIPTION TO OR UNDERWRITING PURCHASE OR SALE OF SECURITIES OR PROPERTY PROHIBITED; CONTROL OF DISPOSITION OF PROPERTY. (a) A life insurance company organized under the laws of this state may not:

(1) subscribe to, or participate in, any underwriting of the purchase or sale of securities or property;

(2) enter into a transaction described by Subdivision (1) for a purpose described by Subdivision (1);

(3) sell on account of the company jointly with any other person, firm, or corporation; or

(4) enter into any agreement to withhold from sale any of the company's property.

(b) The disposition of the life insurance company's property must be at all times within the control of the company's

board of directors. (V.T.I.C. Art. 3.39a.)

Source Law

Art. 3.39a. No life insurance company organized under the laws of this state shall subscribe to, or participate in, any underwriting of the purchase or sale of securities or property or enter into any such transaction for such purpose, or sell on account of such company jointly with any other person, firm or corporation, nor shall any such company enter into any agreement to withhold from sale any of its property, but the disposition of its property shall be at all times within the control of its Board of Directors.

Revised Law

Sec. 425.008. AUTHORIZED INVESTMENTS FOR FOREIGN COMPANIES. A foreign company shall invest the company's assets in:

(1) securities or property of the same classes in which the law of this state permits a domestic insurance company to invest; or

(2) securities permitted by other law of this state and approved by the commissioner as being of substantially the same grade as securities or property in which a domestic insurance company is permitted to invest. (V.T.I.C. Art. 3.41.)

Source Law

Art. 3.41. The assets of any "foreign company" shall be invested in securities or property of the same classes permitted by the laws of this State as to "domestic" companies or by other laws of this State in other securities approved by the Board of Insurance Commissioners as being of substantially the same grade.

Revised Law

Sec. 425.009. STUDENT LOANS. A foreign or domestic life insurance company may make loans to a student enrolled in an institution of higher education if the principal amount of the loan is insured by:

(1) the federal government under the Higher Education Act of 1965 (Pub. L. No. 89-329), as amended; or

(2) the Texas Guaranteed Student Loan Corporation under Chapter 57, Education Code. (V.T.I.C. Art. 3.41a.)

Source Law

Art. 3.41a. A foreign or domestic life insurance company may make loans to a student enrolled in an

institution of higher education provided that the principal amount of the loans is insured by the federal government pursuant to the provisions of the Federal Higher Education Act of 1965, as amended (P.L. 89-329, as amended), or by the Texas Guaranteed Student Loan Corporation, Section 57.01 et seq., Texas Education Code, as added.

Revisor's Note
(End of Subchapter)

Section 1, V.T.I.C. Article 3.18, provides that "[a]fter the effective date of this Section 1, of this Article," meaning Article 3.18, an insurance company may not register a life insurance policy or annuity contract in the manner "heretofore" authorized by V.T.I.C. Chapter 3. The revised law omits this provision as executed. V.T.I.C. Article 3.18 was amended by Chapter 469, Acts of the 57th Legislature, Regular Session, 1961, which added Section 1 to that article. Before the 1961 amendment, Article 3.18 required companies to register certain life insurance policies and annuity contracts with the Board of Insurance Commissioners. The termination of the requirement to register insurance policies and annuity contracts accomplished its purpose when it took effect August 28, 1961, and is thus unnecessary. The omitted law reads:

Art. 3.18
Sec. 1. After the effective date of this Section 1, of this Article, no policy or annuity bond shall be registered in the manner heretofore authorized by this Chapter.

[Sections 425.010-425.050 reserved for expansion]

SUBCHAPTER B. STANDARD VALUATION LAW

Revised Law

Sec. 425.051. SHORT TITLE. This subchapter may be cited as the Standard Valuation Law. (V.T.I.C. Art. 3.28, Sec. 1.)

Source Law

Art. 3.28
Sec. 1. This Article shall be known as the Standard Valuation Law.

Revised Law

Sec. 425.052. DEFINITIONS. (a) In this subchapter, "reserves" means reserve liabilities.

(b) As used in this subchapter:

(1) an "issue year basis" of valuation means a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract; and

(2) a "change in fund basis" of valuation means a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund. (V.T.I.C. Art. 3.28, Secs. 2 (part), 5(c) (part).)

Source Law

Sec. 2. [The State Board of Insurance shall annually value, or cause to be valued, the reserve liabilities] (hereinafter called reserves) . . . .

[Sec. 5]
(c) . . .
(1) . . .
(vi) . . . As used in this section, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

Revised Law

Sec. 425.053. ANNUAL VALUATION OF RESERVES. (a) The department shall annually value or have valued the reserves for all outstanding life insurance policies and annuity and pure endowment contracts of each life insurance company engaged in business in this state. The department may certify the amount of those

reserves, specifying the mortality table or tables, rate or rates of interest, and methods, including the net level premium method or another method, used in computing those reserves.

(b) In computing reserves under Subsection (a), the department may use group methods and approximate averages for fractions of a year or otherwise.

(c) Instead of valuing the reserves as required by Subsection (a) for a foreign or alien company, the department may accept any valuation made by or for the insurance supervisory official of another state or jurisdiction if:

(1) the valuation complies with the minimum standard provided by this subchapter; and

(2) the official accepts as sufficient and valid for all legal purposes a certificate of valuation made by the department that states the valuation was made in a specified manner according to which the aggregate reserves would be at least as large as they would be if computed in the manner prescribed by the law of that state or jurisdiction. (V.T.I.C. Art. 3.28, Sec. 2 (part).)

Source Law

> Sec. 2. The State Board of Insurance shall annually value, or cause to be valued, the reserve liabilities . . . for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this state, and may certify the amount of any such reserves, specifying the mortality table or tables, rate or rates of interest, and methods (net level premium method or other) used in the calculation of such reserves. In calculating such reserves, the Board may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves herein required of any foreign or alien company, the Board may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard herein provided and if the official of such state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the State Board of Insurance when such certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.

Revised Law

Sec. 425.054. ACTUARIAL OPINION REQUIRED. (a) For purposes of this section, "qualified actuary" means:

(1) a qualified actuary, as that term is defined by Section 802.002; or

(2) a person who, before September 1, 1993, satisfied the requirements of the former State Board of Insurance to submit an opinion under former Section 2A(a)(1), Article 3.28.

(b) In conjunction with the annual statement and in addition to other information required by this subchapter, each life insurance company engaged in business in this state shall annually submit to the department the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by commissioner rule:

(1) are computed appropriately;

(2) are based on assumptions that satisfy contractual provisions;

(3) are consistent with prior reported amounts; and

(4) comply with applicable laws of this state.

(c) The commissioner by rule shall specify the requirements of an actuarial opinion under Subsection (b), including any matters considered necessary to the opinion's scope.

(d) The opinion required by this section must:

(1) apply to all of the life insurance company's business in force, including individual and group health insurance plans; and

(2) be in the form and contain the substance specified by commissioner rule and be acceptable to the commissioner.

(e) The commissioner may accept as an opinion required to be submitted under Subsection (b) by a foreign or alien company the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion filed in the other state reasonably meets the requirements applicable to a company domiciled in this state.

(f) Except as exempted by or as otherwise provided by commissioner rule, a life insurance company shall include in the opinion required by Subsection (b) an opinion that states whether the reserves and related actuarial items held in support of the policies and contracts specified by commissioner rule adequately provide for the company's obligations under the policies and contracts, including the benefits under and expenses associated with the policies and contracts.

(g) In making the opinion under Subsection (f), the reserves and related actuarial items are considered in light of the assets held by the life insurance company with respect to the reserves and related actuarial items, including:

(1) the investment earnings on the assets; and

(2) the considerations anticipated to be received and retained under the policies and contracts.

(h) The person who certifies the opinion required by Subsection (b) must make the opinion required by Subsection (f).

(i) Rules adopted under this section may exempt life insurance companies that would be exempt from the requirements of this section under the most recently adopted regulation by the National Association of Insurance Commissioners entitled "Model Actuarial Opinion and Memorandum Regulation," or a successor to that regulation, if the commissioner considers the exemption appropriate. (V.T.I.C. Art. 3.28, Secs. 2A(a)(1), (2), (3), (b).)

Source Law

Sec. 2A. (a) General. (1) In conjunction with the annual statement and in addition to other information required by this article, every life insurance company doing business in this state shall annually submit to the State Board of Insurance the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by rule of the Board are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The Board by rule shall define the specific requirements of this opinion and shall include any matters deemed to be necessary to the opinion's scope. For purposes of this subdivision, "qualified actuary" has the meaning assigned by Article 1.11(d) of this code. A person who, before

September 1, 1993, satisfied the requirements of the Board to submit an opinion under this subdivision may also submit the opinion required by this subdivision.

(2) The opinion required under this section shall apply to all business in force including individual and group health insurance plans, in form and substance as specified by Board rule and acceptable to the commissioner.

(3) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion filed in the other state reasonably meets the requirements applicable to a company domiciled in this state.

. . .

(b) Actuarial Analysis of Reserves and Assets Supporting Such Reserves. Every life insurance company, except as exempted by or pursuant to rule adopted by the Board, shall also annually include in the opinion required by Subsection (a)(1) of this section, an opinion of the same person who certifies to the opinion under Subsection (a)(1) of this section as to whether the reserves and related actuarial items held in support of the policies and contracts specified by Board rule, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts. The rules adopted by the Board under this section may exempt those companies that would be exempted from the requirements stated in this subsection (b) according to the most recently adopted regulation by the National Association of Insurance Commissioners entitled "Model Actuarial Opinion and Memorandum Regulation" or its successor regulation if the Board considers the exemption appropriate.

Revisor's Note

Section 2A(b), V.T.I.C. Article 3.28, refers to "including but not limited to." Other provisions revised in this chapter contain similar language. Throughout this chapter, "but not limited to" is omitted 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. 425.055. SUPPORTING MEMORANDUM FOR ACTUARIAL OPINION. (a) A memorandum that, in form and substance, complies with the commissioner's rules shall be prepared to support each actuarial opinion required by Section 425.054.

(b) The commissioner may engage an actuary or other financial specialist as defined by commissioner rule if:

(1) a life insurance company does not provide a supporting memorandum at the request of the commissioner in the time specified by rule; or

(2) the company provides a supporting memorandum, but the commissioner determines that the supporting memorandum does not meet the standards prescribed by rule or is otherwise unacceptable to the commissioner.

(c) The actuary or other financial specialist under Subsection (b) shall:

(1) review the actuarial opinion and the basis for the opinion; and

(2) prepare the supporting memorandum.

(d) A life insurance company is responsible for the expense of the actuary or other financial specialist under Subsection (b). (V.T.I.C. Art. 3.28, Secs. 2A(a)(6), (7).)

Source Law

(6) A memorandum, in form and substance in compliance with rules of the State Board of Insurance, shall be prepared to support each opinion.

(7) If an insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by rule or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the Board's rules or is otherwise unacceptable to the commissioner, the commissioner may engage an actuary or other financial specialist as defined by Board rule at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum.

Revised Law

Sec. 425.056. LIMITATION ON LIABILITY FOR ACTUARIAL OPINION. (a) Except in cases of fraud or wilful misconduct or as

provided by Subsection (b), a person who certifies an opinion under Section 425.054 is not liable for damages to a person, other than the life insurance company covered by the opinion, for an act, error, omission, decision, or other conduct with respect to the person's opinion.

(b) Subsection (a) does not apply to an administrative penalty imposed under Chapter 84. (V.T.I.C. Art. 3.28, Sec. 2A(a)(4).)

Source Law

> (4) A. Except in cases of fraud or wilful misconduct or as provided by Subsection (a)(7)B of this section, a person who certifies to an opinion under this section shall not be liable for damages to a person other than the insurance company covered by the opinion prepared by the certifying person for any act, error, omission, decision, or conduct with respect to the person's opinion.
>
> (B) Subsection (a)7A of this section does not apply to a monetary forfeiture imposed under Section 7, Article 1.10, Insurance Code.

Revisor's Note

(1) Section 2A(a)(4)A, V.T.I.C. Article 3.28, refers to "Subsection (a)(7)B of this section." Section 2A(a)(4)(B), V.T.I.C. Article 3.28, refers to "Subsection (a)7A of this section." Section 2A(a)(7), V.T.I.C. Article 3.28, does not contain a Paragraph (A) or a Paragraph (B). From the context of Section 2A(a)(4), it is clear that the references to "(a)(7)" and "(a)7" are typographic errors, and that the intended reference is "(a)(4)." The revised law is drafted accordingly.

(2) Section 2A(a)(4)(B), V.T.I.C. Article 3.28, refers to "a monetary forfeiture imposed under Section 7, Article 1.10, Insurance Code." Section 2A was enacted by Section 11.101, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991. Section 1.06 of that act amended Section 7(a)(3), V.T.I.C. Article 1.10, to provide for "a specified monetary forfeiture" not to exceed $25,000 for a violation or failure to

comply with the insurance laws of this state. Section 1.07, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, amended Section 7(a)(3), V.T.I.C. Article 1.10, by deleting the provision for "a monetary forfeiture" and substituting a reference to "an administrative penalty in accordance with Article 1.10E," revised in 1999 as Chapter 84 of this code. The revised law is drafted accordingly.

Revised Law

Sec. 425.057. DISCIPLINARY ACTION: COMPANY OR PERSON CERTIFYING OPINION. A company or person that certifies an opinion under Section 425.054 and that violates Section 425.054 or 425.055 or rules adopted under those sections is subject to disciplinary action under Chapter 82. (V.T.I.C. Art. 3.28, Sec. 2A(a)(5).)

Source Law

(5) A company or a person who certifies to an opinion under this section and that fails to comply with or violates this section or rules adopted by the Board pursuant to this section is subject to disciplinary action under Section 7, Article 1.10, Insurance Code.

Revisor's Note

Section 2A(a)(5), V.T.I.C. Article 3.28, refers to a company or person that "fails to comply with or violates" Section 2A. The revised law omits the reference to "fails to comply with" as unnecessary because the meaning of that phrase is included in the meaning of "violates."

Revised Law

Sec. 425.058. VALUATION OF POLICY OR CONTRACT: GENERAL RULE. (a) Except as otherwise provided by Section 425.059, 425.060, 425.061, 425.062, or 425.063, the minimum standard for the valuation of an outstanding life insurance policy or annuity or pure endowment contract issued by a life insurance company on or after the date on which Chapter 1105 applies to policies issued by the company, as determined under Section 1105.002(a) or (b), is the

commissioners reserve valuation method described by Sections 425.064, 425.065, and 425.068, computed using the table prescribed by this section and with interest at 3-1/2 percent or at the following rate, if applicable:

(1) in the case of a policy or contract issued on or after June 14, 1973, and before August 29, 1977, other than an annuity or pure endowment contract, four percent;

(2) in the case of a single premium life insurance policy issued on or after August 29, 1977, 5-1/2 percent; or

(3) in the case of a life insurance policy issued on or after August 29, 1977, other than a single premium life insurance policy, 4-1/2 percent.

(b) Except as provided by Subsection (c), for an ordinary life insurance policy issued on the standard basis, excluding any disability or accidental death benefits in the policy, the applicable table is the Commissioners 1941 Standard Ordinary Mortality Table, if the policy was issued before the date on which Section 1105.152 would apply to the policy, as determined under Section 1105.152(a) or (b), or the Commissioners 1958 Standard Ordinary Mortality Table, if Section 1105.152 applies to the policy. For a policy that is issued to insure a female risk:

(1) a modified net premium or present value for a policy issued before August 29, 1977, may be computed according to an age not more than three years younger than the insured's actual age; and

(2) a modified net premium or present value for a policy issued on or after August 29, 1977, may be computed according to an age not more than six years younger than the insured's actual age.

(c) For an ordinary life insurance policy issued on the standard basis, excluding any disability or accidental death benefits in the policy, and to which Subchapter B, Chapter 1105, applies, the applicable table is:

(1) the Commissioners 1980 Standard Ordinary

Mortality Table;

(2) at the insurer's option for one or more specified life insurance plans, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

(3) any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by commissioner rule for use in determining the minimum standard valuation for a policy to which this subdivision applies.

(d) For an industrial life insurance policy issued on the standard basis, excluding any disability or accidental death benefits in the policy, the applicable table is:

(1) the 1941 Standard Industrial Mortality Table, if the policy was issued before the date on which Section 1105.153 would apply to the policy as determined under Section 1105.153(a) or (b); or

(2) if Section 1105.153 applies to the policy:

(A) the Commissioners 1961 Standard Industrial Mortality Table; or

(B) any industrial mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by commissioner rule for use in determining the minimum standard of valuation for a policy to which this subdivision applies.

(e) For an individual annuity or pure endowment contract, excluding any disability or accidental death benefits in the policy, the applicable table is the 1937 Standard Annuity Mortality Table, or at the insurer's option, the Annuity Mortality Table for 1949, Ultimate, or a modification of either table that is approved by the commissioner.

(f) For a group annuity or pure endowment contract, excluding any disability or accidental death benefits in the policy, the applicable table is:

(1) the Group Annuity Mortality Table for 1951;

(2) a modification of that table approved by the

commissioner; or

(3) at the insurance company's option, a table or a modification of a table prescribed for an individual annuity or pure endowment contract by Subsection (e).

(g) For total and permanent disability benefits in or supplementary to an ordinary policy or contract, the applicable tables are:

(1) for a policy or contract issued on or after January 1, 1966:

(A) the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit; or

(B) any table of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners that are approved by commissioner rule for use in determining the minimum standard of valuation for a policy to which this subdivision applies;

(2) for a policy or contract issued on or after January 1, 1961, and before January 1, 1966:

(A) a table described by Subdivision (1); or

(B) at the insurance company's option, the Class (3) Disability Table (1926); or

(3) for a policy issued before January 1, 1961, the Class (3) Disability Table (1926).

(h) A table described by Subsection (g) must, for an active life, be combined with a mortality table permitted for computing the reserves for a life insurance policy.

(i) For accidental death benefits in or supplementary to a policy, the applicable table is:

(1) for a policy issued on or after January 1, 1966:

(A) the 1959 Accidental Death Benefits Table; or

(B) any accidental death benefits table adopted after 1980 by the National Association of Insurance Commissioners that is approved by commissioner rule for use in determining the

minimum standard of valuation for a policy to which this subdivision applies;

(2) for a policy issued on or after January 1, 1961, and before January 1, 1966:

(A) a table described by Subdivision (1); or

(B) at the insurance company's option, the Inter-Company Double Indemnity Mortality Table; or

(3) for a policy issued before January 1, 1961, the Inter-Company Double Indemnity Mortality Table.

(j) A table described by Subsection (i) must be combined with a mortality table permitted for computing the reserves for a life insurance policy.

(k) For group life insurance, life insurance issued on the substandard basis and other special benefits, the applicable table is a table approved by the commissioner.

(l) Notwithstanding any other law, the minimum reserve requirements applicable to a policy issued under Chapter 1153 are met if, in the aggregate, the reserves are maintained at 100 percent of the 1980 Commissioner's Standard Ordinary Mortality Table, with interest that does not exceed 5.5 percent. This subsection expires September 1, 2013. (V.T.I.C. Art. 3.28, Secs. 3 (part), (a), (b), (c), (d), (e), (f), (g), (h).)

Source Law

Sec. 3. . . . Except as otherwise provided in Sections 4 and 5 of this article, the minimum standard for the valuation of all such policies and contracts issued on or after the operative date of Article 3.44a (the Standard Nonforfeiture Law for Life Insurance) shall be the commissioners reserve valuation methods defined in Sections 6, 7, and 10 of this article, three and one-half per cent (3 1/2%) interest; in the case of policies and contracts, other than annuity and pure endowment contracts, issued on or after June 14, 1973, four per cent (4%) interest for such policies issued prior to August 29, 1977; or five and one-half per cent (5 1/2%) interest for single premium life insurance policies and four and one-half per cent (4 1/2%) interest for all other such policies issued on and after August 29, 1977, and the following tables:

(a) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, the Commissioners 1941 Standard Ordinary Mortality Table for such policies issued prior to the

operative date of Section 6 of the Standard Nonforfeiture Law for Life Insurance, as amended, the Commissioners 1958 Standard Ordinary Mortality Table for such policies issued on or after the operative date of Section 6 of the Standard Nonforfeiture Law for Life Insurance, as amended, and prior to the operative date of Section 8 of the Standard Nonforfeiture Law for Life Insurance, as amended, provided that for any category of such policies issued on female risks, all modified net premiums and present values referred to in this Act may be calculated according to an age not more than three years younger than the actual age of the insured for policies issued prior to August 29, 1977 and not more than six years younger than the actual age of the insured for policies issued on and after August 29, 1977; and for such policies issued on or after the operative date of Section 8 of the Standard Nonforfeiture Law for Life Insurance, as amended, (i) the Commissioners 1980 Standard Ordinary Mortality Table, or (ii) at the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors, or (iii) any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by regulation promulgated by the State Board of Insurance for use in determining the minimum standard valuation for such policies.

(b) For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, the 1941 Standard Industrial Mortality Table for such policies issued prior to the operative date of Section 7 of the Standard Nonforfeiture Law for Life Insurance, as amended, and for such policies issued on or after such operative date, the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by regulation promulgated by the State Board of Insurance for use in determining the minimum standard of valuation for such policies.

(c) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 Standard Annuity Mortality Table, or, at the option of the company, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the State Board of Insurance.

(d) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the Group Annuity Mortality Table for 1951, any modification of such table approved by the State Board of Insurance, or, at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(e) For total and permanent disability benefits in or supplementary to ordinary policies or contracts, for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit, or any tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners that are approved by regulation promulgated by the State Board of Insurance

for use in determining the minimum standard of valuation for such policies; for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either such tables or, at the option of the company, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(f) For accidental death benefits in or supplementary to policies, for policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the National Association of Insurance Commissioners that is approved by regulation promulgated by the State Board of Insurance for use in determining the minimum standard of valuation for such policies; for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table or, at the option of the company, the Inter-Company Double Indemnity Mortality Table; and for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(g) For group life insurance, life insurance issued on the substandard basis and other special benefits, such tables as may be approved by the State Board of Insurance.

(h) Notwithstanding any other law, the minimum reserve requirements applicable to a policy issued under Article 3.53 of this code are met if, in aggregate, the reserves are maintained at 100 percent of the 1980 Commissioner's Standard Ordinary Mortality Table, with interest not to exceed 5.5 percent. This subsection expires September 1, 2013.

Revisor's Note

(1) Section 3, V.T.I.C. Article 3.28, provides for the minimum standard for the valuation of all life insurance policies and contracts "issued on or after the operative date of Article 3.44a (the Standard Nonforfeiture Law for Life Insurance)." Similar references to "the operative date" of V.T.I.C. Article 3.44a appear throughout the source law for this subchapter.

V.T.I.C. Article 3.44a was codified as Chapter 1105 of this code by Chapter 1419, Acts of the 77th Legislature, Regular Session, 2001. Section 13, V.T.I.C. Article 3.44a, which defined the "operative date" of that article, is codified as Section 1105.002 of this code. Section 1105.002 omits the reference to

"the operative date" of the law and substitutes a clear statement of the law's applicability to certain policies. In accordance with Chapter 1105, the revised law in this subchapter, for purposes of describing the policies and contracts to which a particular minimum standard of valuation applies, omits references to "the operative date" and substitutes language consistent with Section 1105.002.

(2) Section 3(a), V.T.I.C. Article 3.28, provides for the use of a specified mortality table for computing the valuation of all life insurance policies and contracts "issued prior to the operative date of Section 6 of the Standard Nonforfeiture Law for Life Insurance, as amended" (V.T.I.C. Article 3.44a) and for the use of a different table for life insurance policies "issued on or after the operative date of Section 6 of the Standard Nonforfeiture Law for Life Insurance, as amended." Section 3(a) contains similar references to "the operative date of Section 8 of the Standard Nonforfeiture Law for Life Insurance, as amended." Section 3(b), V.T.I.C. Article 3.28, refers to policies issued "prior to the operative date of Section 7 of the Standard Nonforfeiture Law for Life Insurance, as amended," and to policies issued "on or after such operative date."

As stated in Revisor's Note (1) to this section, V.T.I.C. Article 3.44a was codified as Chapter 1105 of this code. Section 6, Article 3.44a, is codified as Section 1105.152 of this code; Section 7, Article 3.44a, is codified as Section 1105.153 of this code; Section 8, Article 3.44a, is codified as Subchapter B, Chapter 1105 of this code. Each of those provisions omits the reference to "the operative date" of the law

and substitutes a clear statement of the law's applicability to certain policies. In accordance with Chapter 1105, the revised law in this subchapter, for purposes of prescribing the mortality table used in computing the valuation of certain policies, omits references to "the operative date" and substitutes language consistent with Chapter 1105.

Throughout this chapter, the revised law omits references to "as amended" with respect to state statutes 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, and amendments of the statute.

Revised Law

Sec. 425.059. VALUATION OF CERTAIN ANNUITIES AND PURE ENDOWMENT CONTRACTS. (a) This section applies to an individual annuity or pure endowment contract issued on or after January 1, 1979, and an annuity or pure endowment purchased on or after January 1, 1979, under a group annuity or pure endowment contract. This section also applies to an annuity or pure endowment contract issued by an insurer after the date specified in a written notice:

(1) that was filed with the State Board of Insurance after June 14, 1973, but before January 1, 1979; and

(2) under which the insurance company filing the notice elected to comply before January 1, 1979, with former Section 4, Article 3.28, with respect to individual or group annuities and pure endowment contracts as specified by the company in the notice.

(b) Except as provided by Section 425.060, 425.061, 425.062, or 425.063, the minimum standard for the valuation of an individual or group annuity or pure endowment contract, excluding any disability or accidental death benefits in the contract, is the commissioners reserve valuation method described by Sections

425.064 and 425.065, computed using the table prescribed by this section and with interest at the following interest rate, as applicable:

(1) for an individual annuity or pure endowment contract issued before August 29, 1977, other than an individual single premium immediate annuity contract, four percent;

(2) for an individual single premium immediate annuity contract issued before August 29, 1977, six percent;

(3) for an individual annuity or pure endowment contract issued on or after August 29, 1977, other than an individual single premium immediate annuity contract or an individual single premium deferred annuity or pure endowment contract, 4-1/2 percent;

(4) for an individual single premium immediate annuity contract issued on or after August 29, 1977, 7-1/2 percent;

(5) for an individual single premium deferred annuity or pure endowment contract issued on or after August 29, 1977, 5-1/2 percent;

(6) for an annuity or pure endowment purchased before August 29, 1977, under a group annuity or pure endowment contract, six percent; or

(7) for an annuity or pure endowment purchased on or after August 29, 1977, under a group annuity or pure endowment contract, 7-1/2 percent.

(c) For an individual annuity or pure endowment contract issued before August 29, 1977, the applicable table is:

(1) the 1971 Individual Annuity Mortality Table; or

(2) a modification of that table approved by the commissioner.

(d) For an individual annuity or pure endowment contract issued on or after August 29, 1977, including an individual single premium immediate annuity contract, the applicable table is:

(1) the 1971 Individual Annuity Mortality Table;

(2) an individual annuity mortality table adopted

after 1980 by the National Association of Insurance Commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for a specified type of contract to which this subsection applies; or

(3) a modification of one of those tables approved by the commissioner.

(e) For an annuity or pure endowment purchased before August 29, 1977, under a group annuity or pure endowment contract, the applicable table is:

(1) the 1971 Group Annuity Mortality Table; or

(2) a modification of that table approved by the commissioner.

(f) For an annuity or pure endowment purchased on or after August 29, 1977, under a group annuity or pure endowment contract, the applicable table is:

(1) the 1971 Group Annuity Mortality Table;

(2) a group annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for an annuity or pure endowment to which this subsection applies; or

(3) a modification of one of those tables approved by the commissioner. (V.T.I.C. Art. 3.28, Sec. 4.)

Source Law

Sec. 4. Except as provided in Section 5 of this article, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this Section 4, as defined herein, and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts shall be the commissioners reserve valuation methods defined in Sections 6 and 7 of this article and the following tables and interest rates:

(a) For individual annuity and pure endowment contracts issued prior to August 29, 1977, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the State Board of Insurance, and six per cent (6%) interest for single premium immediate annuity contracts, and four per cent (4%) interest for all other individual annuity and pure endowment

contracts.

(b) For individual single premium immediate annuity contracts issued on or after August 29, 1977, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by regulation promulgated by the State Board of Insurance for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the State Board of Insurance, and seven and one-half per cent (7 1/2%) interest.

(c) For individual annuity and pure endowment contracts issued on or after August 29, 1977, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by regulation promulgated by the State Board of Insurance for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the State Board of Insurance, and five and one-half per cent (5 1/2%) interest for single premium deferred annuity and pure endowment contracts and four and one-half per cent (4 1/2%) interest for all other such individual annuity and pure endowment contracts.

(d) For all annuities and pure endowments purchased prior to August 29, 1977, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any modification of this table approved by the State Board of Insurance, and six per cent (6%) interest.

(e) For all annuities and pure endowments purchased on or after August 29, 1977, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table or any group annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by regulation promulgated by the State Board of Insurance for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of these tables approved by the State Board of Insurance, and seven and one-half per cent (7 1/2%) interest.

After June 14, 1973, any company may file with the State Board of Insurance a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1979, which shall be the operative date of this section for such company; provided, a company may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If a company makes no such election, the operative date of this section for such company shall be January 1, 1979.

Revised Law

Sec. 425.060. APPLICABILITY OF CALENDAR YEAR STATUTORY

VALUATION INTEREST RATES. The calendar year statutory valuation interest rates as defined by Sections 425.061, 425.062, and 425.063 are the interest rates used in determining the minimum standard for the valuation of:

(1) a life insurance policy to which Subchapter B, Chapter 1105, applies;

(2) an individual annuity or pure endowment contract issued on or after January 1, 1982;

(3) an annuity or pure endowment purchased on or after January 1, 1982, under a group annuity or pure endowment contract; or

(4) the net increase, if any, in a calendar year after January 1, 1982, in amounts held under a guaranteed interest contract. (V.T.I.C. Art. 3.28, Sec. 5(a).)

Source Law

Sec. 5. (a) Applicability of This Section

(1) The calendar year statutory valuation interest rates as defined in this Section shall be the interest rates used in determining the minimum standard for valuation of:

(A) all life insurance policies issued in a particular calendar year on or after the operative date of Section 8 of the Standard Nonforfeiture Law for Life Insurance;

(B) all individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982;

(C) all annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982, under group annuity and pure endowment contracts; and

(D) the net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts.

Revised Law

Sec. 425.061. COMPUTATION OF CALENDAR YEAR STATUTORY VALUATION INTEREST RATE: GENERAL RULE. (a) For purposes of Subsection (b):

(1) R1 is the lesser of R or .09;

(2) R2 is the greater of R or .09;

(3) R is the reference interest rate determined under Section 425.063; and

(4) W is the weighting factor determined under Section

425.062.

(b) The calendar year statutory valuation interest rate ("I") is determined as provided by this section, with the results rounded to the nearest one-quarter of one percent:

(1) for life insurance:

$$I = .03 + W(R1 - .03) + (W/2)(R2 - .09); \text{ and}$$

(2) for a single premium immediate annuity or annuity benefits involving life contingencies arising from another annuity with a cash settlement option or from a guaranteed interest contract with a cash settlement option, or for an annuity or guaranteed interest contract without a cash settlement option, or for an annuity or guaranteed interest contract with a cash settlement option that is valued on a change in fund basis:

$$I = .03 + W(R - .03).$$

(c) For an annuity or guaranteed interest contract with a cash settlement option that is valued on an issue year basis, other than an annuity or contract described by Subsection (b)(2):

(1) the formula prescribed by Subsection (b)(1) applies to an annuity or guaranteed interest contract with a guarantee duration determined under Section 425.062(f) greater than 10 years; and

(2) the formula prescribed by Subsection (b)(2) applies to an annuity or guaranteed interest contract with a guarantee duration determined under Section 425.062(f) of 10 years or less.

(d) Notwithstanding Subsections (b) and (c), if the calendar year statutory valuation interest rate for a life insurance policy issued in a calendar year as determined under Subsection (b) or (c), as applicable, would differ from the corresponding actual rate for similar policies issued in the preceding calendar year by less than one-half of one percent, the calendar year statutory valuation interest rate for the policy is the corresponding actual rate for the preceding calendar year. For purposes of this subsection, the calendar year statutory valuation

interest rate for a life insurance policy issued in a calendar year is determined for 1980 using the reference interest rate defined for 1979, and is determined for each subsequent calendar year regardless of whether Subchapter B, Chapter 1105, applies to the policy. (V.T.I.C. Art. 3.28, Sec. 5(b).)

Source Law

(b) Calendar Year Statutory Valuation Interest Rates

(1) The calendar year statutory valuation interest rates, "I," shall be determined as follows and the results rounded to the nearer one-fourth of one per cent (1/4 of 1%):

(A) For life insurance,

$$I = .03 + W(R1 - .03) + W/2(R2 - .09).$$

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options,

$$I = .03 + W(R - .03)$$

where R1 is the lesser of R and .09,
R2 is the greater of R and .09,
R is the reference interest rate defined in this section, and
W is the weighting factor defined in this section.

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in Paragraph (B) of Subdivision (1) of Subsection (b) of this section, the formula for life insurance stated in Paragraph (A) of Subdivision (1) of Subsection (b) of this section shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of 10 years and the formula for single premium immediate annuities stated in Paragraph (B) of Subdivision (1) of Subsection (b) of this section shall apply to annuities and guaranteed interest contracts with guarantee duration of 10 years or less.

(D) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in Paragraph (B) of Subdivision (1) of Subsection (b) of this section shall apply.

(E) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in Paragraph (B) of Subdivision (1) of Subsection (b) of this section shall apply.

(2) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one per cent (1/2 of 1%), the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately

preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined for 1979) and shall be determined for each subsequent calendar year regardless of when Section 8 of the Standard Nonforfeiture Law for Life Insurance becomes operative.

Revisor's Note

Section 5(b)(2), V.T.I.C. Article 3.28, refers to the "immediately preceding calendar year." Similar provisions elsewhere in the source law for this chapter contain similar references. Throughout this chapter, the revised law omits "immediately" as unnecessary. The "preceding" means the "immediately preceding."

Revised Law

Sec. 425.062. WEIGHTING FACTORS. (a) This section prescribes the weighting factors referred to in the formulas prescribed by Section 425.061.

(b) The weighting factor for a life insurance policy is determined by the following table:

| Guarantee Duration (Years) | Weighting Factor |
|---|---|
| 10 or less | .50 |
| More than 10, but not more than 20 | .45 |
| More than 20 | .35 |

(c) For purposes of Subsection (b), the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to life insurance plans with premium rates or nonforfeiture values, or both, that are guaranteed in the original policy.

(d) The weighting factor for a single premium immediate annuity or for annuity benefits involving life contingencies arising from another annuity with a cash settlement option or from a guaranteed interest contract with a cash settlement option is .80.

(e) The weighting factor for an annuity or a guaranteed interest contract, other than an annuity or contract to which

Subsection (d) applies, is determined by the following tables:

(1) For an annuity or guaranteed interest contract that is valued on an issue year basis:

| Guarantee Duration (Years) | Weighting Factor for Plan Type | | |
|---|---|---|---|
| | A | B | C |
| 5 or less: | .80 | .60 | .50 |
| More than 5, but not more than 10: | .75 | .60 | .50 |
| More than 10, but not more than 20: | .65 | .50 | .45 |
| More than 20: | .45 | .35 | .35 |

(2) For an annuity or guaranteed interest contract that is valued on a change in fund basis, the factors prescribed by Subdivision (1) increased by:

| Plan Type | | |
|---|---|---|
| A | B | C |
| .15 | .25 | .05 |

(3) For an annuity or guaranteed interest contract that is valued on an issue year basis that does not guarantee interest on considerations received more than one year after issue or purchase, other than an annuity or contract that does not have a cash settlement option, or an annuity or guaranteed interest contract that is valued on a change in fund basis that does not guarantee interest rates on considerations received more than 12 months after the valuation date, the factors prescribed by Subdivision (1) or determined under Subdivision (2), as appropriate, increased by:

| Plan Type | | |
|---|---|---|
| A | B | C |
| .05 | .05 | .05 |

(f) For purposes of Subsection (e):

(1) for an annuity or guaranteed interest contract with a cash settlement option, the guarantee duration is the number of years for which the contract guarantees interest rates greater

than the calendar year statutory valuation interest rate for life insurance policies with guarantee duration greater than 20 years; and

(2) for an annuity or guaranteed interest contract without a cash settlement option, the guarantee duration is the number of years from the issue or purchase date to the date annuity benefits are scheduled to begin.

(g) For purposes of Subsection (e):

(1) a policy is a "Plan Type A" policy if:

(A) the policyholder may withdraw funds at any time, but only:

(i) with an adjustment to reflect changes in interest rates or asset values after the insurance company receives the funds;

(ii) without an adjustment described by Subparagraph (i), provided that the withdrawal is in installments over five years or more; or

(iii) as an immediate life annuity; or

(B) the policyholder is not permitted to withdraw funds at any time;

(2) a policy is a "Plan Type B" policy if:

(A) before the expiration of the interest rate guarantee:

(i) the policyholder may withdraw funds, but only:

(a) with an adjustment to reflect changes in interest rates or asset values after the insurance company receives the funds; or

(b) without an adjustment described by Subsubparagraph (a), provided that the withdrawal is in installments over five years or more; or

(ii) the policyholder is not permitted to withdraw funds; and

(B) on the expiration of the interest rate

guarantee, the policyholder may withdraw funds in a single sum or in installments over less than five years, without an adjustment described by Paragraph (A)(i); and

(3) a policy is a "Plan Type C" policy if the policyholder may withdraw funds before the expiration of the interest rate guarantee in a single sum or in installments over less than five years:

(A) without an adjustment to reflect changes in interest rates or asset values after the insurance company receives the funds; or

(B) subject only to a fixed surrender charge that is a percentage of the fund stipulated in the contract.

(h) An insurance company may elect to value an annuity or guaranteed interest contract with a cash settlement option on an issue year basis or on a change in fund basis. A company must value an annuity or guaranteed interest contract without a cash settlement option on an issue year basis. (V.T.I.C. Art. 3.28, Sec. 5(c) (part).)

Source Law

(c) Weighting Factors

(1) The weighting factors referred to in the formulas stated above are given in the following tables:

(A) Weighting Factors for Life Insurance:

| Guarantee Duration (Years) | Weighting Factors |
|---|---|
| 10 or less | .50 |
| More than 10, but not more than 20 | .45 |
| More than 20 | .35 |

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy;

(B) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options:

.80

(C) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in Paragraph (B) of Subdivision (1) of Subsection (c) of this section, shall be as specified in tables (i), (ii), and (iii) below, according to the rules and definitions in (iv), (v), and (vi) below:

(i) For annuities and

guaranteed interest contracts valued on an issue year basis:

| Guarantee Duration (Years) | Weighting Factor for Plan Type | | |
|---|---|---|---|
| | A | B | C |
| 5 or less: | .80 | .60 | .50 |
| More than 5, but not more than 10: | .75 | .60 | .50 |
| More than 10, but not more than 20: | .65 | .50 | .45 |
| More than 20: | .45 | .35 | .35 |

(ii) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in (i) above increased by:

| Plan Type | | |
|---|---|---|
| A | B | C |
| .15 | .25 | .05 |

(iii) For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors shown in (i) or derived in (ii) increased by:

| Plan Type | | |
|---|---|---|
| A | B | C |
| .05 | .05 | .05 |

(iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(v) Plan type as used in the above tables (i), (ii), and (iii) is defined as follows:

Plan Type A: At any time policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of funds by the insurance company, or (2) without such adjustment but in installments over five years or more, or (3) as an immediate life annuity, or (4) no withdrawal permitted.

Plan Type B: Before expiration of the interest rate guarantee, the policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without such adjustment but in installments over five years or more, or (3) no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

Plan Type C: Policyholder

may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either (1) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(vi) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. . . .

Revised Law

Sec. 425.063. REFERENCE INTEREST RATE. (a) In this section, "Moody's Corporate Bond Yield Average" means the Moody's Corporate Bond Yield Average--Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(b) Except as provided by Subsection (g), the reference interest rate for purposes of Section 425.061 is determined as provided by Subsections (c)-(f).

(c) The reference interest rate for a life insurance policy is the lesser of the average over a period of 36 months or the average over a period of 12 months, ending on June 30 of the calendar year preceding the year of issue, of the Moody's Corporate Bond Yield Average.

(d) The reference interest rate is the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of the Moody's Corporate Bond Yield Average for:

(1) a single premium immediate annuity or annuity benefits involving life contingencies arising from another annuity with a cash settlement option or from a guaranteed interest contract with a cash settlement option;

(2) an annuity or guaranteed interest contract with a cash settlement option, other than an annuity or contract described by Subdivision (1), that is valued on an issue year basis and has a guarantee duration as determined under Section 425.062(f) of 10 years or less; or

(3) an annuity or guaranteed interest contract without

a cash settlement option.

(e) The reference interest rate is the lesser of the average over a period of 36 months or the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Moody's Corporate Bond Yield Average for an annuity or guaranteed interest contract with a cash settlement option, other than an annuity or contract described by Subsection (d)(1), that is valued on an issue year basis and has a guarantee duration as determined under Section 425.062(f) greater than 10 years.

(f) The reference interest rate is the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of the Moody's Corporate Bond Yield Average, for an annuity or guaranteed interest contract with a cash settlement option, other than an annuity or contract described by Subsection (d)(1), that is valued on a change in fund basis.

(g) At least annually, the commissioner shall:

(1) determine whether the reference interest rates prescribed by Subsections (c), (d), (e), and (f) continue to be a reasonably accurate approximation of the average yield achieved from purchases in the United States in publicly quoted markets of investment grade fixed term and fixed interest corporate obligations for the periods referenced in Subsection (c), (d), (e), or (f), as applicable; and

(2) if the commissioner determines that a reference interest rate prescribed by Subsection (c), (d), (e), or (f) is not a reasonably accurate approximation of the average yield described by Subdivision (1), adopt rules in the manner prescribed by Chapters 2001 and 2002, Government Code, to prescribe an alternative method of determining a reference interest rate, as appropriate, that is a reasonably accurate approximation of that average yield. (V.T.I.C. Art. 3.28, Secs. 5(d), (e).)

Source Law

(d) Reference Interest Rate

(1) Except as provided in Subsection (e) of this section, the reference interest rate referred

to in Subsection (b) of this section shall be defined as follows:

(A) For all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of Moody's Corporate Bond Yield Average--Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of Moody's Corporate Bond Yield Average--Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Paragraph (B) of Subdivision (1) of Subsection (d) of this section, with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average--Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(D) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Paragraph (B) of Subdivision (1) of Subsection (d) of this section, with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average--Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(E) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average--Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(F) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in Paragraph (B) of Subdivision (1) of Subsection (d) of this section, the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of Moody's Corporate Bond Yield Average--Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(e) State Board of Insurance Promulgation of Definitions of Reference Interest Rate

The State Board of Insurance shall, not less than annually, determine whether the definition of reference interest rates as specified in Subsection (d) of this section continues to be a reasonably accurate approximation of the average yield achieved from purchases in the United States in publicly quoted markets of investment grade fixed term and fixed

interest corporate obligations for the times specified in such subsection and shall, if it determines that such definition is no longer such reasonably accurate approximation, promulgate rules in the manner specified in the Administrative Procedure and Texas Register Act, as amended (Article 6252-13a, Vernon's Texas Civil Statutes), to adopt such alternative methods as are appropriate to achieve such purpose.

Revisor's Note

Section 5(e), V.T.I.C. Article 3.28, refers to "the Administrative Procedure and Texas Register Act, as amended (Article 6252-13a, Vernon's Texas Civil Statutes)." Article 6252-13a was codified in 1993 as Chapters 2001 and 2002, Government Code. The revised law is drafted accordingly.

Revised Law

Sec. 425.064. COMMISSIONERS RESERVE VALUATION METHOD. (a) Except as otherwise provided by Sections 425.065 and 425.068 and subject to Subsection (b), for the life insurance and endowment benefits of a policy that provides for a uniform amount of insurance and that requires the payment of uniform premiums, the reserve according to the commissioners reserve valuation method is the difference, if greater than zero, of the present value on the date of valuation of those future guaranteed benefits, minus the present value on that date of any future modified net premiums for a policy described by this subsection. The modified net premiums for a policy described by this subsection are a uniform percentage of the respective contract premiums for those benefits, so that the present value on the policy's issue date of all the modified net premiums is equal to the sum of:

(1) the present value on that date of those benefits; and

(2) the difference, if greater than zero, between:

(A) a net level annual premium equal to the present value on the policy's issue date of the benefits provided for after the first policy year, divided by the present value on the policy's issue date of an annuity of one per year, payable on the first policy anniversary and on each subsequent policy anniversary

on which a premium becomes due; and

(B) a net one-year term premium for the benefits provided for in the first policy year.

(b) A net level annual premium under Subsection (a)(2)(A) may not exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age that is one year older than the age on the policy's issue date.

(c) This subsection applies only to a life insurance policy issued on or after January 1, 1985, for which the contract premium for the first policy year exceeds the contract premium for the second year, for which a comparable additional benefit is not provided in the first year for the excess premium, and that provides an endowment benefit, a cash surrender value, or a combination of an endowment benefit and cash surrender value, in an amount greater than the excess premium. For purposes of this subsection, the "assumed ending date" is the first policy anniversary on which the sum of any endowment benefit and any cash surrender value available on that date is greater than the excess premium. The reserve according to the commissioners reserve valuation method for a policy to which this subsection applies as of any policy anniversary occurring on or before the assumed ending date is, except as otherwise provided by Section 425.068, the greater of:

(1) the reserve as of the policy anniversary computed as prescribed by Subsection (a); or

(2) the reserve as of the policy anniversary computed as prescribed by Subsection (a) but with:

(A) the value prescribed by Subsection (a)(2)(A) reduced by 15 percent of the amount of the excess first-year premium;

(B) each present value of a benefit or premium determined without reference to a premium or benefit provided under the policy after the assumed ending date;

(C) the policy assumed to mature on the assumed ending date as an endowment; and

(D) the cash surrender value provided on the assumed ending date considered to be an endowment benefit.

(d) In making the comparison required by Subsection (c), the mortality tables and interest bases described by Sections 425.058, 425.061, 425.062, and 425.063 must be used.

(e) Reserves according to the commissioners reserve valuation method for the following policies, contracts, and benefits must be computed by a method consistent with the principles of this section:

(1) a life insurance policy that provides for a varying amount of insurance or that requires the payment of varying premiums;

(2) a group annuity or pure endowment contract purchased under a retirement or deferred compensation plan established or maintained by an employer, including a partnership or sole proprietorship, by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408, Internal Revenue Code of 1986, and that section's subsequent amendments;

(3) disability or accidental death benefits in a policy or contract; and

(4) all other benefits, other than life insurance and endowment benefits in a life insurance policy or benefits provided by any other annuity or pure endowment contract. (V.T.I.C. Art. 3.28, Sec. 6.)

Source Law

Sec. 6. Except as otherwise provided in Sections 7 and 10 of this article, reserves according to the commissioners reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present

value of such benefits provided for by the policy and the excess of (a) over (b), as follows:

(a) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net level annual premium shall not exceed the net level annual premium on the nineteen year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy.

(b) A net one year term premium for such benefits provided for in the first policy year.

Provided that for any life insurance policy issued on or after January 1, 1985, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in Section 10 of this article, be the greater of the reserve as of such policy anniversary calculated as previously described in this Section 6 and the reserve as of such policy anniversary calculated as previously described in this Section 6 but with (i) the value defined in Subsection (a) of Section 6 of this article being reduced by fifteen per cent (15%) of the amount of such excess first year premium, (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, (iii) the policy being assumed to mature on such date as an endowment, and (iv) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in Sections 3 and 5 of this article shall be used.

Reserves according to the commissioners reserve valuation method for: (1) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums; (2) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended; (3) disability and accidental death benefits in all policies and contracts; and (4) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts; shall be calculated by a method consistent with the principles of the preceding paragraphs of this section.

Revised Law

Sec. 425.065. COMMISSIONERS ANNUITY RESERVE VALUATION METHOD. (a) This section applies to an annuity or pure endowment contract other than a group annuity or pure endowment contract purchased under a retirement or deferred compensation plan established or maintained by an employer, including a partnership or sole proprietorship, by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408, Internal Revenue Code of 1986, and that section's subsequent amendments.

(b) Reserves according to the commissioners annuity reserve method for benefits under an annuity or pure endowment contract, excluding any disability or accidental death benefits in the contract, are the greatest of the respective excesses of the present values on the valuation date of the future guaranteed benefits under the contract at the end of each respective contract year, including guaranteed nonforfeiture benefits, minus the present value on the valuation date of any future valuation considerations derived from future gross considerations that are required by the contract terms and that become payable before the end of the respective contract year. The future guaranteed benefits must be determined by using the mortality table, if any, and the interest rate or rates specified in the contract for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the contract terms to determine nonforfeiture values. (V.T.I.C. Art. 3.28, Sec. 7.)

Source Law

Sec. 7. This section shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended.

Reserves according to the commissioners annuity

reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate or rates specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

Revised Law

Sec. 425.066. MINIMUM AGGREGATE RESERVES. (a) An insurance company's aggregate reserves for all life insurance policies, excluding disability or accidental death benefits, issued by the company on or after the date on which Chapter 1105 applies to policies issued by the company, as determined under Section 1105.002(a) or (b), may not be less than the aggregate reserves computed in accordance with the methods prescribed by Sections 425.064, 425.065, 425.068, and 425.069 and the mortality table or tables and interest rate or rates used in computing nonforfeiture benefits for those policies.

(b) The aggregate reserves of an insurance company to which this section applies for all policies, contracts, and benefits may not be less than the aggregate reserves determined to be necessary to issue a favorable opinion under Section 425.054. (V.T.I.C. Art. 3.28, Secs. 8, 8A.)

Source Law

Sec. 8. In no event shall a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after the operative date of Article 3.44a (the Standard Nonforfeiture Law for Life Insurance), be less than the aggregate reserves calculated in accordance with the methods set forth in Sections 6, 7, 10, and 11 and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

Sec. 8A. In no event shall aggregate reserves of a company covered by Section 8 of this article for all policies, contracts, and benefits be less than the

aggregate reserves determined to be necessary to render the opinion required by Section 2A of this article.

Revisor's Note

Section 8A, V.T.I.C. Article 3.28, refers to the aggregate reserves necessary to render "the opinion" required by Section 2A, V.T.I.C. Article 3.28, revised in relevant part in this chapter as Section 425.054. That section requires a life insurance company to submit to the Texas Department of Insurance the opinion of an actuary regarding, in part, whether the company's reserves comply with applicable laws of this state. Throughout this subchapter, the revised law substitutes references to "a favorable opinion" for references to "the opinion" in this context for clarity because the opinion submitted under Section 2A could be a negative opinion, and it is clear from the context of Section 8A that the quoted reference is intended to refer to aggregate reserves necessary for a favorable opinion.

Revised Law

Sec. 425.067. OPTIONAL RESERVE COMPUTATIONS. (a) Reserves for a policy or contract issued by a life insurance company before the date on which Chapter 1105 would apply to the policy or contract, as determined under Section 1105.002(a) or (b), may be computed, at the company's option, according to any standard that produces greater aggregate reserves for all those policies and contracts than the minimum reserves required by the laws applicable to those policies and contracts immediately before that date.

(b) Reserves for any category, as established by the commissioner, of policies, contracts, or benefits issued by a life insurance company on or after the date on which Chapter 1105 applies to policies, contracts, or benefits issued by the company, as determined under Section 1105.002(a) or (b), may be computed, at the company's option, according to any standard that produces

greater aggregate reserves for the category than the minimum aggregate reserves computed according to the standard provided by this subchapter, but the interest rate or rates used for those policies and contracts, other than annuity and pure endowment contracts, may not be higher than the corresponding interest rate or rates used in computing any nonforfeiture benefits provided in those policies or contracts.

(c) An insurance company that has adopted a standard of valuation that produces greater minimum aggregate reserves than the aggregate reserves computed according to the standard provided by this subchapter may, with the commissioner's approval, adopt any lower standard of valuation that produces aggregate reserves at least equal to the minimum aggregate reserves computed according to the standard provided by this subchapter.

(d) For purposes of this section, the holding of additional reserves previously determined to be necessary to issue a favorable opinion under Section 425.054 may not be considered to be the adoption of a higher standard of valuation. (V.T.I.C. Art. 3.28, Secs. 9, 9A.)

Source Law

> Sec. 9. Reserves for all policies and contracts issued prior to the operative date of Article 3.44a (the Standard Nonforfeiture Law for Life Insurance) may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to such date.
>
> Reserves for any category of policies, contracts or benefits as established by the State Board of Insurance, issued on or after the operative date of Article 3.44a (the Standard Nonforfeiture Law for Life Insurance), may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided therein.
>
> Any such company which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard herein provided may, with the approval of the State Board of Insurance, adopt any

lower standard of valuation, but not lower than the minimum herein provided.

Sec. 9A. For the purposes of Section 9 of this article, the holding of additional reserves previously determined to be necessary to render the opinion required by Section 2A of this article shall not be deemed to be the adoption of a higher standard of valuation.

Revised Law

Sec. 425.068. RESERVE COMPUTATION: GROSS PREMIUM CHARGED LESS THAN VALUATION NET PREMIUM. (a) If in a contract year the gross premium charged by a life insurance company on a policy or contract is less than the valuation net premium for the policy or contract computed by the method used in computing the reserve on the policy or contract but using the minimum valuation mortality standards and interest rate, the minimum reserve required for the policy or contract is the greater of:

(1) the reserve computed according to the mortality table, interest rate, and method actually used for the policy or contract; or

(2) the reserve computed by the method actually used for the policy or contract but using the minimum valuation mortality standards and interest rate and replacing the valuation net premium with the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium.

(b) The minimum valuation mortality standards and interest rate under Subsection (a) are the standards and rate provided by Sections 425.058, 425.061, 425.062, and 425.063.

(c) This subsection applies only to a life insurance policy issued on or after January 1, 1985, for which the gross premium for the first policy year exceeds the gross premium for the second policy year, for which a comparable additional benefit is not provided in the first year for the excess premium, and that provides an endowment benefit, a cash surrender value, or a combination of an endowment benefit and cash surrender value, in an amount greater than the excess premium. For a policy to which this subsection applies, Subsections (a) and (b) shall be applied as if the method actually used in computing the reserve for the policy were the

method described in Section 425.064, ignoring Section 425.064(c). The minimum reserve at each policy anniversary is the greater of:

(1) the minimum reserve computed in accordance with Section 425.064, including Section 425.064(c); or

(2) the minimum reserve computed in accordance with this section. (V.T.I.C. Art. 3.28, Sec. 10.)

Source Law

> Sec. 10. If in any contract year the gross premium charged by any life insurance company on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in Sections 3 and 5 of this article.
>
> Provided that for any life insurance policy issued on or after January 1, 1985, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this Section 10 shall be applied as if the method actually used in calculating the reserve for such policy were the method described in Section 6 of this article, ignoring the second paragraph of Section 6. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with Section 6, including the second paragraph of that section, and the minimum reserve calculated in accordance with this Section 10.

Revised Law

Sec. 425.069. RESERVE COMPUTATION: INDETERMINATE PREMIUM PLANS AND CERTAIN OTHER PLANS. (a) For a life insurance plan that provides for future premium determination, the amounts of which are to be determined by the insurance company based on estimates of future experience, or a life insurance plan or annuity for which the minimum reserves cannot be determined by the methods described by

Sections 425.064, 425.065, and 425.068, the reserves held must:

(1) be appropriate in relation to the benefits and the pattern of premiums for the plan; and

(2) be computed by a method that is consistent with the principles of this subchapter, as determined by commissioner rule.

(b) Notwithstanding any other provision of state law, the commissioner must affirmatively approve a policy, contract, or certificate that provides life insurance under a plan described by Subsection (a) before the policy, contract, or certificate may be marketed, issued, delivered, or used in this state. (V.T.I.C. Art. 3.28, Sec. 11.)

Source Law

> Sec. 11. In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in Sections 6, 7, and 10 of this article, the reserves which are held under any such plan must:
>
> (a) be appropriate in relation to the benefits and the pattern of premiums for that plan, and
>
> (b) be computed by a method which is consistent with the principles of this Standard Valuation Law, as determined by regulations promulgated by the State Board of Insurance.
>
> Notwithstanding any other provision in the laws of this state, any policy, contract, or certificate providing life insurance under any such plan must be affirmatively approved by the State Board of Insurance before it can be marketed, issued, delivered, or used in this state.

Revisor's Note

Section 11, V.T.I.C. Article 3.28, refers to "then" estimates of future experience. The revised law omits the reference to "then" as unnecessary because it does not add to the clear meaning of the law. Similar changes have been made throughout this chapter.

Revised Law

Sec. 425.070. COMPUTATION OF RESERVE FOR CERTAIN POLICIES BY CALENDAR YEAR OF ISSUE. (a) The reserve for a policy or

contract issued by a life insurance company before the date on which Chapter 1105 would apply to the policy or contract, as determined under Section 1105.002(a) or (b), must be computed in accordance with the terms of the policy or contract and this section.

(b) For a policy issued before January 1, 1910, the computation must be based on the American Experience Table of Mortality and 4-1/2 percent annual interest.

(c) For a policy issued on or after January 1, 1910, and before January 1, 1948, the computation must be based on:

(1) the Actuaries or Combined Experience Table of Mortality and four percent annual interest, if the interest rate guaranteed in the policy is four percent annually or higher; or

(2) the American Experience Table of Mortality and the lower rate specified in the policy, if the policy was issued on a reserve basis of an interest rate lower than four percent annually.

(d) For a policy issued on or after January 1, 1948, the computation must be based on the mortality table and interest rate specified in the policy, provided that:

(1) the specified interest rate may not exceed 3-1/2 percent annually;

(2) the specified table for a policy, other than an industrial life insurance policy, is the American Experience Table of Mortality, the American Men Ultimate Table of Mortality, the Commissioners 1941 Standard Ordinary Mortality Table, or, for a policy issued after December 31, 1959, the Commissioners 1958 Standard Ordinary Mortality Table; and

(3) the specified table for an industrial life insurance policy is the American Experience Table of Mortality, the Standard Industrial Mortality Table, the Sub-Standard Industrial Mortality Table, the 1941 Standard Industrial Mortality Table, or the 1941 Sub-Standard Industrial Mortality Table, or, for a policy issued after December 31, 1963, the Commissioners 1961 Standard Industrial Mortality Table.

(e) For a policy, other than an industrial life insurance policy, issued after December 31, 1959, to insure a female risk, the computation must be based on any mortality table and interest rate permitted under Subsection (d) and specified in the policy but may, at the insurance company's option, be based on an age not more than three years younger than the insured's actual age.

(f) Except as otherwise provided by Section 425.059 for coverage purchased under a group annuity or pure endowment contract to which that section applies, for a policy issued on a substandard risk, an annuity contract, or a contract or policy for disability benefits or accidental death benefits, the computation must be based on the standards and methods adopted by the insurance company and approved by the commissioner.

(g) For a group insurance policy issued before May 15, 1947, the computation must be based on the American Men Ultimate Table of Mortality with interest at the rate of three percent or 3-1/2 percent annually as provided by the policy. The reserve value of a group insurance policy issued on or after May 15, 1947, and before January 1, 1961, must be computed on the basis of either the American Men Ultimate Table of Mortality or the Commissioners 1941 Standard Ordinary Mortality Table with interest at a rate not to exceed 3-1/2 percent annually as provided by the policy. For a group insurance policy issued on or after January 1, 1961, the computation must be based on an interest rate not to exceed 3-1/2 percent annually and the mortality table adopted by the insurance company with the commissioner's approval. (V.T.I.C. Art. 3.28, Secs. 3 (part), 12.)

Source Law

> Sec. 3. The minimum standard for the valuation of all such policies and contracts issued prior to the operative date of Article 3.44a (the Standard Nonforfeiture Law for Life Insurance) shall be that provided in Section 12 of this article. . . .
>
> Sec. 12. This section shall apply only to those policies and contracts issued prior to the operative date of Article 3.44a (the Standard Nonforfeiture Law for Life Insurance). The reserve liability of all such policies and contracts shall be computed in accordance

with their terms and the following rules:

(a) As respects policies issued prior to the first day of January, 1910, the computation shall be on the basis of the American Experience Table of Mortality and four and one-half per cent (4 1/2%) interest per annum.

(b) As respects policies issued after the 31st day of December, 1909, and prior to January 1, 1948, the computation shall be on the basis of the Actuaries or Combined Experience Table of Mortality with four per cent (4%) interest per annum, if the interest rate guaranteed in the policy is four per cent (4%) per annum or higher. If any such policies were issued upon a reserve basis of an interest rate lower than four per cent (4%) per annum, then the computation shall be made on the basis of the American Experience Table of Mortality with interest at such lower specified rate.

(c) As respects policies issued after the 31st day of December, 1947, the computation shall be on the basis of the mortality table and interest rate specified in the respective policies, provided that (A) the specified rate of interest shall not exceed three and one-half per cent (3 1/2%) per annum; (B) the specified table for policies other than policies of industrial life insurance shall be the American Experience Table of Mortality, the American Men Ultimate Table of Mortality, the Commissioners 1941 Standard Ordinary Mortality Table, or, as respects policies issued after the 31st day of December, 1959, the Commissioners 1958 Standard Ordinary Mortality Table; and (C) the specified table for policies of industrial life insurance shall be the American Experience Table of Mortality, the Standard Industrial Mortality Table, the Sub-Standard Industrial Mortality Table, the 1941 Standard Industrial Mortality Table, or the 1941 Sub-Standard Industrial Mortality Table, or, as respects policies issued after the 31st day of December, 1963, the Commissioners 1961 Standard Industrial Mortality Table.

(d) As respects policies on female risks issued after the 31st day of December, 1959, other than policies of industrial life insurance, computation shall be based on any mortality table and rate of interest permitted under Subsection (c) of Section 12 of this article and specified in the respective policies but may at the option of the company be based on an age not more than three (3) years younger than the actual age of the insured.

(e) Except as otherwise provided in Section 4 of this article with respect to coverages purchased on or after the operative date of such subsection under group annuity and pure endowment contracts, as respects policies issued on substandard risks and annuity contracts and contracts or policies for disability benefits and accidental death benefits, the computation shall be on the basis of the standards and methods adopted by the respective companies and approved by the State Board of Insurance.

(f) The reserve values of all policies of group insurance issued prior to May 15, 1947, shall be computed upon the basis of the American Men Ultimate Table of Mortality with interest at the rate of three per cent (3%) or three and one-half per cent (3 1/2%) per annum as provided in such policies. The reserve values of all policies of group insurance issued on and subsequent to May 15, 1947, and prior to January 1, 1961, shall be computed upon the basis of either the

American Men Ultimate Table of Mortality or the Commissioners 1941 Standard Ordinary Mortality Table with interest at a rate not in excess of three and one-half per cent (3 1/2%) per annum as provided in such policies. The reserve values of all policies of group insurance issued on and subsequent to January 1, 1961, shall be computed on the basis of an interest rate not exceeding three and one-half per cent (3 1/2%) per annum and such mortality table as shall be adopted by the company with the approval of the State Board of Insurance.

Revisor's Note
(End of Subchapter)

(1) Section 13, V.T.I.C. Article 3.28, repeals all laws in conflict with that article. This revision omits that provision as unnecessary because, under general rules of statutory construction, a statute automatically has the effect of repealing prior conflicting enactments. The provision is, of course, ineffective to repeal subsequent legislation. The omitted law reads:

> Sec. 13. All acts and parts of acts inconsistent with the provisions of this article are hereby repealed.

(2) V.T.I.C. Article 3.31 provides that if a "foreign insurance company shall fail to file the certificate authorized by the preceding article" (meaning former V.T.I.C. Article 3.30), the company shall "forthwith . . . file with the Board of Insurance Commissioners full detailed lists of its policies and securities" and is "liable for all charges and expenses" because of the company's failure to file the certificate.

As enacted as part of the Insurance Code in 1951, V.T.I.C. Article 3.30 provided that the Board of Insurance Commissioners could accept from a foreign insurance company a certificate as to "the computation of reserve liability made by the insurance commissioner of the state under whose authority [the] life insurance company was organized." V.T.I.C. Article 3.30 was repealed by Chapter 434, Acts of the

58th Legislature, Regular Session, 1963. That act also enacted the Standard Valuation Law (V.T.I.C. Article 3.28), revised as this subchapter. Section 2, V.T.I.C. Article 3.28, revised in relevant part as Section 425.053(c), permits the State Board of Insurance, as to a "foreign or alien company," to accept "any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction" of the company's reserves. Unlike former V.T.I.C. Article 3.30, Section 2, V.T.I.C. Article 3.28, does not expressly require the foreign or alien insurer to provide a certificate from the insurance supervisory official of the other jurisdiction.

Accordingly, the revised law omits V.T.I.C. Article 3.31 as obsolete. The omitted provision reads:

> Art. 3.31. If any such foreign insurance company shall fail to file the certificate authorized by the preceding article, it shall be required forthwith to file with the Board of Insurance Commissioners full detailed lists of its policies and securities and shall be liable for all charges and expenses consequent upon its failure so to file such certificate.

[Sections 425.071-425.100 reserved for expansion]

SUBCHAPTER C. AUTHORIZED INVESTMENTS AND TRANSACTIONS FOR CAPITAL STOCK LIFE, HEALTH, AND ACCIDENT INSURERS

Revised Law

Sec. 425.101. DEFINITIONS. In this subchapter:

(1) "Assets" means the statutory accounting admitted assets of an insurance company. The term includes lawful money of the United States, whether in the form of cash or demand deposits in solvent banks, savings and loan associations, credit unions, and branches of those entities, organized under the laws of the United States or a state of the United States, if held in accordance with

the laws or regulations applicable to those entities. The term does not include the company's separate accounts that are subject to Chapter 1152.

(2) "Securities valuation office" means the Securities Valuation Office of the National Association of Insurance Commissioners. (V.T.I.C. Art. 3.33, Sec. 7(a); New.)

Source Law

Sec. 7. (a) The term "assets" as used in this article shall mean the statutory accounting admitted assets of the insurer, including lawful money of the United States, whether in the form of cash or demand deposits in solvent banks, savings and loan associations, and credit unions and branches thereof, organized under the laws of the United States of America or its states, when held in accordance with the laws or regulations applicable to such entities, less the insurer's separate accounts that are subject to Part III of Article 3.39, Article 3.72, Article 3.73, and Article 3.75 of this code.

Revisor's Note

(1) Section 7, V.T.I.C. Article 3.33, and other provisions of that article refer to an "insurer." Section 1, V.T.I.C. Article 3.33, revised in this chapter as Section 425.103, specifies the types of domestic insurance companies and other insurance companies governed by Article 3.33, revised as this subchapter. For consistency with the terminology used in Section 425.103 and in Chapter 841 of this code, the revised law throughout this subchapter substitutes "insurance company" for "insurer."

(2) Section 7(a), V.T.I.C. Article 3.33, refers to an "insurer's separate accounts that are subject to Part III of Article 3.39, Article 3.72, Article 3.73, and Article 3.75." As added by Chapter 181, Acts of the 59th Legislature, Regular Session, 1965, Part III, V.T.I.C. Article 3.39, provided for domestic life insurance companies to establish separate accounts for amounts paid to the company in connection with a pension, retirement, or profit-sharing plan with

variable benefits. As enacted by Chapter 210, Acts of the 60th Legislature, Regular Session, 1967, V.T.I.C. Article 3.72 provided for insurance companies to issue variable annuity contracts; Section 7 of that article required an insurance company to establish one or more separate accounts for variable annuity contracts. As enacted by Chapter 529, Acts of the 62nd Legislature, Regular Session, 1971, V.T.I.C. Article 3.73 provided for insurance companies to issue variable life insurance contracts and variable annuities; Section 2 of that article permitted an insurance company to establish one or more separate accounts for those contracts and annuities.

Part III, V.T.I.C. Article 3.39, and V.T.I.C. Articles 3.72 and 3.73 were repealed by Chapter 648, Acts of the 68th Legislature, Regular Session, 1983. That act also added V.T.I.C. Article 3.75, revised in this code as Chapter 1152, which provides for variable annuity contracts and variable life insurance policies, and permitted separate accounts for those contracts and policies. Section 9(b), V.T.I.C. Article 3.75 was revised in 2001 in this code as Section 1152.001(c). That section provides that a separate account established under one of the repealed articles is considered to be established under Chapter 1152 of this code. Accordingly, the revised law omits the references to former Part III, V.T.I.C. Article 3.39, and former V.T.I.C. Articles 3.72 and 3.73 as unnecessary.

(3) The revised law adds the definition of "securities valuation office" for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 425.102. INAPPLICABILITY OF CERTAIN LAW. The definition of "state" assigned by Section 311.005, Government Code, does not apply to this subchapter. (New.)

Revisor's Note

Section 311.005(7), Government Code (Code Construction Act), defines "state" to include a district, commonwealth, territory, and insular possession of the United States. That definition generally applies to the revised law. However, it is clear that in V.T.I.C. Article 3.33, revised as this subchapter, the term "state" has a narrower meaning, because Section 4(n), revised in this chapter as Section 425.151, permits an insurer to invest in "commonwealths, territories, or possessions of the United States," but provides additional limitations on those investments that are not provided for investments in states and districts of the United States. The revised law provides that the Code Construction Act definition does not apply in this subchapter to ensure that no substantive change is made by the revision of the phrase "state of the United States" in the context of this subchapter.

Revised Law

Sec. 425.103. APPLICABILITY OF SUBCHAPTER. (a) This subchapter and rules adopted to interpret and implement this subchapter apply to all domestic insurance companies as defined in Section 841.001 and to other insurance companies specifically made subject to this subchapter, including a stipulated premium company that elects under Section 884.311 to be governed by this subchapter.

(b) Subchapter D does not apply to an insurance company to which this subchapter applies.

(c) This subchapter does not limit or restrict investments

in or transactions with or within subsidiaries and affiliates made under Chapter 823. (V.T.I.C. Art. 3.33, Sec. 1 (part).)

Source Law

> Art. 3.33
>
> Sec. 1. This article and the rules promulgated to interpret and implement it shall apply to all domestic insurance companies as defined in Section 841.001 of this code and other insurers specifically made subject to the provisions hereof, including a stipulated premium insurance company electing to be governed by this article under Section 884.311 of this code. Articles 3.39, 3.40, and 3.40-1 of this code shall not be applicable to such companies, but . . . . This article shall not limit or restrict the investments in or transactions with or within subsidiaries and affiliates which are made pursuant to the authority of the Texas Insurance Holding Company System Regulatory Act (Chapter 823, Insurance Code).

Revisor's Note

Section 1, V.T.I.C. Article 3.33, refers to a "stipulated premium insurance company," meaning a company operating under Chapter 884 of this code. The term most frequently used to describe that type of entity is "stipulated premium company." For consistent use of terminology in this code, the revised law substitutes "stipulated premium company" for "stipulated premium insurance company."

Revised Law

Sec. 425.104. PURPOSE. The purpose of this subchapter is to protect and further the interests of insureds, insurance companies, creditors, and the public by providing standards for development and administration of plans for investment of insurance companies' assets. (V.T.I.C. Art. 3.33, Sec. 2.)

Source Law

> Sec. 2. The purpose of this article is to protect and further the interests of insureds, insurers, creditors, and the public by providing standards for the development and administration of plans for the investment of the assets of insurers.

Revised Law

Sec. 425.105. WRITTEN INVESTMENT PLAN. (a) Each insurance company's board of directors or, if the company does not have a board of directors, the corresponding authority designated

by the company's charter, bylaws, or plan of operation, shall adopt a written investment plan consistent with this subchapter.

(b) The investment plan must:

(1) specify the diversification of the insurance company's investments, so as to reduce the risk of large losses, by:

(A) broad categories, such as bonds and real property loans;

(B) kinds, such as government obligations, obligations of business entities, mortgage-backed securities, and real property loans on office, retail, industrial, or residential properties;

(C) quality;

(D) maturity;

(E) industry; and

(F) geographical areas, as to both domestic and foreign investments;

(2) balance safety of principal with yield and growth;

(3) seek a reasonable relationship of assets and liabilities as to term and nature; and

(4) be appropriate considering the capital and surplus and the business conducted by the company.

(c) At least annually, the board of directors or corresponding authority shall review the adequacy of the investment plan and the implementation of the plan.

(d) An insurance company shall maintain the company's investment plan in the company's principal office and provide the plan to the commissioner or the commissioner's designee on request. The commissioner or the commissioner's designee shall maintain the plan as a privileged and confidential document. The plan is not subject to public disclosure. (V.T.I.C. Art. 3.33, Secs. 3(a), (b) (part).)

Source Law

Sec. 3. (a) The board of directors of each insurer or corresponding authority designated by the charter, bylaws, or plan of operations of an insurer

which has no board of directors shall:

(1) adopt a written investment plan consistent with the provisions of this article which:

(A) specifies the diversification of the insurer's investments, so as to reduce the risk of large losses, by:

(i) broad categories (such as bonds and real estate loans),

(ii) kinds (such as obligations of governments, or business entities, mortgage-backed securities, and real estate loans on office, retail, industrial or residential properties),

(iii) quality,

(iv) maturity,

(v) industry, and

(vi) geographical areas (as to both domestic and foreign investments);

(B) balances safety of principal with yield and growth;

(C) seeks a reasonable relationship of assets and liabilities as to term and nature;

(D) is appropriate considering the capital and surplus and the business conducted by the insurer;

(2) at least annually, review the adequacy of such investment plan and the implementation thereof.

(b) The insurer shall maintain the investment plan in its principal office and shall provide same to the commissioner or his designee upon request, and such plans shall be maintained as a privileged and confidential document by the Commissioner of Insurance or his designee and it shall not be subject to public disclosure. . . .

Revisor's Note

Section 3(b), V.T.I.C. Article 3.33, refers to the "Commissioner of Insurance." 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. Throughout this chapter, the revised law is drafted accordingly.

Revised Law

Sec. 425.106. INVESTMENT RECORDS; DEMONSTRATION OF COMPLIANCE. An insurance company shall maintain investment records covering each transaction. The company must be able to demonstrate at all times that the company's investments are within the limitations imposed by this subchapter. (V.T.I.C. Art. 3.33, Sec. 3(b) (part).)

Source Law

(b) . . . The insurer shall maintain investment records covering each transaction. At all times, the insurer shall be able to demonstrate that its

investments are within the limitations prescribed in this article.

Revised Law

Sec. 425.107. COMMUNITY INVESTMENT REPORT. (a) The department shall, after consulting with the insurance industry of this state and the office of public insurance counsel, develop a report of insurance industry community investments in this state.

(b) The commissioner may request, and an insurance company shall provide, information necessary to complete the report required by this section.

(c) The department shall provide the report required by this section to the legislature not later than December 1 of each even-numbered year. (V.T.I.C. Art. 3.33, Sec. 3A.)

Source Law

Sec. 3A. (a) The Texas Department of Insurance shall, after consultation with the insurance industry of this state and the Office of Public Insurance Counsel, develop a report of insurance industry community investments in Texas.

(b) The commissioner may request and insurance companies shall provide information necessary to complete the requirements of Subsection (a).

(c) The report established under Subsection (a) shall be provided to the Texas Legislature no later than December 1 of each even-numbered year.

Revisor's Note

Section 3A(a), V.T.I.C. Article 3.33, refers to the "Texas Department of Insurance." Section 31.001 of this code defines "department" for purposes of this code and the other insurance laws of this state to mean the Texas Department of Insurance. The revised law is drafted accordingly.

Revised Law

Sec. 425.108. AUTHORIZED INVESTMENTS AND TRANSACTIONS IN GENERAL. (a) Subject to the limitations and restrictions imposed by this subchapter, and, unless otherwise specified, based on the insurance company's capital, surplus, and admitted assets as reported in the company's most recently filed statutory financial statement, the investments and transactions described by this subchapter and Subchapter F, Chapter 823, are authorized

investments and transactions for a company subject to this subchapter.

(b) An insurance company may not make an investment or enter into a transaction that is not authorized by this subchapter or Subchapter F, Chapter 823. (V.T.I.C. Art. 3.33, Sec. 4 (part).)

Source Law

> Sec. 4. Subject to the limitations and restrictions herein contained and, unless otherwise specified, based upon the insurer's capital, surplus and admitted assets as reported in the most recently filed statutory financial statement, the investments and transactions described in the following subsections, and in Section 6, Article 21.49-1, and none other, are authorized for the insurers subject hereto:
>
> . . .

Revised Law

Sec. 425.109. AUTHORIZED INVESTMENTS: GOVERNMENT OBLIGATIONS. (a) An insurance company may invest in:

(1) a bond, evidence of indebtedness, or other obligation of the United States;

(2) a bond, evidence of indebtedness, or other obligation guaranteed as to principal and interest by the full faith and credit of the United States;

(3) a bond, evidence of indebtedness, or other obligation of an agency or instrumentality of the United States government; and

(4) subject to Subsections (b) and (c), a bond, evidence of indebtedness, or other obligation of a governmental unit in the United States, Canada, or any province or municipality of Canada, or of an instrumentality of one of those governmental units.

(b) An insurance company may not invest in a bond, evidence of indebtedness, or other obligation under Subsection (a)(4) if the governmental unit or instrumentality is in default in the payment of principal of or interest on any of the governmental unit's or instrumentality's obligations.

(c) An insurance company's investments in the obligations

of a single governmental unit or instrumentality under Subsection (a)(4) may not exceed 20 percent of the company's capital and surplus. (V.T.I.C. Art. 3.33, Secs. 4(a), (b).)

Source Law

> [Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]
>
> (a) United States Government Bonds. Bonds, evidences of indebtedness or obligations of the United States of America, or bonds, evidences of indebtedness or obligations guaranteed as to principal and interest by the full faith and credit of the United States of America, and bonds, evidences of indebtedness, or obligations of agencies and instrumentalities of the government of the United States of America;
>
> (b) Other Governmental Bonds. Bonds, evidences of indebtedness or obligations of governmental units in the United States, Canada, or any province or city of Canada, and of the instrumentalities of such governmental units; provided:
>
> (1) such governmental unit or instrumentality is not in default in the payment of principal or interest in any of its obligations; and
>
> (2) investments in the obligations of any one governmental unit or instrumentality may not exceed 20 percent of the insurer's capital and surplus;

Revisor's Note

Section 4(b), V.T.I.C. Article 3.33, refers to a "city." The revised law substitutes "municipality" for "city" for the reason stated in Revisor's Note (6) to Section 425.002.

Revised Law

Sec. 425.110. AUTHORIZED INVESTMENTS: OBLIGATIONS OF AND OTHER INVESTMENTS IN BUSINESS ENTITIES. (a) In this section:

(1) "Business entity" includes a sole proprietorship, corporation, association, general or limited partnership, limited liability company, joint-stock company, joint venture, trust, or other form of business organization, regardless of whether organized for profit, that is organized under the laws of the United States, another state, Canada, or any district, province, or territory of Canada.

(2) "Counterparty exposure amount" has the meaning assigned by Section 425.125.

(b) Subject to this section, an insurance company may invest

in an obligation, including a bond or evidence of indebtedness, a participation in a bond or evidence of indebtedness, or an asset-backed security, that is issued, assumed, guaranteed, or insured by a business entity.

(c) An insurance company's investments in the obligations or counterparty exposure amounts of a single business entity rated by the securities valuation office may not exceed 20 percent of the company's statutory capital and surplus.

(d) An insurance company may not invest in an obligation, counterparty exposure amount, or preferred stock of a business entity if, after making the investment:

(1) the aggregate amount of those investments then held by the company that are rated 3, 4, 5, or 6 by the securities valuation office would exceed 20 percent of the company's assets;

(2) the aggregate amount of those investments then held by the company that are rated 4, 5, or 6 by the securities valuation office would exceed 10 percent of the company's assets;

(3) the aggregate amount of those investments then held by the company that are rated 5 or 6 by the securities valuation office would exceed three percent of the company's assets; or

(4) the aggregate amount of those investments then held by the company that are rated 6 by the securities valuation office would exceed one percent of the company's assets.

(e) If an insurance company attains or exceeds the limit of a rating category referred to in Subsection (d), the company is not precluded from acquiring investments in other rating categories subject to the specific and multiple category limits applicable to those investments.

(f) Notwithstanding Subsections (c)-(e), an insurance company may invest in an additional obligation of a business entity in which the company holds one or more obligations if the investment is made to protect an investment previously made in that business entity. Obligations invested in under this subsection may not

exceed one-half percent of the company's assets.

(g) This section does not prohibit an insurance company from investing in an obligation as a result of a restructuring of an already held obligation or preferred stock that is rated 3, 4, 5, or 6 by the securities valuation office.

(h) An insurance company shall include all counterparty exposure amounts in determining compliance with the limitations of this section. (V.T.I.C. Art. 3.33, Secs. 4(c), (u)(5).)

Source Law

[Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]

(c) Obligations of Business Entities. Obligations, including bonds or evidences of indebtedness, or participations in those bonds or evidences of indebtedness, or asset-backed securities, that are issued, assumed, guaranteed, or insured by any business entity, including a sole proprietorship, a corporation, an association, a general or limited partnership, a limited liability company, a joint-stock company, a joint venture, a trust, or any other form of business organization, whether for-profit or not-for-profit, that is organized under the laws of the United States, another state, Canada, or any state, district, province, or territory of Canada, subject to all conditions set forth below:

(1) an insurer may acquire obligations or counterparty exposure amounts, as defined in Subsection (u), in any one business entity rated by the Securities Valuation Office of the National Association of Insurance Commissioners, but not to exceed 20 percent of the insurer's statutory capital and surplus;

(2) an insurer shall not acquire an obligation, counterparty exposure amount or preferred stock of any business entity if, after giving effect to the investment:

(A) the aggregate amount of such investments then held by the insurer that are rated 3, 4, 5 or 6 by the Securities Valuation Office of the National Association of Insurance Commissioners would exceed 20 percent of its assets;

(B) the aggregate amount of such investments then held by the insurer that are rated 4, 5, or 6 by the Securities Valuation Office would exceed 10 percent of its assets;

(C) the aggregate amount of such investments then held by the insurer that are rated 5 or 6 by the Securities Valuation Office would exceed three percent of its assets; or

(D) the aggregate amount of such investments then held by the insurer that are rated 6 by the Securities Valuation Office would exceed one percent of its assets.

If an insurer attains or exceeds the limit of any one rating category referred to in this

subsection, the insurer shall not be precluded from acquiring investments in other rating categories subject to the specific and multiple category limits applicable to those investments;

(3) notwithstanding the foregoing, an insurer may acquire an obligation of a business entity in which the insurer already holds one or more obligations if the obligation is acquired in order to protect an investment previously made in that business entity, but obligations so acquired may not exceed one-half percent of the insurer's assets; and

(4) this subsection does not prohibit an insurer from acquiring an obligation as a result of a restructuring of an already held obligation or preferred stock that is rated 3, 4, 5 or 6 by the Securities Valuation Office;

(u) . . .

(5) An insurer shall include all counterparty exposure amounts in determining compliance with the limitations of Subsection (c).

Revisor's Note

Section 4(c), V.T.I.C. Article 3.33, refers to "any state, district, province, or territory of Canada." The revised law omits the reference to a "state" of Canada because that country does not have "states."

Revised Law

Sec. 425.111. AUTHORIZED INVESTMENTS: BONDS ISSUED, ASSUMED, OR GUARANTEED IN INTERNATIONAL MARKET. (a) Subject to this section, an insurance company may invest in bonds issued, assumed, or guaranteed by:

(1) the Inter-American Development Bank;

(2) the International Bank for Reconstruction and Development (the World Bank);

(3) the Asian Development Bank;

(4) the State of Israel;

(5) the African Development Bank; and

(6) the International Finance Corporation.

(b) An insurance company's investments in the bonds of a single entity under this section may not exceed 20 percent of the company's capital and surplus.

(c) The aggregate of all investments made by an insurance company under this section may not exceed 20 percent of the

company's assets. (V.T.I.C. Art. 3.33, Sec. 4(d).)

Source Law

> [Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]
>
> (d) International Market. Bonds issued, assumed, or guaranteed by the Interamerican Development Bank, the International Bank for Reconstruction and Development (the World Bank), the Asian Development Bank, the State of Israel, the African Development Bank, and the International Finance Corporation; provided:
>
> (1) investments in the bonds of any one of the entities specified above may not exceed 20 percent of the insurer's capital and surplus; and
>
> (2) the aggregate of all investments made under this subsection may not exceed 20 percent of the insurer's assets;

Revised Law

Sec. 425.112. AUTHORIZED INVESTMENTS: POLICY LOANS. An insurance company may invest in loans on the security of the company's own policies in an amount that does not exceed the amount of the reserve values of those policies. (V.T.I.C. Art. 3.33, Sec. 4(e).)

Source Law

> [Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]
>
> (e) Policy Loans. Loans upon the security of the insurer's own policies not in excess of the amount of the reserve values thereof;

Revised Law

Sec. 425.113. AUTHORIZED INVESTMENTS: DEPOSITS IN CERTAIN FINANCIAL INSTITUTIONS. (a) Subject to this section, an insurance company may invest in any type of savings deposit, time deposit, certificate of deposit, NOW account, or money market account in a solvent bank, savings and loan association, or credit union that is organized under the laws of the United States or a state, or in a branch of one of those financial institutions.

(b) An investment under this section must be made in accordance with the laws or regulations applicable to the bank, savings and loan association, or credit union.

(c) The amount of an insurance company's deposits in a

single bank, savings and loan association, or credit union may not exceed the greater of:

(1) 20 percent of the company's capital and surplus;

(2) the amount of federal or state deposit insurance coverage that applies to the deposits; or

(3) 10 percent of the amount of capital, surplus, and undivided profits of the financial institution receiving the deposits. (V.T.I.C. Art. 3.33, Sec. 4(f).)

Source Law

[Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]

(f) Time and Savings Deposits. Any type or form of savings deposits, time deposits, certificates of deposit, NOW accounts, and money market accounts in solvent banks, savings and loan associations, and credit unions and branches thereof, organized under the laws of the United States of America or its states, when made in accordance with the laws or regulations applicable to such entities; provided the amount of the deposits in any one bank, savings and loan association, or credit union will not exceed the greater of:

(1) 20 percent of the insurer's capital and surplus;

(2) the amount of federal or state deposit insurance coverage pertaining to such deposit; or

(3) 10 percent of the amount of capital, surplus, and undivided profits of the entity receiving such deposits;

Revisor's Note

Section 4(f), V.T.I.C. Article 3.33, refers to any "type or form" of deposit in a financial institution. The revised law omits the reference to "form" because, in this context, the term is included in the meaning of "type."

Revised Law

Sec. 425.114. AUTHORIZED INVESTMENTS: INSURANCE COMPANY INVESTMENT POOLS. (a) In this section, "affiliate" means, with respect to a person, another person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person.

(b) Subject to Subsections (c)-(g), an insurance company

may acquire investments in an investment pool that invests only in:

(1) obligations that have a rating by the securities valuation office of one or two, or an equivalent rating issued by a nationally recognized statistical rating organization recognized by the securities valuation office, or that are issued by an issuer with outstanding obligations that have a securities valuation office one or two rating or an equivalent rating described by this subdivision, and that:

(A) have a remaining maturity of 397 days or less or a put that:

(i) entitles the holder to receive the principal amount of the obligation; and

(ii) may be exercised through maturity at specified intervals not exceeding 397 days; or

(B) have a remaining maturity of three years or less and a floating interest rate that resets at least quarterly on the basis of a current short-term index (federal funds, prime rate, treasury bills, London InterBank Offered Rate, or commercial paper) and is not subject to a maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(2) securities lending, repurchase, and reverse repurchase transactions that meet the requirements of Section 425.121 and any applicable department rules;

(3) money market funds as authorized by Section 425.123, except that a short-term investment pool may not acquire investments in a single business entity that exceed 10 percent of the total assets of the pool; or

(4) investments that an insurance company may make under this subchapter, if:

(A) the company's proportionate interest in the amount invested in those investments does not exceed the limits of this subchapter; and

(B) the aggregate amount of the company's

investments in all investment pools under this subdivision does not exceed 25 percent of the company's assets.

(c) An insurance company may not acquire an investment in an investment pool under Subsection (b) if, after making the investment, the aggregate amount of the company's investments in all investment pools would exceed 35 percent of the company's assets.

(d) For an investment in an investment pool to be qualified under this section, the pool may not:

(1) acquire securities issued, assumed, guaranteed, or insured by an investing insurer or an affiliate of the investing insurance company; or

(2) borrow or incur an indebtedness for borrowed money, except for securities lending and reverse repurchase transactions.

(e) For an investment pool to be qualified under this section:

(1) the pool manager must:

(A) be organized under the laws of the United States or a state and designated as the pool manager in a pooling agreement; or

(B) be:

(i) the investing insurance company, an affiliated insurance company, a business entity affiliated with the investing company, a custodian bank, a business entity registered under the Investment Advisers Act of 1940 (15 U.S.C. Section 80b-1 et seq.), as amended;

(ii) in the case of a reciprocal or interinsurance exchange, the exchange's attorney-in-fact; or

(iii) in the case of a United States branch of an alien insurance company, the United States manager or an affiliate or subsidiary of the United States manager;

(2) the pool manager or an entity designated by the pool manager of the type described by Subdivision (1)(B) must

maintain:

(A) detailed accounting records showing:

(i) the cash receipts and disbursements reflecting each participant's proportionate investment in the pool; and

(ii) a complete description of all the pool's underlying assets, including the amount, interest rate, maturity date, if any, and other appropriate designations; and

(B) other records that, on a daily basis, allow a third party to verify each participant's investments in the pool; and

(3) the assets of the pool must be held in one or more accounts, in the name or on behalf of the pool, at the principal office of the pool manager or under a custody agreement or trust agreement with a custodian bank, provided that the agreement:

(A) states and recognizes the claims and rights of each participant;

(B) acknowledges that the pool's underlying assets are held solely for the benefit of each participant in proportion to the aggregate amount of the participant's investments in the pool; and

(C) contains an agreement that the pool's underlying assets may not be commingled with the general assets of the custodian bank or any other person.

(f) The pooling agreement for each investment pool must be in writing and must provide that:

(1) 100 percent of the interests in the pool must be held at all times by the insurance company, the company's subsidiaries or affiliates, or, in the case of a United States branch of an alien insurance company, the affiliates or subsidiaries of the United States manager, and any unaffiliated insurance company;

(2) the pool's underlying assets may not be commingled with the general assets of the pool manager or any other person;

(3) in proportion to the aggregate amount of each pool participant's interest in the pool:

(A) each participant owns an undivided interest in the pool's underlying assets; and

(B) the pool's underlying assets are held solely for the benefit of each participant;

(4) a participant, or, in the event of the participant's insolvency, bankruptcy, or receivership, the participant's trustee, receiver, conservator, or other successor in interest, may withdraw all or part of the participant's investment from the pool under the terms of the pooling agreement;

(5) a withdrawal may be made on demand without penalty or other assessment on any business day, and settlement of funds must occur within a reasonable and customary period after the withdrawal, except that:

(A) in the case of publicly traded securities, the settlement period may not exceed five business days; and

(B) in the case of securities and investments other than publicly traded securities, the settlement period may not exceed 10 business days;

(6) the amount of a distribution under Subdivision (5) must be computed after subtracting all the pool's applicable fees and expenses;

(7) the pool manager shall distribute to a participant, at the manager's discretion:

(A) in cash, an amount that represents the fair market value of the participant's pro rata share of each of the pool's underlying assets;

(B) in kind, an amount that represents a pro rata share of each underlying asset; or

(C) in a combination of cash and in-kind distributions, an amount that represents a pro rata share in each underlying asset; and

(8) the pool manager shall make the records of the pool

available for inspection by the commissioner.

(g) An investment in an investment pool is not considered to be an affiliate transaction under Subchapter C, Chapter 823, but each pooling agreement is subject to the standards of Section 823.101 and the reporting requirements of Section 823.052. (V.T.I.C. Art. 3.33, Sec. 4(g).)

Source Law

(g) Insurer Investment Pools. For the purposes of this Subsection (g), the following definition shall apply:

(A) "Affiliate" means, as to any person, another person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person.

(1) An insurer may acquire investments in investment pools that:

(A) invest only in:

(i) obligations that are rated 1 or 2 by the Securities Valuation Office or have an equivalent of a Securities Valuation Office 1 or 2 rating (or, in the absence of a 1 or 2 rating or equivalent rating, the issuer has outstanding obligations with a Securities Valuation Office 1 or 2 or equivalent rating) by a nationally recognized statistical rating organization recognized by the Securities Valuation Office and have:

(a) a remaining maturity of 397 days or less or a put that entitles the holder to receive the principal amount of the obligation which put may be exercised through maturity at specified intervals not exceeding 397 days; or

(b) a remaining maturity of three years or less and a floating interest rate that resets no less frequently than quarterly on the basis of a current short-term index (federal funds, prime rate, treasury bills, London InterBank Offered Rate (LIBOR) or commercial paper) and is subject to no maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(ii) securities lending, repurchase and reverse repurchase transactions that meet the requirements of Subsection (q) and any applicable regulations of the department; or

(iii) money market mutual funds as authorized in Subsection (s); provided that this short-term investment pool shall not acquire investments in any one business entity that exceed 10 percent of the total assets of the investment pool;

(B) invest only in investments which an insurer may acquire under this article, if the insurer's proportionate interest in the amount invested in these investments does not exceed the applicable limits of this article, and the aggregate amount of all investments in such other investment pools may not exceed 25 percent of the insurer's assets.

(2) An insurer shall not acquire an investment in an investment pool under this subsection

if after giving effect to the investment, the aggregate amount of investments in all investment pools then held by the insurer would exceed 35 percent of its assets.

(3) For an investment in an investment pool to be qualified under this article, the investment pool shall not:

(A) acquire securities issued, assumed, guaranteed or insured by the insurer or an affiliate of the insurer;

(B) borrow or incur any indebtedness for borrowed money, except for securities lending and reverse repurchase transactions.

(4) For an investment pool to be qualified under this article:

(A) the manager of the investment pool shall:

(i) be organized under the laws of the United States or a state and designated as the pool manager in a pooling agreement;

(ii) be the insurer, an affiliated insurer, a business entity affiliated with the insurer, a custodian bank, a business entity registered under the Investment Advisors Act of 1940 (15 U.S.C. Section 80a-1 et seq.), as amended, or, in the case of a reciprocal insurer or interinsurance exchange, its attorney-in-fact or, in the case of a United States branch of an alien insurer, its United States manager or affiliates or subsidiaries of its United States manager;

(B) the pool manager or an entity designated by the pool manager of the type set forth in (4)(A)(ii) shall maintain detailed accounting records setting forth:

(i) the cash receipts and disbursements reflecting each participant's proportionate investment in the investment pool;

(ii) a complete description of all underlying assets of the investment pool (including amount, interest rate, maturity date (if any) and other appropriate designations); and

(iii) other records which, on a daily basis, allow third parties to verify each participant's investments in the investment pool;

(C) the assets of the investment pool shall be held in one or more accounts, in the name or on behalf of the investment pool, either (i) under a custody agreement or trust agreement with a custodian bank or (ii) at the principal office of the pool manager. The applicable agreement shall:

(i) state and recognize the claims and rights of each participant;

(ii) acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its investments in the investment pool; and

(iii) contain an agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the custodian bank or any other person.

(5) The pooling agreement for each investment pool shall be in writing and shall provide that:

(A) the insurer, its subsidiaries, affiliates or, in the case of a United States branch of an alien insurer, affiliates or subsidiaries of its United States manager, and any unaffiliated insurer

shall, at all times, hold 100 percent of the interests in the investment pool;

(B) the underlying assets of the investment pool shall not be commingled with the general assets of the pool manager or any other person;

(C) in proportion to the aggregate amount of each pool participant's interest in the investment pool:

(i) each participant owns an undivided interest in the underlying assets or the investment pool; and

(ii) the underlying assets of the investment pool are held solely for the benefit of each participant;

(D) a participant, or, in the event of the participant's insolvency, bankruptcy, or receivership, its trustee, receiver, conservator or other successor-in-interest, may withdraw all or any portion of its investment from the investment pool under the terms of the pooling agreement;

(E) withdrawals may be made on demand without penalty or other assessment on any business day, but settlement of funds shall occur within a reasonable and customary period thereafter provided: (i) in the case of publicly traded securities, settlement shall not exceed five business days, and (ii) in the case of all other securities and investments, settlement shall not exceed 10 business days. Distributions under this paragraph shall be calculated in each case net of all then applicable fees and expenses of the investment pool. The pooling agreement shall provide that the pool manager shall distribute to a participant, at the discretion of the pool manager:

(i) in cash, the then fair market value of the participant's pro rata share of each underlying asset of the investment pool;

(ii) in kind, a pro rata share of each underlying asset; or

(iii) in a combination of cash and in kind distributions, a pro rata share in each underlying asset; and

(F) the pool manager shall make the records of the investment pool available for inspection by the commissioner.

(6) An investment in an investment pool shall not be deemed to be an affiliate transaction under Section 4, Article 21.49-1, of this code; however each pooling agreement shall be subject to the standards of Section 4(a), Article 21.49-1, of this code and the reporting requirements of Section 3(b), Article 21.49-1, of this code.

Revisor's Note

(1) Section 4(g)(1)(A)(iii), V.T.I.C. Article 3.33, refers to "money market mutual funds." The revised law substitutes "money market funds" for "money market mutual funds" for the reason stated in the revisor's note to Section 425.123.

(2) Section 4(g)(4)(A)(ii), V.T.I.C. Article 3.33, refers to the "Investment Advisors Act of 1940

(15 U.S.C. Section 80a-1 et seq.)." The revised law corrects the cite for that act to reflect its proper spelling and that the act begins at 15 U.S.C. Section 80b-1.

(3) Section 4(g)(4)(A)(ii), V.T.I.C. Article 3.33, refers to a "reciprocal insurer or interinsurance exchange," meaning the type of entity organized under Chapter 942 of this code. The most commonly used term for that type of entity is "reciprocal or interinsurance exchange." For consistent use of terminology in this code, the revised law substitutes "reciprocal or interinsurance exchange" for "reciprocal insurer or interinsurance exchange."

(4) Section 4(g)(5)(C)(i), V.T.I.C. Article 3.33, provides that "in proportion to the aggregate amount of each pool participant's interest in the investment pool[,] . . . each participant owns an undivided interest in the underlying assets or the investment pool." It is clear that the "or" between "underlying assets" and "the investment pool" is a typographical error and should read "of." To say that "in proportion to a participant's interest in an investment pool, the participant owns an interest in the pool" merely states the obvious. Additionally, Section 4(g)(5)(E), V.T.I.C. Article 3.33, clearly provides for distribution to a pool participant of the participant's pro rata share of the pool's underlying assets. Finally, similar language is found in Section 5(g)(3), V.T.I.C. Article 2.10-5 (revised in relevant part as Section 424.111(3) of this code), which applies to investments by various types of insurers; that section provides that "each participant owns an undivided interest in the underlying assets of the

investment pool in proportion to the aggregate amount of each pool participant's interest in the investment pool."

Revised Law

Sec. 425.115. AUTHORIZED INVESTMENTS: EQUITY INTERESTS. (a) In this section, "business entity" means a real estate investment trust, corporation, limited liability company, association, limited partnership, joint venture, mutual fund, trust, joint tenancy, or other similar form of business organization, regardless of whether organized for profit.

(b) Subject to this section, an insurance company may invest in an equity interest, including common stock, an equity investment in an investment company other than a money market fund described by Section 425.123, a real estate investment trust, a limited partnership interest, a warrant, another right to acquire an equity interest that is created by the person that owns or would issue the equity in which the interest is acquired, and an equity interest in a business entity that is organized under the laws of the United States, a state of the United States, Canada, or a province or territory of Canada.

(c) If a market value from a generally recognized source is not available for an equity interest, the business entity or other investment in which the interest is acquired must be subject to:

(1) an annual audit by an independent certified public accountant; or

(2) another method of valuation acceptable to the commissioner.

(d) An insurance company may not invest in a partnership as a general partner except through an investment subsidiary.

(e) An insurance company's investments under this section in a single business entity, other than a money market fund described by Section 425.123, may not exceed 15 percent of the company's capital and surplus.

(f) The aggregate amount of an insurance company's

investments under this section may not exceed 25 percent of the company's assets. (V.T.I.C. Art. 3.33, Sec. 4(h).)

Source Law

[Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]

(h) Equity Interests. Equity interests including common stock, equity investment in an investment company (other than a money market mutual fund as defined in Subsection (s) of this section), real estate investment trust, limited partnership interests, warrants or other rights to acquire equity interests that are created by the person that owns or would issue the equity to be acquired, and equity interests in any business entity that is organized under the laws of the United States, any of its states, Canada or any province or territory of Canada provided:

(1) if no market value from a generally recognized source is available for the equity interest, the business entity or other investment shall be subject to an annual audit by an independent certified public accountant or subject to another method of valuation acceptable to the commissioner; and

(2) an insurer shall not be permitted to invest in a partnership, as a general partner, except through an investment subsidiary;

(3) such investments in any one business entity other than a money market fund defined in Subsection (s) may not exceed 15 percent of the insurer's capital and surplus;

(4) the aggregate amount of all investments made under this subsection may not exceed 25 percent of the insurer's assets.

For purposes of this subsection, a business entity shall mean a real estate investment trust, corporation, limited liability company, association, limited partnership, joint venture, mutual fund, trust, joint tenancy or other similar form of business organization, whether organized for profit or not-for-profit.

Revisor's Note

Section 4(h), V.T.I.C. Article 3.33, refers to "a money market mutual fund." The revised law substitutes "money market fund" for "money market mutual fund" for the reason stated in the revisor's note to Section 425.123.

Revised Law

Sec. 425.116. AUTHORIZED INVESTMENTS: PREFERRED STOCK. (a) Subject to this section, an insurance company may invest in preferred stock of a business entity, as defined by Section

425.110.

(b) An insurance company may invest in preferred stock only if:

(1) the stock is rated by the securities valuation office; and

(2) the sum of the company's aggregate investment in preferred stock rated 3, 4, 5, or 6 and the company's investments under Section 425.110(d) does not exceed the limitations specified by Section 425.110(d).

(c) An insurance company's investments in the preferred stock of a single business entity may not exceed 20 percent of the company's capital and surplus.

(d) The aggregate amount of an insurance company's investments in preferred stock as to which there is not a sinking fund for the redemption and retirement of the stock that meets the standards established by the National Association of Insurance Commissioners may not exceed 10 percent of the company's assets.

(e) The aggregate amount of an insurance company's investments under this section may not exceed 40 percent of the company's assets. (V.T.I.C. Art. 3.33, Sec. 4(i).)

Source Law

[Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]

(i) Preferred Stock. Preferred stock of business entities as described in Subsection (c) of this section; provided:

(1) investments in the preferred stock of any one business entity will not exceed 20 percent of the insurer's capital and surplus;

(2) the preferred stock is rated by the Securities Valuation Office, and the aggregate investment in preferred stock rated 3, 4, 5, or 6, when added to the investments under Subsection (c)(2) do not result in the combined total of such investments exceeding the limitations specified in Subsection (c)(2);

(3) in the aggregate not more than 10 percent of the insurer's assets may be invested in preferred stock, the redemption and retirement of which is not provided for by a sinking fund meeting the standards established by the National Association of Insurance Commissioners; and

(4) the aggregate of all investments made under this subsection may not exceed 40 percent of the

insurer's assets;

Revised Law

Sec. 425.117. AUTHORIZED INVESTMENTS: COLLATERAL LOANS. (a) Subject to this section, an insurance company may invest in a collateral loan secured by:

(1) a first lien on an asset; or

(2) a valid and perfected first security interest in an asset.

(b) The amount of a loan invested in under this section may not exceed 80 percent of the value of the collateral asset at any time during the duration of the loan.

(c) The asset used as collateral for a loan under this section must be an asset, other than real property described by Section 425.119, in which the insurance company is authorized by this subchapter to directly invest. (V.T.I.C. Art. 3.33, Sec. 4(j).)

Source Law

[Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]

(j) Collateral Loans. Collateral loans secured by a first lien upon or a valid and perfected first security interest in an asset; provided:

(1) the amount of any such collateral loan will not exceed 80 percent of the value of the collateral asset at any time during the duration of the loan; and

(2) the asset used as collateral would be authorized for direct investment by the insurer under other provisions of this Section 4, except real property in Subsection (l);

Revisor's Note

Section 4(j)(2), V.T.I.C. Article 3.33, refers to an asset that would be authorized for direct investment by an insurance company "under other provisions of this Section 4." The revised law substitutes a reference to an investment authorized by "this subchapter." Although this subchapter includes provisions derived from other sections of Article 3.33, the only provisions included in this subchapter

that authorize investments by insurance companies were derived from Section 4.

Revised Law

Sec. 425.118. AUTHORIZED INVESTMENTS: OBLIGATIONS SECURED BY REAL PROPERTY LOANS. (a) Subject to this section, an insurance company may invest in a note, an evidence of indebtedness, or a participation in a note or evidence of indebtedness that is secured by a valid first lien on real property or a leasehold estate in real property located in the United States.

(b) The amount of an obligation secured by a first lien on real property or a leasehold estate in real property may exceed 90 percent of the value of the real property or leasehold estate only if:

(1) the amount does not exceed 100 percent of the value of the real property or leasehold estate and the insurance company or one or more wholly owned subsidiaries of the company owns, in the aggregate, a 10 percent or greater equity interest in the real property or leasehold estate;

(2) the amount does not exceed 95 percent of the value of the real property or leasehold estate and:

(A) the property contains only a dwelling designed exclusively for occupancy by not more than four families for residential purposes; and

(B) the portion of the unpaid balance of the obligation that exceeds 90 percent of the value of the property or leasehold estate is guaranteed or insured by a mortgage guaranty insurer authorized to engage in business in this state; or

(3) the amount exceeds 90 percent of the value of the real property or leasehold estate only to the extent the obligation is insured or guaranteed by:

(A) the United States;

(B) the Federal Housing Administration under the National Housing Act (12 U.S.C. Section 1701 et seq.), as amended; or

(C) this state.

(c) The term of an obligation secured by a first lien on a leasehold estate in real property may not, as of the date the obligation is acquired, exceed a period equal to four-fifths of the unexpired term of the leasehold estate, and the obligation must fully amortize during that period. The term of the leasehold estate may not expire sooner than the 10th anniversary of the expiration date of the term of the obligation.

(d) An obligation secured by a first lien on a leasehold estate in real property must be payable in one or more installments of an amount or amounts sufficient to ensure that, at any time after the expiration of two-thirds of the original term of the obligation, the principal balance on the obligation is not greater than the principal balance would have been if the obligation had been amortized over the original term of the obligation in equal monthly, quarterly, semiannual, or annual payments of principal and interest.

(e) If any part of the value of buildings is to be included in the value of real property or a leasehold estate in real property to secure an obligation under this section:

(1) the buildings must be covered by adequate property insurance, including fire and extended coverage insurance, issued by:

(A) an insurer authorized to engage in business in this state; or

(B) an insurer recognized as acceptable to issue that coverage by the insurance regulatory official of the state in which the real property is located;

(2) the amount of insurance provided by one or more policies may not be less than the lesser of:

(A) the unpaid balance of the obligation; or

(B) the insurable value of the buildings; and

(3) the loss clause under each policy must be payable to the insurance company as the company's interest may appear.

(f) To the extent that a note, evidence of indebtedness, or participation in a note or evidence of indebtedness under this section represents an equity interest in the underlying real property:

(1) the value of that equity interest must be determined at the time the note, evidence of indebtedness, or participation is executed; and

(2) the portion of the obligation that represents an equity interest in the property must be designated as an investment subject to Section 425.119(c).

(g) An insurance company's investment in a single obligation under this section may not exceed 25 percent of the company's capital and surplus.

(h) An insurance company may purchase a first lien on real property after the origination of the lien if:

(1) the first lien is insured by a mortgagee's title policy issued to the original mortgagee that contains a provision that inures the policy to the use and benefit of the owners of the evidence of indebtedness indicated in the policy and to any subsequent owners of that evidence of indebtedness; and

(2) the company maintains evidence of an assignment or other transfer of the first lien on real property to the company.

(i) For purposes of Subsection (h)(2), an assignment or other transfer to the insurance company that is duly recorded in the county in which the real property is located is presumed to create legal ownership of the first lien by the company. (V.T.I.C. Art. 3.33, Sec. 4(k).)

Source Law

[Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]

(k) Real Estate Loans. Notes, evidences of indebtedness, or participations therein secured by a valid first lien upon real property or leasehold estate therein located in the United States of America; provided:

(1) the amount of any such obligation secured by a first lien upon real property or leasehold

estate therein shall not exceed 90 percent of the value of such real property or leasehold estate therein, but the amount of such obligation:

(A) may exceed 90 percent but shall not exceed 100 percent of the value of such real property or leasehold estate therein if the insurer or one or more wholly owned subsidiaries of the insurer owns in the aggregate a 10 percent or greater equity interest in such real property or leasehold estate therein;

(B) may be 95 percent of the value of such real property or leasehold estate therein if it contains only a dwelling designed exclusively for occupancy by not more than four families for residential purposes, and the portion of the unpaid balance of such obligation which is in excess of an amount equal to 90 percent of such value is guaranteed or insured by a mortgage insurance company qualified to do business in the State of Texas; or

(C) may be greater than 90 percent of the value of such real property or leasehold estate therein to the extent the obligation is insured or guaranteed by the United States of America, the Federal Housing Administration pursuant to the National Housing Act of 1934, as amended (12 U.S.C. Section 1701 et seq.), or the State of Texas; and

(2) the term of an obligation secured by a first lien upon a leasehold estate in real property shall not exceed a period equal to four-fifths of the then unexpired term of such leasehold estate; provided the unexpired term of the leasehold estate must extend at least 10 years beyond the term of the obligation, and each obligation shall be payable in an installment or installments of sufficient amount or amounts so that at any time after the expiration of two-thirds of the original loan term, the principal balance will be no greater than the principal balance would have been if the loan had been amortized over the original loan term in equal monthly, quarterly, semiannual, or annual payments of principal and interest, it being required that under any method of repayment such obligation will fully amortize during a period of time not exceeding four-fifths of the then unexpired term of the security leasehold estate; and

(3) if any part of the value of buildings is to be included in the value of such real property or leasehold estate therein to secure the obligations provided for in this subsection, such buildings shall be covered by adequate property insurance, including but not limited to fire and extended coverage insurance issued by a company authorized to transact business in the State of Texas or by a company recognized as acceptable for such purpose by the insurance regulatory official of the state in which such real estate is located, and the amount of insurance granted in the policy or policies shall be not less than the unpaid balance of the obligation or the insurable value of such buildings, whichever is the lesser; the loss clause shall be payable to the insurer as its interest may appear; and

(4) to the extent any note, evidence of indebtedness, or participation therein under this subsection represents an equity interest in the underlying real property, the value of such equity interest shall be determined at the time of execution of such note, evidence of indebtedness, or participation therein and that portion shall be designated as an investment subject to the provisions

of Subsection (l)(2) of this section; and

(5) the amount of any one such obligation may not exceed 25 percent of the insurer's capital and surplus; and

(6) a first lien on real property may be purchased after its origination if the first lien is insured by a mortgagee's title policy issued to the original mortgagee that contains a provision that inures the policy to the use and benefit of the owners of the evidence of debt indicated in the policy and to any subsequent owners of that evidence of debt, and if the insurer maintains evidence of assignments or other transfers of the first lien on real property to the insurer. An assignment or other transfer to the insurer, duly recorded in the county in which the real property is located, shall be presumed to create legal ownership of the first lien by the insurer;

Revisor's Note

Section 4(k)(1)(B), V.T.I.C. Article 3.33, refers to a "mortgage insurance company" that is "qualified" to engage in business. The revised law substitutes "mortgage guaranty insurer" for "mortgage insurance company" for consistency with the terminology used in V.T.I.C. Article 21.50, revised in this code as Chapter 3502, which regulates mortgage guaranty insurance. The revised law also substitutes "authorized" for "qualified" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 425.119. AUTHORIZED INVESTMENTS: REAL PROPERTY. (a) Subject to this section, an insurance company may invest in a real property fee simple or leasehold estate located in the United States.

(b) An insurance company may invest in home and branch office real property or a participation in home or branch office real property. At least 30 percent of the available space in a building used as a home or branch office must be occupied for the business purposes of the company and the company's affiliates. A company's aggregate investment in home and branch office real property may not exceed 20 percent of the company's assets.

(c) An insurance company may invest in real property other than home and branch office real property or participations in home and branch office real property. A company's investment under this subsection in a single piece of property or in an interest in a single piece of property, including improvements, fixtures, and equipment relating to the property, may not exceed five percent of the company's assets.

(d) Investment real property held under Subsection (b) or (c) must be materially enhanced in value by:

(1) the construction of durable, permanent-type buildings and other improvements that cost an amount at least equal to the cost of the real property, excluding buildings and improvements at the time the real property is acquired; or

(2) the construction, commenced before the second anniversary of the date the real property is acquired, of buildings and improvements described by Subdivision (1).

(e) The admissible asset value of each investment in real property under Subsection (b) or (c) is subject to review and approval by the commissioner. The commissioner may, at the time the investment is made or any time the insurance company is being examined, have the investment appraised by an appraiser appointed by the commissioner. The company shall pay the reasonable expense of the appraisal. The expense of the appraisal is considered to be a part of the expense of examination of the company unless the company applies for the appraisal to be made. A company may not increase the valuation of real property described by Subsection (b) or (c) unless:

(1) the company applies for the increase in valuation; and

(2) the commissioner approves the increase.

(f) Except as provided by Subsection (g), an insurance company may not own, develop, or hold an equity interest in any residential property or subdivision, single or multiunit family dwelling property, or undeveloped real property to subdivide for or

develop residential or single or multiunit family dwellings.

(g) An insurance company may invest in other real property acquired:

(1) in good faith to secure a loan previously contracted for, or for money due;

(2) in satisfaction of a debt previously contracted for in the course of the company's dealings; or

(3) by purchase at a sale under a judgment or decree of a court or under a mortgage or other lien held by the company.

(h) Regardless of the manner in which an insurance company acquires real property under this section, on the sale of the property, the company may retain indefinitely the fee title to the mineral estate or any portion of the mineral estate. (V.T.I.C. Art. 3.33, Sec. 4(l).)

Source Law

[Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]

(l) Real Estate. Real property fee simple or leasehold estates located within the United States of America, as follows:

(1) home and branch office real property or participations therein, which must be materially enhanced in value by the construction of durable, permanent-type buildings and other improvements costing an amount at least equal to the cost of such real property, exclusive of buildings and improvements at the time of acquisition, or by the construction of such buildings and improvements which must be commenced within two years of the date of the acquisition of such real property; provided:

(A) at least 30 percent of the available space in such building shall be occupied for the business purposes of the insurer and its affiliates; and

(B) the aggregate investment in such home and branch offices shall not exceed 20 percent of the insurer's assets; and

(2) other investment property or participations therein, which must be materially enhanced in value by the construction of durable, permanent-type buildings and other improvements costing an amount at least equal to the cost of such real property, exclusive of buildings and improvements at the time of acquisition, or by the construction of such buildings and improvements which must be commenced within two years of the date of acquisition of such real property; provided that such investment in any one piece of property or interest therein, including the improvements, fixtures, and equipment pertaining thereto may not exceed five percent of the

insurer's assets; provided, however, nothing in this article shall allow ownership of, development of, or equity interest in any residential property or subdivision, single or multiunit family dwelling property, or undeveloped real estate for the purpose of subdivision for or development of residential, single, or multiunit family dwellings, except acquisitions as provided in Subdivision (4) below, and such ownership, development, or equity interests shall be specifically prohibited;

(3) the admissible asset value of each such investment in the properties acquired under Subdivisions (1) and (2) of this subsection shall be subject to review and approval by the Commissioner of Insurance. The commissioner shall have discretion at the time such investment is made or any time when an examination of the company is being made to cause any such investment to be appraised by an appraiser, appointed by the commissioner, and the reasonable expense of such appraisal shall be paid by such insurance company and shall be deemed to be a part of the expense of examination of such company; if the appraisal is made upon application of the company, the expense of such appraisal shall not be considered a part of the expense of examination of such company; no insurance company may hereafter make any write-up in the valuation of any of the properties described in Subdivision (1) or (2) of this subsection unless and until it makes application therefor and such increase in valuation shall be approved by the commissioner; and

(4) other real property acquired:

(A) in good faith by way of security for loans previously contracted or money due; or

(B) in satisfaction of debts previously contracted for in the course of its dealings; or

(C) by purchase at sales under judgment or decrees of court, or mortgage or other lien held by such insurer; and

(5) regardless of the mode of acquisition specified herein, upon sale of any such real property, the fee title to the mineral estate or any portion thereof may be retained by the insurance company indefinitely;

Revisor's Note

Section 4(l)(3), V.T.I.C. Article 3.33, refers to a "write-up" in the valuation of an asset and to "such increase" in valuation. The revised law substitutes "increase" for "write-up" because, in context, the terms are synonymous and "increase" is the more modern term.

Revised Law

Sec. 425.120. AUTHORIZED INVESTMENTS: OIL, GAS, AND MINERALS. (a) In this section:

(1) "Producing" means producing oil, gas, or other

minerals in paying quantities. A well that has been shut in is considered to be producing oil, gas, or other minerals in paying quantities if shut-in royalties are being paid.

(2) "Production payment" means a right to oil, gas, or other minerals in place or as produced that entitles the owner of the right to a specified fraction of production until the owner receives a specified amount of money, or a specified number of units of oil, gas, or other minerals.

(3) "Royalty" or "overriding royalty" means a right to oil, gas, and other minerals in place or as produced that entitles the owner of the right to a specified fraction of production without limitation to a specified amount of money or a specified number of units of oil, gas, or other minerals.

(b) Subject to this section, in addition to and without limitation on the purposes for which real property may be acquired, secured, held, or retained under other provisions of this subchapter, an insurance company may secure, hold, retain, and convey production payments, producing royalties, and producing overriding royalties, or participations in production payments, producing royalties, or producing overriding royalties as an investment for the production of income.

(c) An insurance company may not carry an asset described by Subsection (b) in an amount that exceeds 90 percent of the appraised value of the asset.

(d) A single investment under this section may not exceed 10 percent of the amount of the insurance company's capital and surplus that exceeds the statutory minimum capital and surplus applicable to the company.

(e) The aggregate amount of an insurance company's investments under this section may not exceed 10 percent of the company's assets as of December 31 preceding the date of the investment. (V.T.I.C. Art. 3.33, Sec. 4(m).)

Source Law

(m) Oil, Gas, and Minerals. In addition to and

without limitation on the purposes for which real property may be acquired, secured, held, or retained pursuant to other provisions of this section, every such insurance company may secure, hold, retain, and convey production payments, producing royalties and producing overriding royalties, or participations therein as an investment for the production of income; provided:

(1) in no event may such company carry such assets in an amount in excess of 90 percent of the appraised value thereof; and

(2) no one investment under this subsection may exceed 10 percent of the insurer's capital and surplus in excess of statutory minimum capital and surplus applicable to that insurer, and the aggregate of all such investments may not exceed 10 percent of the insurer's assets as of December 31st next preceding the date of such investment; and

(3) for the purposes of this subsection, the following definitions apply:

(A) a production payment is defined to mean a right to oil, gas, or other minerals in place or as produced that entitles its owner to a specified fraction of production until a specified sum of money, or a specified number of units of oil, gas, or other minerals, has been received;

(B) a royalty and an overriding royalty are each defined to mean a right to oil, gas, and other minerals in place or as produced that entitles the owner to a specified fraction of production without limitation to a specified sum of money or a specified number of units of oil, gas, or other minerals;

(C) "producing" is defined to mean producing oil, gas, or other minerals in paying quantities, provided that it shall be deemed that oil, gas, or other minerals are being produced in paying quantities if a well has been "shut in" and "shut-in royalties" are being paid;

Revised Law

Sec. 425.121. AUTHORIZED INVESTMENTS: SECURITIES LENDING, REPURCHASE, REVERSE REPURCHASE, AND DOLLAR ROLL TRANSACTIONS. (a) In this section:

(1) "Dollar roll transaction" means two simultaneous transactions with settlement dates not more than 96 days apart, in one of which an insurance company sells to a business entity, and in the other of which the company is obligated to purchase from the same business entity, substantially similar securities that are:

(A) mortgage-backed securities issued, assumed, or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, or a successor to one of those organizations; or

(B) other mortgage-backed securities referred to in 15 U.S.C. Section 77r-1, as amended.

(2) "Repurchase transaction" means a transaction in which an insurance company purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the company at a specified price, either within a specified period or on demand.

(3) "Reverse repurchase transaction" means a transaction in which an insurance company sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period or on demand.

(4) "Securities lending transaction" means a transaction in which an insurance company lends securities to a business entity that is obligated to return the loaned securities or equivalent securities to the company, either within a specified period or on demand.

(b) Subject to this section, an insurance company may engage in securities lending, repurchase, reverse repurchase, and dollar roll transactions.

(c) An insurance company must enter into a written agreement for each transaction under this section, other than a dollar roll transaction. The agreement must require that the transaction terminate on or before the first anniversary of the transaction's inception.

(d) With respect to cash received in a transaction under this section, an insurance company shall:

(1) invest the cash in accordance with this subchapter and in a manner that recognizes the liquidity needs of the transaction; or

(2) use the cash for the company's general corporate purposes.

(e) While a transaction under this section is outstanding, the insurance company or the company's agent or custodian shall

maintain, as to acceptable collateral received in the transaction, either physically or through the book-entry system of the Federal Reserve, Depository Trust Company, Participants Trust Company, or another securities depository approved by the commissioner:

(1) possession of the collateral;

(2) a perfected security interest in the collateral; or

(3) in the case of a jurisdiction outside of the United States, title to, or rights of a secured creditor to, the collateral.

(f) The limitations of Sections 425.110 and 425.157(b) do not apply to the business entity counterparty exposure created by a transaction under this section. An insurance company may not enter into a transaction under this section if, as a result of and after making the transaction:

(1) the aggregate amount of securities loaned or sold to or purchased from any one business entity counterparty under this section would exceed five percent of the company's assets; or

(2) the aggregate amount of all securities loaned or sold to or purchased from all business entities under this section would exceed 40 percent of the company's assets.

(g) For purposes of Subsection (f)(1), in computing the amount sold to or purchased from a business entity counterparty under a repurchase or reverse repurchase transaction, effect may be given to netting provisions under a master written agreement.

(h) The amount of collateral required for securities lending, repurchase, and reverse repurchase transactions is the amount required under the Purposes and Procedures Manual of the securities valuation office or a successor publication. (V.T.I.C. Art. 3.33, Secs. 4(q)(a), (b), (c), (d), (e).)

<u>Source Law</u>

(q) Securities Lending, Repurchase, Reverse Repurchase and Dollar Roll Transactions. (a) For purposes of this Subsection (q), the following definitions shall apply:

(1) "Repurchase transaction" means a

transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period of time or upon demand.

(2) "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or upon demand.

(3) "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period of time or upon demand.

(4) "Dollar roll transaction" means two simultaneous transactions with settlement dates no more than 96 days apart so that in one transaction an insurer sells to a business entity, and in the other transaction the insurer is obligated to purchase from the same business entity, substantially similar securities of the following types:

(A) mortgage-backed securities issued, assumed or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation or their respective successors; and

(B) other mortgage-backed securities referred to in Section 106 of Title I of the Secondary Mortgage Market Enhancement Act of 1984 (15 U.S.C. Section 77r-1), as amended.

(b) An insurer may engage in securities lending, repurchase, reverse repurchase and dollar roll transactions as set forth herein. The insurer shall enter into a written agreement for all transactions, except dollar roll transactions, that shall require each transaction terminate no more than one year from its inception.

(c) Cash received in a transaction under this section shall be invested in accordance with this article and in a manner that recognizes the liquidity needs of the transaction or used by the insurer for its general corporate purposes. For so long as the transaction remains outstanding, the insurer, its agent or custodian shall maintain, as to acceptable collateral received in a transaction under this subsection, either physically or through the book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company or other securities depositories approved by the commissioner:

(1) possession of the acceptable collateral;

(2) a perfected security interest in the acceptable collateral; or

(3) in the case of a jurisdiction outside of the United States, title to, or rights of a secured creditor to, the acceptable collateral; and

(d) The limitations of Section 4(c) and Section 5(a) shall not apply to the business entity counterparty exposure created by transactions under this section. An insurer shall not enter into a transaction under this subsection if, as a result of and after giving effect to the transaction:

(1) the aggregate amount of securities then loaned, sold to, or purchased from, any one

business entity counterparty under this subsection would exceed 5 percent of its assets. In calculating the amount sold to or purchased from a business entity counterparty under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement; or

(2) the aggregate amount of all securities then loaned, sold to or purchased from all business entities under this subsection would exceed 40 percent of its assets.

(e) The amount of collateral required for securities lending, repurchase and reverse repurchase transactions is the amount required pursuant to the provisions of the Purposes and Procedures of the Securities Valuation Office or such successor publication.

Revisor's Note

(1) Section 4(q)(a)(4)(B), V.T.I.C. Article 3.33, refers to "Section 106 of Title I of the Secondary Mortgage Market Enhancement Act of 1984 (15 U.S.C. Section 77r-1)." The revised law omits the reference to "Section 106 of Title I of the Secondary Mortgage Market Enhancement Act of 1984" as unnecessary because it is simply a cite to the provisions in which 15 U.S.C. Section 77r-1 was originally enacted and does not add any meaning to the substance of the law.

(2) Section 4(q)(e), V.T.I.C. Article 3.33, refers to "the Purposes and Procedures of the Securities Valuation Office or such successor publication." Other provisions of Section 4, V.T.I.C. Article 3.33, contain similar references. Throughout this subchapter, the revised law substitutes "Purposes and Procedures Manual" for "Purposes and Procedures" because that is the correct name of that publication.

(3) Section 4(q)(f), V.T.I.C. Article 3.33, provides that V.T.I.C. Article 3.39-1 does not apply to a transaction authorized by Section 4(q), V.T.I.C. Article 3.33. V.T.I.C. Article 3.39-1 was repealed by Chapter 556, Acts of the 75th Legislature, Regular Session, 1997. V.T.I.C. Article 3.39-1 permitted an insurance company to enter into repurchase agreements,

subject to the limitations prescribed by that article. Chapter 556, Acts of the 75th Legislature, Regular Session, 1997, also added Subsection (q), revised as this section, to Section 4, V.T.I.C. Article 3.33. Because Section 4(q), V.T.I.C. Article 3.33, effectively supersedes V.T.I.C. Article 3.39-1, the revised law omits Section 4(q)(f) as unnecessary. The omitted law reads:

> (f) Article 3.39-1 shall not apply to transactions authorized by this Subsection (q).

Revised Law

Sec. 425.122. AUTHORIZED INVESTMENTS: PREMIUM LOANS. (a) Subject to Subsection (b), an insurance company may make loans to finance the payment of premiums for the company's own insurance policies or annuity contracts.

(b) The amount of a loan under this section may not exceed the sum of:

(1) the available cash value of the insurance policy or annuity contract for which the premium loan is made; and

(2) the amount of any escrowed commissions payable relating to the insurance policy or annuity contract. (V.T.I.C. Art. 3.33, Sec. 4(r).)

Source Law

> [Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]
>
> (r) Premium Loans. Loans to finance the payment of premiums for the insurer's own insurance policies or annuity contracts; provided that the amount of any such loan does not exceed the sum of: (i) the available cash value of such insurance policy or annuity contract; and (ii) the amount of any escrowed commissions payable relating to such insurance policy or annuity contract for which the premium loan is made; and

Revised Law

Sec. 425.123. AUTHORIZED INVESTMENTS: MONEY MARKET FUNDS. (a) An insurance company may invest in a money market fund as described by 17 C.F.R. Section 270.2a-7 under the Investment

Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), that is:

(1) a government money market fund that:

(A) invests only in obligations issued, guaranteed, or insured by the United States government or collateralized repurchase agreements composed of these obligations; and

(B) qualifies for investment without a reserve under the Purposes and Procedures Manual of the securities valuation office or a successor publication; or

(2) a class one money market fund that qualifies for investment using the bond class one reserve factor described by the Purposes and Procedures Manual of the securities valuation office or a successor publication.

(b) For purposes of complying with Section 425.115, a money market fund that qualifies for listing in the categories prescribed by Subsection (a) must conform to the Purposes and Procedures Manual of the securities valuation office or a successor publication. (V.T.I.C. Art. 3.33, Sec. 4(s).)

Source Law

[Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]

(s) Money Market Funds. (1) Money market mutual funds as defined by 17 CFR 270.2a-7 under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.) that may be either of the following:

(A) government money market mutual fund which is a money market mutual fund that:

(i) invests only in obligations issued, guaranteed or insured by the federal government of the United States or collateralized repurchase agreements composed of these obligations; and

(ii) qualifies for investment without a reserve under the Purposes and Procedures of the Securities Valuation Office or any successor publication; or

(B) class one money market mutual fund which is a money market mutual fund that qualifies for investment using the bond class one reserve factor under the Purposes and Procedures of the Securities Valuation Office or any successor publication.

(2) For purposes of complying with Subsection (h) of this section, money market funds qualifying for listing within these categories must conform to the Purposes and Procedures of the Securities Valuation Office or such successor

publication;

Revisor's Note

Section 4(s)(1), V.T.I.C. Article 3.33, refers to "[m]oney market mutual funds as defined by 17 CFR 270.2a-7 under the Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.)." Section 270.2a-7 does not define or use the term "money market mutual fund," but does prescribe requirements for a registered investment company that holds itself out as a "money market fund." Therefore, the revised law substitutes "money market fund" for "money market mutual fund."

Revised Law

Sec. 425.124. AUTHORIZED INVESTMENTS: RISK CONTROL TRANSACTIONS. Subject to Sections 425.126-425.132, an insurance company may use derivative instruments, as defined by Section 425.125, to engage in hedging transactions, replication transactions, and income generation transactions, as those terms are defined by Section 425.125. (V.T.I.C. Art. 3.33, Sec. 4(u) (part).)

Source Law

(u) Risk Control Transactions. An insurer may use derivative instruments to engage in hedging transactions, replication transactions and income generation transactions as set forth herein.

. . .

Revisor's Note

Section 4(u)(11), V.T.I.C. Article 3.33, provides that V.T.I.C. Article 3.39-2 does not apply to a transaction authorized by Section 4(u), V.T.I.C. Article 3.33. V.T.I.C. Article 3.39-2 was repealed by Chapter 556, Acts of the 75th Legislature, Regular Session, 1997. V.T.I.C. Article 3.39-2 permitted an insurance company to enter into risk-limiting transactions, including put and call options and interest rate futures contracts, subject to the limitations prescribed by that article. Chapter 556,

Acts of the 75th Legislature, Regular Session, 1997, also added Subsection (u), revised as this section and Sections 425.110(h) and 425.125-425.132, to Section 4, V.T.I.C. Article 3.33. Because Section 4(u), V.T.I.C. Article 3.33, effectively supersedes V.T.I.C. Article 3.39-2, the revised law omits Section 4(u)(11) as unnecessary. The omitted law reads:

> (11) Article 3.39-2 shall not apply to transactions authorized by this Subsection (u).

Revised Law

Sec. 425.125. RISK CONTROL TRANSACTIONS: DEFINITIONS. In Sections 425.124-425.132:

(1) "Acceptable collateral" means cash, cash equivalents, letters of credit, and direct obligations, or securities that are fully guaranteed as to principal and interest by the United States government.

(2) "Business entity" includes a sole proprietorship, corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund, bank, trust, joint tenancy, or other similar form of business organization, regardless of whether organized for profit.

(3) "Cap" means an agreement obligating the seller to make payments to the buyer, with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number that is sometimes called the strike rate or strike price.

(4) "Cash equivalent" means an investment or security that is short-term, highly rated, highly liquid, and readily marketable. The term includes a money market fund described by Section 425.123. For purposes of this subdivision, an investment or security is:

(A) short-term if it has a remaining term to maturity of one year or less; and

(B) highly rated if it has:

(i) a rating of "P-1" by Moody's Investors Service, Inc.;

(ii) a rating of "A-1" by the Standard and Poor's Division of the McGraw Hill Companies, Inc.; or

(iii) an equivalent rating by a nationally recognized statistical rating organization recognized by the securities valuation office.

(5) "Collar" means an agreement to receive payments as the buyer of an option, cap, or floor and to make payments as the seller of a different option, cap, or floor.

(6)(A) "Counterparty exposure amount" means:

(i) for an over-the-counter derivative instrument not entered into under a written master agreement that provides for netting of payments owed by the respective parties, the market value of the over-the-counter derivative instrument, if the liquidation of the derivative instrument would result in a final cash payment to the insurer, or zero, if the liquidation of the derivative instrument would not result in a final cash payment to the insurance company; or

(ii) for an over-the-counter derivative instrument entered into under a written master agreement that provides for netting of payments owed by the respective parties, and for which the counterparty's domiciliary jurisdiction is within the United States or a jurisdiction outside the United States that is listed in the Purposes and Procedures Manual of the securities valuation office as eligible for netting, the greater of zero or the net sum payable to the company in connection with all derivative instruments subject to the written master agreement on the liquidation of the instruments in the event of the counterparty's default under the master agreement, if there is no condition precedent to the counterparty's obligation to make the payment and if there is no setoff of amounts payable under another instrument or agreement.

(B) For purposes of this subdivision, market

value or the net sum payable, as applicable, must be determined at the end of the most recent quarter of the insurance company's fiscal year and must be reduced by the market value of acceptable collateral held by the company or a custodian on the company's behalf.

(7) "Derivative instrument":

(A) means an agreement, option, or instrument, or a series or combinations of agreements, options, or instruments:

(i) to make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement instead of making or taking delivery of, or assuming or relinquishing, a specified amount of an underlying instrument; or

(ii) that has a price, performance, value, or cash flow based primarily on the actual or expected price, yield, level, performance, value, or cash flow of one or more underlying interests;

(B) includes an option, a warrant not otherwise permitted to be held by the insurance company under this subchapter, a cap, a floor, a collar, a swap, a swaption, a forward, a future, any other substantially similar agreement, option, or instrument, and a series or combination of those agreements, options, or instruments; and

(C) does not include a collateralized mortgage obligation, another asset-backed security, a principal-protected structured security, a floating rate security, an instrument that a company would otherwise be authorized to invest in or receive under a provision of this subchapter other than Sections 425.124-425.132, or a debt obligation of the company.

(8) "Derivative transaction" means a transaction involving the use of one or more derivative instruments. The term does not include a dollar roll transaction, repurchase transaction, reverse repurchase transaction, or securities lending transaction.

(9) "Floor" means an agreement obligating the seller

to make payments to the buyer, each of which is based on the amount by which a predetermined number that is sometimes called the floor rate or floor price exceeds a reference price, level, performance, or value of one or more underlying interests.

(10) "Forward" means an agreement to make or take delivery in the future of one or more underlying interests, or to effect a cash settlement, based on the actual or expected price, level, performance, or value of those interests. The term does not include a future, a spot transaction effected within a customary settlement period, a when-issued purchase, or another similar cash market transaction.

(11) "Future" means an agreement traded on a futures exchange to make or take delivery of one or more underlying interests, or to effect a cash settlement based on the actual or expected price, level, performance, or value of those interests.

(12) "Futures exchange" means a foreign or domestic exchange, contract market, or board of trade on which trading in futures is conducted and that, in the United States, is authorized to conduct that trading by the Commodity Futures Trading Commission or a successor to that agency.

(13) "Hedging transaction" means a derivative transaction entered into and maintained to manage, with respect to an asset, liability, or portfolio of assets or liabilities, that an insurance company has acquired or incurred or anticipates acquiring or incurring:

(A) the risk of a change in value, yield, price, cash flow, or quantity; or

(B) the currency exchange rate risk.

(14) "Income generation transaction" means a derivative transaction entered into to generate income. The term does not include a hedging transaction or a replication transaction.

(15) "Market value" means the price for a security or derivative instrument obtained from a generally recognized source,

the most recent quotation from a generally recognized source, or if a generally recognized source does not exist, the price determined under the terms of the instrument or in good faith by the insurance company, as can be reasonably demonstrated to the commissioner on request, plus the amount of accrued but unpaid income on the security or instrument to the extent that amount is not included in the price as of the date the security or instrument is valued.

(16) "Option" means an agreement giving the buyer the right to buy or receive, referred to as a "call option," to sell or deliver, referred to as a "put option," to enter into, extend, or terminate, or to effect a cash settlement based on the actual or expected price, spread, level, performance, or value of, one or more underlying interests.

(17) "Over-the-counter derivative instrument" means a derivative instrument entered into with a business entity in a manner other than through a securities exchange or futures exchange or cleared through a qualified clearinghouse.

(18) "Potential exposure" means:

(A) as to a futures position, the amount of initial margin required for that position; or

(B) as to a swap, collar, or forward, one-half of one percent multiplied by the notional amount multiplied by the square root of the remaining years to maturity.

(19) "Qualified clearinghouse" means a clearinghouse that:

(A) is subject to the rules of a securities exchange or a futures exchange; and

(B) provides clearing services, including acting as a counterparty to each of the parties to a transaction in a manner that eliminates the parties' credit risk to each other.

(20) "Replication transaction" means a derivative transaction or a combination of derivative transactions effected separately or in conjunction with cash market investments included in the insurance company's investment portfolio to replicate the

risks and returns of another authorized transaction, investment, or instrument, or to operate as a substitute for cash market transactions. The term does not include a hedging transaction.

(21) "Securities exchange" means:

(A) an exchange registered as a national securities exchange or a securities market registered under the Securities Exchange Act of 1934 (15 U.S.C. Section 78a et seq.), as amended;

(B) the Private Offerings, Resales and Trading through Automated Linkages system; or

(C) a designated offshore securities market as defined by 17 C.F.R. Section 230.902, as amended.

(22) "Swap" means an agreement to exchange or to net payments at one or more times based on the actual or expected price, yield, level, performance, or value of one or more underlying interests.

(23) "Swaption" means an option to purchase or sell a swap at a given price and time or at a series of prices and times. The term does not include a swap with an embedded option.

(24) "Underlying interest" means an asset, liability, or other interest underlying a derivative instrument or a combination of those assets, liabilities, or other interests. The term includes a security, currency, rate, index, commodity, or derivative instrument.

(25) "Warrant" means an instrument that gives the holder the right to purchase or sell the underlying interest at a given price and time or at a series of prices and times outlined in the warrant agreement. (V.T.I.C. Art. 3.33, Sec. 4(u)(1).)

Source Law

(1) For the purposes of this Subsection (u), the following definitions shall apply:

(A) "Acceptable collateral" means cash, cash equivalents, letters or credit and direct obligations, or securities that are fully guaranteed as to principal and interest by, the government of the United States.

(B) "Business entity" includes a sole proprietorship, corporation, limited liability

company, association, partnership, joint stock company, joint venture, mutual fund, bank, trust, joint tenancy or other similar form of business organization, whether organized for-profit or not-for-profit.

(C) "Cap" means an agreement obligating the seller to make payments to the buyer with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number, sometimes called the strike rate or strike price.

(D) "Cash equivalents" means short-term, highly rated, highly liquid and readily marketable investments or securities, which includes money market funds as defined in Subsection (s). For purposes of this definition:

(i) "short-term" means investments with a remaining term to maturity of one year or less; and

(ii) "highly rated" means an investment rated "P-1" by Moody's Investors Service, Inc., or "A-1" by the Standard and Poor's Division of the McGraw Hill Companies, Inc., or its equivalent rating by a nationally recognized statistical rating organization recognized by the Securities Valuation Office.

(E) "Collar" means an agreement to receive payments as the buyer of an option, cap or floor and to make payments as the seller of a different option, cap or floor.

(F) "Counterparty exposure amount" means:

(i) for an over-the-counter derivative instrument not entered into pursuant to a written master agreement which provides for netting of payments owed by the respective parties:

(a) the market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

(b) zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer;

(ii) for over-the-counter derivative instruments entered into pursuant to a written master agreement which provides for netting of payments owed by the respective parties, and the domiciliary jurisdiction of the counterparty is either within the United States, or if not within the United States, is within a foreign (not United States) jurisdiction listed in the Purposes and Procedures Manual of the Securities Valuation Office as eligible for netting, the greater of zero or the net sum payable to the insurer in connection with all derivative instruments subject to the written master agreement upon their liquidation in the event of default by the counterparty pursuant to the master agreement (assuming no conditions precedent to the obligations of the counterparty to make such a payment and assuming no setoff of amounts payable pursuant to any other instrument or agreement);

(iii) for purposes of this definition, market value or the net sum payable, as the case may be, shall be determined at the end of the most recent quarter of the insurer's fiscal year and shall be reduced by the market value of acceptable collateral held by the insurer or a custodian on the

insurer's behalf.

(G) "Derivative instrument" means any agreement, option or instrument, or any series or combinations thereof:

(i) to make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or

(ii) that have a price, performance, value or cash flow based primarily upon the actual or expected price, yield, level, performance, value or cash flow of one or more underlying interests.

Derivative instruments include options, warrants not otherwise permitted to be held by the insurer under this article, caps, floors, collars, swaps, swaptions, forwards, futures and any other agreements, options or instruments substantially similar thereto, or any series or combinations thereof.

Derivative instruments do not include collateralized mortgage obligations, other asset-backed securities, principal-protected structured securities, floating rate securities, or instruments which an insurer is otherwise permitted to invest in or receive under this article other than under this subsection, and any debt obligations of the insurer.

(H) "Derivative transaction" means a transaction involving the use of one or more derivative instruments. Dollar roll transactions, repurchase transactions, reverse repurchase transactions and securities lending transactions shall not be included as derivative transactions for purposes of this subsection.

(I) "Floor" means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount by which a predetermined number, sometimes called the floor rate or price, exceeds a reference price, level, performance or value of one or more underlying interests.

(J) "Forward" means an agreement (other than a future) to make or take delivery in the future of one or more underlying interests, or effect a cash settlement, based on the actual or expected price, level, performance or value of such underlying interests, but shall not mean or include spot transactions effected within customary settlement periods, when-issued purchases or other similar cash market transactions.

(K) "Future" means an agreement, traded on a futures exchange, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests.

(L) "Futures exchange" means a foreign or domestic exchange, contract market or board of trade on which trading in futures is conducted and, in the United States, which has been authorized for such trading by the Commodities Futures Trading Commission or any successor thereof.

(M) "Hedging transaction" means a derivative transaction which is entered into and maintained to manage:

(i) the risk of a change in the value, yield, price, cash flow or quantity of assets or liabilities (or a portfolio of assets and/or

liabilities) which the insurer has acquired or incurred or anticipates acquiring or incurring; or

(ii) the currency exchange rate risk related to assets or liabilities (or a portfolio of assets and/or liabilities) which an insurer has acquired or incurred or anticipates acquiring or incurring.

(N) "Income generation transaction" means a derivative transaction which is entered into to generate income. A derivative transaction which is entered into as a hedging transaction or a replication transaction shall not be considered an income generation transaction.

(O) "Market value" means the price for the security or derivative instrument obtained from a generally recognized source or the most recent quotation from such a source or, to the extent no generally recognized source exists, the price for the security or derivative instrument as determined pursuant to the terms of the instrument or in good faith by the insurer as can be reasonably demonstrated to the Commissioner upon request, plus accrued but unpaid income thereon to the extent not included in the price as of the date.

(P) "Option" means an agreement giving the buyer the right to buy or receive (a "call option"), sell or deliver (a "put option"), enter into, extend or terminate or effect a cash settlement based on the actual or expected price, spread, level, performance or value of one or more underlying interests.

(Q) "Over-the-counter derivative instrument" means a derivative instrument entered into with a business entity, other than through a securities exchange, futures exchange, or cleared through a qualified clearinghouse.

(R) "Potential exposure" means:

(i) as to a futures position, the amount of initial margin required for that position; or

(ii) as to swaps, collars and forwards, one-half percent times the notional amount times the square root of the remaining years to maturity.

(S) "Qualified clearinghouse" means a clearinghouse subject to the rules of a securities exchange or a futures exchange, which provides clearing services, including acting as a counterparty to each of the parties to a transaction such that the parties no longer have credit risk to each other.

(T) "Replication transaction" means a derivative transaction or combination of derivative transactions effected either separately or in conjunction with cash market investments included in the insurer's investment portfolio in order to replicate the risks and returns of another authorized transaction, investment or instrument and/or operate as a substitute for cash market transactions. A derivative transaction entered into by the insurer as a hedging transaction shall not be considered a replication transaction.

(U) "Securities exchange" means:

(i) an exchange registered as a national securities exchange or a securities market registered under the Securities Exchange Act of 1934 (15 U.S.C. Section 78 et seq.), as amended;

(ii) Private Offerings Resales and Trading through Automated Linkages (PORTAL); or

(iii) a designated offshore securities market as defined in Securities Exchange Commission Regulation S, 17 C.F.R. Part 230, as amended.

(V) "Swap" means an agreement to exchange or to net payments at one or more times based on the actual or expected price, yield, level, performance or value of one or more underlying interests.

(W) "Swaption" means an option to purchase or sell a swap at a given price and time or at a series of prices and times. A swaption does not mean a swap with an embedded option.

(X) "Underlying interest" means the assets, liabilities or other interests, or a combination thereof, underlying a derivative instrument, such as any one or more securities, currencies, rates, indices, commodities or derivatives instruments.

(Y) "Warrant" means an instrument that gives the holder the right to purchase or sell the underlying interest at a given price and time or at a series of prices and times outlined in the warrant agreement.

Revisor's Note

(1) Section 4(u)(1)(A), V.T.I.C. Article 3.33, in part defines "acceptable collateral" as "cash, cash equivalents, letters or credit and direct obligations." From the context, it is clear that "letters or credit" is a typographical error, and that the statute was intended to say "letters of credit." The revised law is drafted accordingly.

(2) Section 4(u)(1)(U)(i), V.T.I.C. Article 3.33, refers to the Securities Exchange Act of 1934 (15 U.S.C. Section 78 et seq.), as amended. The revised law corrects the citation for that act to reflect that the act begins at 15 U.S.C. Section 78a.

(3) Section 4(u)(1)(U)(iii), V.T.I.C. Article 3.33, refers to a designated offshore securities market as defined in "Securities Exchange Commission Regulation S, 17 C.F.R. Part 230, as amended." For the reader's convenience, the revised law substitutes for the quoted language a more specific reference to 17 C.F.R. Section 230.902, which contains the definition of "designated offshore securities market."

Revised Law

Sec. 425.126. RISK CONTROL TRANSACTIONS: DERIVATIVE USE PLAN. (a) Before an insurance company enters into a derivative transaction, the company's board of directors must approve a derivative use plan as part of the investment plan required by Section 425.105.

(b) The derivative use plan must:

(1) describe investment objectives and risk constraints, such as counterparty exposure amounts;

(2) define permissible transactions identifying the risks to be hedged or the assets or liabilities being replicated; and

(3) require compliance with internal control procedures. (V.T.I.C. Art. 3.33, Sec. 4(u)(2).)

Source Law

(2) Prior to entering into any derivative transaction, the board of directors of the insurer shall approve a derivative use plan, as part of the investment plan required in Section 3 of this article, that:

(A) describes investment objectives and risk constraints, such as counterparty exposure amounts;

(B) defines permissible transactions identifying the risks to be hedged, the assets or liabilities being replicated; and

(C) requires compliance with internal control procedures.

Revised Law

Sec. 425.127. RISK CONTROL TRANSACTIONS: INTERNAL CONTROL PROCEDURES. An insurance company that enters into a derivative transaction shall establish written internal control procedures that provide for:

(1) a quarterly report to the board of directors that reviews:

(A) each derivative transaction entered into, outstanding, or closed out;

(B) the results and effectiveness of the derivatives program; and

(C) the credit risk exposure to each counterparty

for over-the-counter derivative transactions based on the counterparty exposure amount;

(2) a system for determining whether hedging or replication strategies used have been effective;

(3) a system of regular reports, at least monthly, to management that include:

(A) a description of each derivative transaction entered into, outstanding, or closed out during the period since the last report;

(B) the purpose of each outstanding derivative transaction;

(C) a performance review of the derivative instrument program; and

(D) the counterparty exposure amount for each over-the-counter derivative transaction;

(4) a written authorization that identifies the responsibilities and limitations of authority of each person authorized to effect and maintain derivative transactions; and

(5) appropriate documentation for each transaction, including:

(A) the purpose of the transaction;

(B) the assets or liabilities to which the transaction relates;

(C) the specific derivative instrument used in the transaction;

(D) for an over-the-counter derivative transaction, the name of the counterparty and the counterparty exposure amount; and

(E) for an exchange-traded derivative instrument, the name of the exchange and the name of the firm that handled the transaction. (V.T.I.C. Art. 3.33, Sec. 4(u)(3).)

Source Law

(3) The insurer shall establish written internal control procedures that provide for:

(A) a quarterly report to the board

of directors that reviews:

(i) all derivative transactions entered into, outstanding or closed out;

(ii) the results and effectiveness of the derivatives program; and

(iii) the credit risk exposure to each counterparty for over-the-counter derivative transactions based upon the counterparty exposure amount;

(B) a system for determining whether hedging or replication strategies utilized have been effective;

(C) a system of regular reports (not less frequently than monthly) to management including:

(i) a description of all the derivative transactions entered into, outstanding or closed out during the period since the last report;

(ii) the purpose of each outstanding derivative transaction;

(iii) a performance review of the derivative instrument program; and

(iv) the counterparty exposure amount for over-the-counter derivative transactions;

(D) written authorizations that identify the responsibilities and limitations of authority of persons authorized to effect and maintain derivative transactions;

(E) documentation appropriate for each transaction including:

(i) the purpose of the transaction;

(ii) the assets or liabilities to which the transaction relates;

(iii) the specific derivative instrument used in the transaction;

(iv) for over-the-counter derivative instrument transactions, the name of the counterparty and the counterparty exposure amount; and

(v) for exchange-traded derivative instruments, the name of the exchange and the name of the firm that handled the transaction.

Revisor's Note

Section 4(u)(3)(E)(iv), V.T.I.C. Article 3.33, refers to "over-the-counter derivative instrument transactions." For consistent use of the terminology, the revised law substitutes "over-the-counter derivative transaction" for "over-the-counter derivative instrument transactions."

Revised Law

Sec. 425.128. RISK CONTROL TRANSACTIONS: OVERSIGHT BY COMMISSIONER. (a) An insurance company must be able to demonstrate to the commissioner on request the intended hedging characteristics and continuing effectiveness of a derivative transaction or combination of transactions through:

(1) cash flow testing;

(2) duration analysis; or

(3) other appropriate analysis.

(b) Ten days before entering into an initial hedging transaction, an insurance company shall notify the commissioner in writing that:

(1) the company's board of directors has adopted an investment plan that authorizes hedging transactions; and

(2) each hedging transaction will comply with Sections 425.124-425.132.

(c) After providing the notice under Subsection (b), the insurance company may enter into a hedging transaction under Section 425.124 if as a result of and after making the transaction:

(1) the aggregate statement value of all outstanding options other than collars, and of all caps, floors, swaptions, and warrants under Sections 425.124-425.132 not attached to another financial instrument purchased by the company does not exceed 7.5 percent of the company's assets;

(2) the aggregate statement value of all outstanding options other than collars, and of all caps, floors, swaptions, and warrants written by the company under Sections 425.124-425.132 does not exceed three percent of the company's assets; and

(3) the aggregate potential exposure of all outstanding collars, swaps, forwards, and futures entered into or acquired by the company under Sections 425.124-425.132 does not exceed 6.5 percent of the company's assets.

(d) If the hedging transaction does not comply with Sections 425.124-425.132, or if continuing the transaction may create a hazardous financial condition for the insurance company that affects the company's policyholders or creditors or the public, the commissioner may, after notice and an opportunity for a hearing, order the company to take action reasonably necessary to:

(1) remedy a hazardous financial condition; or

(2) prevent an impending hazardous financial

condition from occurring. (V.T.I.C. Art. 3.33, Secs. 4(u)(4), 4(u)(6)(a) (part), (b).)

Source Law

(4) An insurer shall be able to demonstrate to the commissioner, upon request, the intended hedging characteristics and ongoing effectiveness of the derivative transaction or combination of transactions through cash flow testing, duration analysis or other appropriate analysis.

(6)(a) Ten days prior to entering into the initial hedging transaction, the insurer shall notify the commissioner in writing that: (i) the insurer's board of directors has adopted an investment plan which authorizes hedging transactions, and (ii) all hedging transactions will comply with this Subsection (u). . . . Thereafter, an insurer may enter into hedging transactions under this subsection, if as a result of and after giving effect to each such transaction:

(A) the aggregate statement value of all outstanding options (other than collars), caps, floors, swaptions and warrants (not attached to another financial instrument purchased by the insurer) pursuant to this subsection does not exceed 7.5 percent of its assets;

(B) the aggregate statement value of all outstanding options (other than collars), swaptions, warrants, caps and floors written by the insurer pursuant to this subsection does not exceed three percent of its assets; and

(C) the aggregate potential exposure of all outstanding collars, swaps, forwards and futures entered into or acquired by the insurer pursuant to this subsection does not exceed 6.5 percent of its assets.

(b) Whenever the derivative transactions entered into under this Subsection (u)(6), are not in compliance with this Subsection (u) or, if continued, may now or subsequently, create a hazardous financial condition to the insurer which affects its policyholders, creditors or the general public, the commissioner may, after notice and an opportunity for a hearing, order the insurer to take such action as may be reasonably necessary to (i) rectify a hazardous financial condition, or (ii) to prevent an impending hazardous financial condition from occurring.

Revisor's Note

(1) Section 4(u)(6)(a), V.T.I.C. Article 3.33, requires insurance companies that are "already" entering into hedging transactions to notify the commissioner of insurance "within 30 days of the effective date of this Subsection (u)." Subsection (u) was added to Section 4, V.T.I.C. Article 3.33, by Chapter 556, Acts of the 75th Legislature, Regular

Session, 1997, and took effect September 1, 1997. The revised law omits the requirement for companies "already" engaged in hedging transactions as executed. The omitted law reads:

> (a) . . . Insurers already engaged in hedging transactions shall notify the commissioner as set forth in the preceding sentence within 30 days of the effective date of this Subsection (u). . . .

(2) Section 4(u)(6)(b), V.T.I.C. Article 3.33, refers to hedging transactions that "may now or subsequently, create a hazardous financial condition." The revised law omits "now or subsequently" as unnecessary. A reference to a hedging transaction that "may create" a hazardous financial condition is not limited to a hazardous financial condition at the present time.

Revised Law

Sec. 425.129. RISK CONTROL TRANSACTIONS: LIMITATIONS ON INCOME GENERATION TRANSACTIONS. An insurance company may enter into an income generation transaction only if:

(1) as a result of and after making the transaction, the sum of the following amounts does not exceed 10 percent of the company's assets:

(A) the aggregate statement value of admitted assets that at the time of the transaction are subject to call or that generate the cash flows for payments the company is required to make under caps and floors sold by the company and that at the time of the transaction are outstanding under Sections 425.124-425.132;

(B) the statement value of admitted assets underlying derivative instruments that at the time of the transaction are subject to calls sold by the company and outstanding under those sections; and

(C) the purchase price of assets subject to puts that at the time of the transaction are outstanding under those sections; and

(2) the transaction is one of the following types, is covered in the manner specified by this subdivision, and meets the other requirements of this subdivision:

(A) a sale of a call option on assets, if during the entire period the option is outstanding, the company holds, or has a currently exercisable right to acquire, the underlying assets;

(B) a sale of a put option on assets, if:

(i) during the entire period the option is outstanding, the company holds sufficient cash, cash equivalents, or interests in a short-term investment pool to purchase the underlying assets on exercise of the option;

(ii) the company has the ability to hold the underlying assets in the company's portfolio; and

(iii) during the entire period the option is outstanding, when the total market value of all put options sold by the company exceeds two percent of the company's assets, the company sets aside, under a custodial or escrow agreement, cash or cash equivalents that have a market value equal to the amount of the company's put option obligations in excess of two percent of the company's assets;

(C) a sale of a call option on a derivative instrument, including a swaption, if:

(i) during the entire period the call option is outstanding, the company holds, or has a currently exercisable right to acquire, assets generating the cash flow to make any payment for which the company is liable under the underlying derivative instrument; and

(ii) the company has the ability to enter into the underlying derivative transaction for the company's portfolio; and

(D) a sale of a cap or floor, if during the entire period the cap or floor is outstanding, the company holds, or has a currently exercisable right to acquire, assets generating the cash

flow to make any payment for which the company is liable under the cap or floor. (V.T.I.C. Art. 3.33, Sec. 4(u)(7).)

Source Law

(7) An insurer may only enter into an income generation transaction if:

(A) as a result of and after giving effect to the transaction, the aggregate statement value of admitted assets that are then subject to call or that generate the cash flows for payments required to be made by the insurer under caps and floors sold by the insurer and then outstanding under this subsection, plus the statement value of admitted assets underlying derivative instruments then subject to calls sold by the insurer and outstanding under this subsection, plus the purchase price of assets subject to puts then outstanding under this subsection does not exceed 10 percent of its assets; and

(B) the transaction is one of the following types, is covered in the manner specified below and meets the other requirements specified below:

(i) sales of call options on assets, provided that the insurer holds or has a currently exercisable right to acquire the underlying assets during the entire period that the option is outstanding;

(ii) sales of put options on assets, provided that the insurer holds sufficient cash, cash equivalents or interests in a short-term investment pool to purchase the underlying assets upon exercise during the entire period that the option is outstanding, and has the ability to hold the underlying assets in its portfolio. If the total market value of all put options sold by the insurer exceeds two percent of the insurer's assets, the insurer shall set aside pursuant to a custodial or escrow agreement cash or cash equivalents having a market value equal to the amount of its put option obligations in excess of two percent of the insurer's assets during the entire period the option is outstanding;

(iii) sales of call options on derivative instruments (including swaptions), provided that the insurer holds or has a currently exercisable right to acquire assets generating the cash flow to make any payments for which the insurer is liable pursuant to the underlying derivative instruments during the entire period that the call options are outstanding and has the ability to enter into the underlying derivative transactions for its portfolio; and

(iv) sales of caps and floors, provided that the insurer holds or has a currently exercisable right to acquire assets generating the cash flow to make any payments for which the insurer is liable pursuant to the caps and floors during the entire period that the caps and floors are outstanding.

Revised Law

Sec. 425.130. RISK CONTROL TRANSACTIONS: LIMITATIONS ON REPLICATION TRANSACTIONS. (a) An insurance company may enter into

a replication transaction only with the prior written approval of the commissioner, and only if:

(1) the company would otherwise be authorized to invest the company's funds under this subchapter in the asset being replicated; and

(2) the asset being replicated is subject to all the provisions of this subchapter relating to the making of investments by the company in that type of asset as if the transaction constituted a direct investment by the company in the replicated asset.

(b) The commissioner may adopt fair and reasonable rules regarding replication transactions to implement this section. (V.T.I.C. Art. 3.33, Sec. 4(u)(8).)

Source Law

(8)(a) An insurer may enter into replication transactions only with prior written approval from the Commissioner, provided that:

(A) the insurer would otherwise be authorized to invest its funds under this article in the asset being replicated; and

(B) the asset being replicated is subject to all the provisions and limitations on the making thereof specified in this article with respect to investments by the insurer as if the transaction constituted a direct investment by the insurer in the replicated asset.

(b) The commissioner may adopt such rules and regulations regarding replication transactions as may be fair and reasonable to implement this Subsection (u)(8).

Revisor's Note

Section 4(u)(8)(a)(B), V.T.I.C. Article 3.33, refers to "provisions and limitations" of that article. The revised law omits the reference to "limitations" because the meaning of that term is included in the meaning of "provisions."

Revised Law

Sec. 425.131. RISK CONTROL TRANSACTIONS: TRADING REQUIREMENTS. For purposes of Sections 425.124-425.132, each derivative instrument must be:

(1) traded on a securities exchange;

(2) entered into with, or guaranteed by, a business entity;

(3) issued or written by, or entered into with, the issuer of the underlying interest on which the derivative instrument is based; or

(4) in the case of futures, traded through a broker that is:

(A) registered as a futures commission merchant under the Commodity Exchange Act (7 U.S.C. Section 1 et seq.); or

(B) exempt from that registration under 17 C.F.R. Section 30.10, adopted under the Commodity Exchange Act. (V.T.I.C. Art. 3.33, Sec. 4(u)(10).)

Source Law

(10) Each derivative instrument shall be:

(A) traded on a securities exchange;

(B) entered into with, or guaranteed by, a business entity;

(C) issued or written by or entered into with the issuer of the underlying interest on which the derivative instrument is based; or

(D) in the case of futures, traded through a broker which is registered as a futures commission merchant under the Commodity Exchange Act or which has received exemptive relief from such registration under Rule 30.10 promulgated under the Commodity Exchange Act.

Revised Law

Sec. 425.132. RISK CONTROL TRANSACTIONS: OFFSETTING TRANSACTIONS. (a) Subject to this section, an insurance company may purchase or sell one or more derivative instruments to wholly or partly offset a derivative instrument previously purchased or sold, without regard to the quantitative limitations of Sections 425.124-425.131.

(b) An offsetting transaction under this section must use the same type of derivative instrument as the derivative instrument being offset. (V.T.I.C. Art. 3.33, Sec. 4(u)(9).)

Source Law

(9) An insurer may purchase or sell one or more derivative instruments to offset, in whole or in part, any derivative instrument previously purchased or sold, as the case may be, without regard to the quantitative limitations of this subsection, provided

that such offsetting transaction utilizes the same type of derivative instrument as the derivative instrument being offset.

[Sections 425.133-425.150 reserved for expansion]

Revised Law

Sec. 425.151. AUTHORIZED INVESTMENTS: FOREIGN COUNTRIES AND UNITED STATES TERRITORIES. (a) In addition to the investments within Canada authorized by this subchapter and subject to this section, an insurance company may make investments within another foreign country or a commonwealth, territory, or possession of the United States.

(b) An investment made under this section must be substantially the same type as an investment authorized to be made within the United States or Canada by this subchapter.

(c) The sum of the amount of investments made under this section and the amount of similar investments made within the United States and Canada may not exceed any limitation imposed by Sections 425.109-425.121, 425.124-425.132, and 425.152.

(d) The aggregate amount of an insurance company's investments under this section may not exceed the sum of:

(1) the amount of the company's reserves attributable to insurance business in force in foreign countries, if any, and any additional investments required by a foreign country as a condition of engaging in business in that country; and

(2) 20 percent of the company's assets.

(e) An insurance company may not invest more than 10 percent of the company's assets in investments denominated in foreign currency that are not hedged under Sections 425.124-425.132. (V.T.I.C. Art. 3.33, Sec. 4(n).)

Source Law

[Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]

(n) Foreign Countries and United States Territories. In addition to the investments in Canada authorized in other subsections of this section, investments in other foreign countries or in commonwealths, territories, or possessions of the United States; provided:

(1) such investments are substantially the same types as those authorized for investment within the United States of America or Canada by other provisions of this section; and

(2) such investments when added to the amount of similar investments made within the United States and Canada do not result in the combined total of such investments exceeding the limitations specified in Subsections (a) through (m), (o), (q) and (u) of this section; and

(3) such investments may not exceed the sum of:

(A) the amount of insurer's reserves attributable to the insurance business in force in foreign countries, if any, and any additional investments required by any foreign country as a condition to doing business therein; and

(B) 20 percent of the insurer's assets of which no more than 10 percent of the insurer's assets may be investments denominated in foreign currency that are not hedged pursuant to the provisions of Subsection (u);

Revised Law

Sec. 425.152. AUTHORIZED INVESTMENTS: INVESTMENTS NOT OTHERWISE SPECIFIED OR PROHIBITED; INVESTMENTS AUTHORIZED BY OTHER LAW. (a) Subject to this section, an insurance company may make an investment that is not otherwise authorized by this subchapter and that is not specifically prohibited by statute, including any portion of an investment that exceeds the limits imposed by Sections 425.109-425.121, 425.124-425.132, and 425.151.

(b) If any aggregate or individual investment limitation imposed by Sections 425.109-425.121, 425.124-425.132, and 425.151 is exceeded, the excess portion of the investment is considered to be an investment under Subsection (a).

(c) The insurance company has the burden of establishing the value of an investment made under Subsection (a).

(d) The amount of a single investment made by an insurance company under Subsection (a) may not exceed 10 percent of the company's capital and surplus in excess of the statutory minimum capital and surplus applicable to that company.

(e) The aggregate amount of an insurance company's investments under Subsection (a) may not exceed the lesser of:

(1) five percent of the company's assets; or

(2) the amount of the company's capital and surplus that exceeds the amount of statutory minimum capital and surplus

applicable to that company.

(f) An insurance company may invest in any investment authorized for an insurance company that is subject to this subchapter by a provision of this code other than this subchapter or by another law of this state. (V.T.I.C. Art. 3.33, Secs. 4(o), (p) (part).)

Source Law

> [Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]
>
> (o) Investments Not Otherwise Specified. Investments which are not otherwise authorized by this article and which are not specifically prohibited by statute, including that portion of any investments which may exceed the limits specified in Subsections (a) through (n), (q) and (u) of this section; provided:
>
> (1) if any aggregate or individual specified investment limitation in Subsections (a) through (n), (q) and (u) of this section is exceeded, then the excess portion of such investment shall be an investment under this subsection; and
>
> (2) the burden of establishing the value of such investments shall be upon the insurer; and
>
> (3) the amount of any one such investment may not exceed 10 percent of the insurer's capital and surplus in excess of the statutory minimum capital and surplus applicable to that insurer; and
>
> (4) the aggregate of all investments made under this subsection may not exceed the lesser of either five percent of the insurer's assets or the insurer's capital and surplus in excess of the statutory minimum capital and surplus applicable to that insurer;
>
> (p) Other Authorized Investments. Those other investments as follows:
>
> . . .
>
> (2) any other investment which may be authorized by other provisions of this code or by other laws of this state for the insurers which are subject to this article.

Revised Law

Sec. 425.153. AUTHORIZED INVESTMENTS: CERTAIN PREVIOUSLY AUTHORIZED INVESTMENTS. (a) An insurance company may continue to hold an investment held by the company on January 1, 1986, that does not conform to the requirements of the investments authorized by Sections 425.109-425.120, 425.151, and 425.152 if the investment was legally authorized at the time the investment was made or acquired or that the company was authorized to hold immediately before January 1, 1986.

(b) An investment described by Subsection (a) is considered an authorized investment of the insurance company. A company shall dispose of the investment at the investment's maturity date, if any, or within the time prescribed by the law under which the investment was acquired, if any.

(c) This section does not alter the legal or accounting status of an investment described by Subsection (a). (V.T.I.C. Art. 3.33, Sec. 4(p) (part).)

Source Law

> [Sec. 4. . . . the investments and transactions described in the following subsections . . . are authorized for the insurers subject hereto:]
>
> [(p) Other Authorized Investments. Those other investments as follows:]
>
> (1) any investment held by an insurer on the effective date of this Act, which was legally authorized at the time it was made or acquired or which the insurer was authorized to hold or possess immediately prior to such effective date, but which does not conform to the requirements of the investments authorized in Subsections (a) through (o) of this section, may continue to be held by and considered as an authorized asset or transaction of the insurer; provided the investment or transaction is disposed of at its maturity date, if any, or within the time prescribed by the law under which it was acquired, if any; and provided further, in no event shall the provisions of this subdivision alter the legal or accounting status of such asset; and
>
> . . .

Revisor's Note

(1) Section 4(p)(1), V.T.I.C. Article 3.33, refers to investments "held by an insurer on the effective date of this Act." Section 4(p) was enacted as part of the original enactment of Article 3.33 by Chapter 36, Acts of the 69th Legislature, Regular Session, 1985. The effective date of that act was January 1, 1986. Accordingly, the revised law substitutes "January 1, 1986," for "the effective date of this Act."

(2) Section 4(p)(1), V.T.I.C. Article 3.33, refers to an insurance company's authorization to "hold or possess" certain investments. The revised

law omits the reference to "possess" as unnecessary because the meaning of that term is included in the meaning of "hold."

Revised Law

Sec. 425.154. APPLICABILITY OF PERCENTAGE AUTHORIZATIONS AND LIMITATIONS. The percentage authorizations and limitations established by this subchapter apply only at the time an investment is originally acquired or a transaction is entered into and do not apply to the insurance company or the investment or transaction after that time, except as provided by Section 425.155. (V.T.I.C. Art. 3.33, Sec. 4(t) (part).)

Source Law

> (t) The percentage authorizations and limitations set forth in any or all of the provisions of this Article 3.33 shall apply only at the time of the original acquisition of an investment or at the time a transaction is entered into and shall not be applicable to the insurer or such investment or transaction thereafter except as provided in Subsection (w) of this section. . . .

Revised Law

Sec. 425.155. QUALIFICATION OF INVESTMENTS. (a) The qualification or disqualification of an investment under one section of this subchapter does not prevent the investment from qualifying, wholly or partly, under another section of this subchapter. An investment authorized by more than one section may be held under the authorizing section elected by the insurance company.

(b) An investment or transaction qualified under any section of this subchapter at the time the insurance company acquired the investment or entered into the transaction continues to be qualified under that section.

(c) An insurance company may elect to transfer at any time the qualification of an investment, wholly or partly, to the authority of any section of this subchapter under which the investment qualifies at the time of the transfer, regardless of whether the investment originally qualified under that section.

(d) An investment, once qualified under this subchapter, remains qualified notwithstanding any refinancing, restructuring, or modification of the investment, except that an insurance company may not refinance, restructure, or modify an investment to circumvent the requirements of this subchapter. (V.T.I.C. Art. 3.33, Secs. 4(t) (part), (w).)

Source Law

> (t) . . . In addition, any investment, once qualified under any subsection of this section, shall remain qualified notwithstanding any refinancing, restructuring or modification of such investment provided that, the insurer shall not engage in any such refinancing, restructuring or modification of any investment for the purpose of circumventing the requirements or limitations of this article.
>
> (w) Qualification of Investments. The qualification or disqualification of an investment under one subsection of this section does not prevent its qualification in whole or in part under another subsection, and an investment authorized by more than one subsection may be held under whichever authorizing subsection the insurer elects. An investment or transaction qualified under any subsection at the time it was acquired or entered into by the insurer shall continue to be qualified under that subsection. An investment, in whole or in part, may be transferred from time to time, at the election of the insurer, to the authority of any subsection under which it then qualifies, whether or not it originally qualified thereunder.

Revisor's Note

Section 4(t), V.T.I.C. Article 3.33, refers to the "requirements or limitations" of that article. The revised law omits the reference to "limitations" because, in context, the meaning of that term is included within the meaning of "requirements."

Revised Law

Sec. 425.156. DISTRIBUTIONS, REINSURANCE, AND MERGER. (a) This subchapter does not prohibit an insurance company from acquiring additional obligations, securities, or other assets received as a dividend or as a distribution of assets.

(b) This subchapter does not apply to securities, obligations, or other assets accepted incident to the workout, adjustment, restructuring, or similar realization of any kind of

previously authorized investment or transaction if the insurance company's board of directors or a committee appointed by the board of directors determines that acceptance of the securities, obligations, or other assets is in the company's best interests.

(c) This subchapter does not apply to assets acquired under a lawful agreement of bulk reinsurance, merger, or consolidation if the assets were legal and authorized investments for the ceding, merged, or consolidated insurance company.

(d) An obligation, security, or other asset acquired as permitted by this section is not required to be qualified under any other section of this subchapter. (V.T.I.C. Art. 3.33, Sec. 4(v).)

Source Law

> (v) Distributions, Reinsurance, and Merger. No provision of this article prohibits the acquisition by an insurer of additional obligations, securities, or other assets if received as a dividend or as a distribution of assets, nor does this article apply to securities, obligations, or other assets accepted incident to the workout, adjustment, restructuring or similar realization of any kind of investment or transaction when deemed by the insurer's board of directors or by a committee appointed by the board of directors to be in the best interests of the insurer, if the investment or transaction had previously been authorized, nor does this article apply to assets acquired pursuant to a lawful agreement of bulk reinsurance, merger, or consolidation if such assets constituted legal and authorized investments for the ceding, merged or consolidated company. No obligation, security or other asset acquired as permitted by this subsection need be qualified under any other subsection of this article.

Revised Law

Sec. 425.157. AGGREGATE DIVERSIFICATION REQUIREMENTS. (a) This section takes precedence over Sections 425.109-425.120, 425.122-425.153, and 425.155(a), (b), and (c).

(b) An insurance company's investments in all or any types of securities, loans, obligations, or evidences of indebtedness of a single issuer or borrower, including the issuer's or borrower's majority-owned subsidiaries or parent and the majority-owned subsidiaries of the issuer's or borrower's parent, may not, in the aggregate, exceed five percent of the company's assets. This subsection does not apply to:

(1) authorized investments that:

(A) are direct obligations of, or are guaranteed by the full faith and credit of, the United States, this state, or a political subdivision of this state; or

(B) are insured by an agency of the United States or this state; or

(2) an investment provided for by Section 425.112 or 425.113.

(c) Except as otherwise provided by this subsection, an insurance company's aggregate investment in real property under Sections 425.119, 425.120, 425.152, and 425.153 may not exceed 33-1/3 percent of the company's assets. If a company acquires real property under Section 425.119(g) and that acquisition causes the company's aggregate real estate investment to exceed the limitation imposed by this subsection, the company shall, on or before the 10th anniversary of the date the real property is acquired, dispose of a sufficient amount of real property to comply with the applicable limitation. A company that does not dispose of excess real property as required by this subsection may not admit as an asset the value of the real property that exceeds the applicable limitation.

(d) If an insurance company's real property acquisitions exceed the limitation imposed by Subsection (c), the company may not acquire additional real property under Section 425.119(b) or (c) or 425.120, 425.152, or 425.153 until the company disposes of the excess real property as specified by Subsection (c). (V.T.I.C. Art. 3.33, Sec. 5.)

Source Law

Sec. 5. The following provisions govern and take precedence over each and every provision of Section 4, except Subsections (q), (t) and (v):

(a) Investment in all or any types of securities, loans, obligations, or evidences of indebtedness of a single issuer or borrower (which shall include such issuer's or borrower's majority-owned subsidiaries or parent or the majority-owned subsidiaries of such parent), other than those authorized investments that are either direct obligations of or guaranteed by the full faith and credit of the United States of America, the State of Texas, or a political subdivision thereof or are

insured by an agency of the United States of America or the State of Texas shall not in the aggregate exceed five percent of the insurer's assets except for those investments provided for in Subsections (e) and (f) of Section 4 of this article; and

(b) The aggregate investment in real property authorized by Subsections (l), (m), (o), and (p) of Section 4 may not exceed 33-1/3 percent of the insurer's assets; provided, in the event an insurer acquires real property under Subdivision (4) of Subsection (l) of Section 4 and such acquisition causes such aggregate real estate to exceed the limitation set forth herein, the insurer shall either dispose of sufficient excess real property to come within such limitations within 10 years of such acquisition or it may not thereafter admit as an asset the value of the real property in excess of such limitation; should an insurer's real property acquisitions exceed such 33-1/3 percent limitation, no additional real property acquisitions under Subdivisions (1) and (2) of Subsection (l), and Subsections (m), (o), and (p) of Section 4 of this article are authorized until such excess is removed.

Revised Law

Sec. 425.158. WAIVER BY COMMISSIONER OF QUANTITATIVE LIMITATIONS. (a) The commissioner may waive a quantitative limitation on any investment authorized by Sections 425.109-425.132 and 425.151-425.156 if:

(1) the insurer seeks the waiver before making the investment;

(2) a hearing is held to determine whether the waiver should be granted;

(3) the applicant seeking the waiver establishes that unreasonable or unnecessary loss or harm will result to the company if the commissioner denies the waiver;

(4) the excess investment will not have a material adverse effect on the company; and

(5) the size of the investment is reasonable in relation to the company's assets, capital, surplus, and liabilities.

(b) The commissioner's waiver must be in writing and may treat the resulting excess investment as a nonadmitted asset. (V.T.I.C. Art. 3.33, Sec. 6.)

Source Law

Sec. 6. The quantitative limitations respecting any investment authorized in Section 4 may be waived by

prior written approval of the commissioner; provided:

(a) A hearing is held to determine whether approval should be granted;

(b) The applicant seeking prior approval establishes that unreasonable or unnecessary loss or harm to the insurer will result if approval is withheld;

(c) The excessive investment will not have a material adverse effect upon the insurer;

(d) The size of the investment is reasonable in relation to the insurer's assets, capital, surplus, and liabilities; and

(e) The commissioner's prior authorization may treat the resulting excess investment as an asset not admitted.

Revisor's Note

Section 6, V.T.I.C. Article 3.33, states that the commissioner of insurance may waive the quantitative limitations for certain investments under that article by prior written approval if certain listed conditions are met, including a condition that "[t]he commissioner's prior authorization may treat the resulting excess investment as an asset not admitted." It is clear from the context that the quoted language is not a condition for granting prior written approval, but rather is a separate grant of authority to the commissioner that results from granting that approval. The revised law is drafted accordingly.

Revised Law

Sec. 425.159. ACCOUNTING PROVISIONS. (a) Each insurance company shall maintain reasonable, adequate, and accurate evidence of the company's ownership of the company's assets and investments.

(b) An insurance company shall evidence the company's ownership of governmental or corporate securities as provided by Sections 423.101, 423.102, 423.104(a), 423.105, 423.106, 423.107, and 423.108.

(c) An insurance company shall hold investments, other than investments made as a participation in a partnership or joint venture, only in the company's own name or as otherwise provided by Chapter 423. (V.T.I.C. Art. 3.33, Secs. 7(b), (c), (d).)

Source Law

(b) Each insurer shall maintain reasonable, adequate, and accurate evidence of its ownership of its assets and investments.

(c) The ownership of governmental or corporate securities shall be evidenced as provided for in Article 21.39-B, Section 4, of this code.

(d) Other than investments made as a participation in a partnership or joint venture, or as otherwise provided in Article 21.39-B of this code, investments shall be held solely in the name of the insurer.

Revisor's Note

Section 7(c), V.T.I.C. Article 3.33, provides that an insurance company's ownership of governmental or corporate securities must "be evidenced as provided for in Article 21.39-B, Section 4, of this code." V.T.I.C. Article 21.39-B was enacted by Chapter 198, Acts of the 64th Legislature, Regular Session, 1975, and originally consisted of only Sections 1-3. Section 4, providing the manner in which a domestic insurance company must evidence the company's ownership of securities, was added by Chapter 267, Acts of the 68th Legislature, Regular Session, 1983. Amendments to Article 21.39-B by Chapter 1436, Acts of the 76th Legislature, Regular Session, 1999, added a new Section 2 and renumbered the subsequent sections, so that Section 4 became Section 5, revised in this code as Sections 423.101, 423.102, 423.104(a), 423.105, 423.106, 423.107, and 423.108. The revised law is drafted accordingly.

Revised Law

Sec. 425.160. INVESTMENTS OF CEDING INSURERS. (a) Subject to this section, if a domestic insurance company assumes and reinsures the business of and takes over the assets of another domestic insurance company or a foreign company, all assets or investments of the ceding company that were authorized as proper assets or investments for the funds of that company and taken over by the assuming company are considered valid assets or investments

of the assuming company under the laws of this state.

(b) The commissioner must approve assets or investments described by Subsection (a) and the terms on which those assets or investments are taken over. The commissioner may require the assuming insurance company to reasonably dispose of any of those assets or investments that do not otherwise meet the requirements of this subchapter within a period that will minimize any financial loss or other hardship caused by disposing of the asset or investment. (V.T.I.C. Art. 3.33, Sec. 8.)

Source Law

> Sec. 8. In any case in which a domestic insurance company shall assume and reinsure the business and take over the assets of another insurance company, either domestic or foreign, all assets or investments of such reinsured company that were authorized as proper assets or investments for the funds of such reinsured company, and which are taken over by such domestic company, shall be considered as valid assets or investments of such reinsuring domestic company under the laws of this state; provided such assets or investments are approved by the Commissioner of Insurance of this state, and the same are taken over on terms satisfactory to said commissioner, and upon the condition that the commissioner shall have the power to require the reinsuring domestic company to reasonably dispose of any of such assets or investments as do not otherwise meet the requirements of this article within such time schedule as will minimize any financial loss or other hardship by the disposition of such asset or investment.

Revisor's Note

> Section 8, V.T.I.C. Article 3.33, refers to a "reinsured insurer" and a "reinsuring insurer." For consistent use of terminology in this code, throughout this chapter, the revised law substitutes "ceding company" for "reinsured insurer" and "assuming company" for "reinsuring insurer."

Revised Law

Sec. 425.161. ACTING AS REAL ESTATE BROKER OR SALESPERSON PROHIBITED. A domestic insurance company or another insurance company specifically made subject to this subchapter may not engage in the business of a broker or salesperson as defined by Chapter 1101, Occupations Code, except that the company may hold, improve,

maintain, manage, rent, lease, sell, exchange, or convey any of the real property interests owned as investments under Sections 425.109-425.132 and 425.151-425.153. (V.T.I.C. Art. 3.33, Sec. 10.)

Source Law

> Sec. 10. Domestic companies as defined in Section 5 of Article 3.01 of this code and other insurers specifically made subject to the provisions of this article shall not engage in the business of a real estate broker or a real estate salesman as defined by The Real Estate License Act, as amended (Article 6573a, Vernon's Texas Civil Statutes), except that such insurers may hold, improve, maintain, manage, rent, lease, sell, exchange, or convey any of the real property interests owned as investments under Section 4 of this article.

Revisor's Note

> Section 10, V.T.I.C. Article 3.33, refers to "a real estate broker or a real estate salesman as defined by The Real Estate License Act, as amended (Article 6573a, Vernon's Texas Civil Statutes)." That statute was codified in 2001 as Chapter 1101, Occupations Code. Section 1101.002, Occupations Code, defines the terms "broker" and "salesperson" rather than "real estate broker" and "real estate salesman." The revised law is drafted accordingly.

Revised Law

Sec. 425.162. RULES. The commissioner may adopt rules, minimum standards, or limitations that are fair and reasonable as appropriate to supplement and implement this subchapter. (V.T.I.C. Art. 3.33, Sec. 9.)

Source Law

> Sec. 9. The State Board of Insurance may adopt such rules, regulations, minimum standards, or limitations which are fair and reasonable as may be appropriate for the augmentation and implementation of this article.

[Sections 425.163-425.200 reserved for expansion]

SUBCHAPTER D. AUTHORIZED INVESTMENTS AND TRANSACTIONS FOR OTHER LIFE, HEALTH, AND ACCIDENT INSURERS

Revised Law

Sec. 425.201. DEFINITION. In this subchapter, "contingency funds" means an insurer's contingency funds over and above the amount of the insurer's policy reserves. (New.)

Revisor's Note

The revised law adds the definition of "contingency funds" for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 425.202. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to an insurer organized under Chapter 881, 884, 885, 886, 887, or 2551, except as specifically provided by those chapters. (V.T.I.C. Art. 3.33, Sec. 1 (part).)

Source Law

> Sec. 1. . . . [Articles 3.39, 3.40, and 3.40-1 of this code shall not be applicable to such companies, but] such articles shall continue to be applicable to insurance companies chartered under Chapters 9, 881, 884, 885, 886, and 887 of this code, except as otherwise specifically provided in those chapters. . . .

Revisor's Note

Section 1, V.T.I.C. Article 3.33, provides that V.T.I.C. Articles 3.39, 3.40, and 3.40-1 "continue to be applicable" to certain specified insurers. When the Insurance Code was originally enacted in 1951, Articles 3.39 and 3.40 governed the investments of life insurance companies and related insurers. Article 3.40-1 was enacted in 1967 by Chapter 660, Acts of the 60th Legislature, Regular Session, to provide additional investment authority for the insurers to which Articles 3.39 and 3.40 applied. Article 3.33, the substance of which is revised as Subchapter C of this chapter, was enacted in 1985 to regulate the

investments of many types of insurance companies, the investments of which were formerly regulated under Articles 3.39, 3.40, and 3.40-1. However, the referenced statement in Section 1, Article 3.33, clarifies that certain insurers, the investments of which were regulated under Articles 3.39, 3.40, and 3.40-1 before the enactment of Article 3.33, continue to be governed by Articles 3.39, 3.40, and 3.40-1 despite the enactment of Article 3.33. The revised law is drafted to preserve that statement of applicability.

Revised Law

Sec. 425.203. LIMITATION ON FUNDS AND OTHER ASSETS. (a) An insurer may not use the insurer's funds to make an investment or loan that is not authorized by this subchapter.

(b) An insurer may not secure, hold, or convey real property except as authorized by this subchapter. (V.T.I.C. Art. 3.39, Parts I (part), II (part); Art. 3.40 (part).)

Source Law

Art. 3.39

PART I. AUTHORIZED INVESTMENTS

A life insurance company organized under the laws of this state [may invest its several funds,] identified as follows, [in the following securities, respectively, and] none other:

. . .

PART II. AUTHORIZED LOANS

A life insurance company organized under the laws of this state [may loan its several funds] identified as follows, [taking as collateral security for the payment of such loans the securities named below, and] none other.

. . .

Art. 3.40. Every such insurance company may secure, hold and convey real property only for the following purposes and in the following manner:

. . .

Revisor's Note

V.T.I.C. Article 3.39 refers to a "life insurance company," and V.T.I.C. Article 3.40 refers to "such insurance company." However, Section 1, V.T.I.C. Article 3.33, which is revised in relevant part as

Section 425.202, provides that the law revised as this subchapter applies to a number of entities that are not "life insurance companies" as that term is defined by Section 841.001 of this code. Accordingly, throughout this subchapter, the revised law substitutes "insurer" for "life insurance company" or "insurance company."

Revised Law

Sec. 425.204. APPROVAL OF INVESTMENTS AND LOANS REQUIRED. (a) An insurer may not make an investment unless the investment has been authorized by the insurer's board of directors or by a committee responsible for supervising investments.

(b) An insurer may not make a loan other than a policy loan unless the loan has been authorized by the insurer's board of directors or by a committee responsible for supervising loans. (V.T.I.C. Art. 3.39, Part I, Sec. F, Para. 2; Part II, Sec. A, Para. 7.)

Source Law

[Part I]
[F]
2. Investments to Be Approved by Board of Directors. No investment shall be made by any such insurance company, unless the same shall first have been authorized by the Board of Directors or by a committee charged with the duty of supervising such investments.

[Part II]
[A]
7. Loans to Be Authorized by Board of Directors. No loan, except policy loans, shall be made by any such insurance company unless the same shall first have been authorized by the Board of Directors or by a committee charged with the duty of supervising such loans.

Revised Law

Sec. 425.205. AUTHORIZED INVESTMENTS FOR ALL FUNDS: GOVERNMENT BONDS. (a) Subject to this section, an insurer may invest any of the insurer's funds and accumulations in:

(1) a bond, treasury bill, note, or certificate of indebtedness of the United States or any other obligation or security fully guaranteed as to principal and interest by the full faith and credit of the United States;

(2) a bond of Canada or a province or municipality of Canada;

(3) a bond of a state, county, or municipality of the United States;

(4) a bond or interest-bearing warrant issued by a county, municipality, school district, or other subdivision that is:

(A) organized under the laws of a state of the United States; and

(B) authorized to issue the bond or warrant under the constitution and laws of that state;

(5) a bond or interest-bearing warrant issued by an educational institution that is:

(A) organized under the laws of a state of the United States; and

(B) authorized to issue the bond or warrant under the constitution and laws of that state;

(6) a bond or warrant, including a revenue or special obligation, of an educational institution located in a state of the United States;

(7) a bond or warrant payable from designated revenues of a municipality, county, drainage district, road district, or other civil administration, agency, authority, instrumentality, or subdivision that is:

(A) organized under the laws of a state of the United States; and

(B) authorized to issue the bond or warrant under the constitution and laws of that state;

(8) a paving certificate or other certificate or evidence of indebtedness issued by a municipality in a state of the United States and secured by a first lien on real estate; and

(9) a bond issued under the Farm Credit Act of 1971 (12 U.S.C. Section 2001 et seq.) that is issued against and secured by promissory notes or obligations, the payment of which is secured by

mortgage, deed of trust, or other valid lien on unencumbered real property located in this state.

(b) An insurer may invest in a bond or warrant described by Subsection (a)(4) or (5) only if the issuer of the bond or warrant has made legal provision to impose a tax to meet the obligation.

(c) An insurer may invest in a bond or warrant described by Subsection (a)(6) only if the special revenue or income to meet the principal and interest payments as they accrue on the obligation has been appropriated, pledged, or otherwise provided by the educational institution.

(d) An insurer may invest in a bond or warrant described by Subsection (a)(7) only if special revenue or income to meet the principal and interest payments as they accrue on the obligation has been appropriated, pledged, or otherwise provided by the municipality or other entity. (V.T.I.C. Art. 3.39, Part I (part), Sec. A, Paras. 1, 2, 3, 4, 5, 6, 7, 8, 9.)

Source Law

Part I. [A life insurance company organized under the laws of this state] may invest its several funds, [identified as follows,] in the following securities, respectively, and . . . .

A. ANY OF ITS FUNDS AND ACCUMULATIONS

1. U.S. Bonds and Obligations Guaranteed by the United States. The bonds, treasury bills, notes and certificates of indebtedness of the United States or any other obligation or security fully guaranteed as to principal and interest by the full faith and credit of the United States.

2. Canadian Bonds. The bonds of the Dominion of Canada or any province or city of the Dominion of Canada.

3. State, County and City Bonds. The bonds of any state, county, or city of the United States.

4. County, City and School District Bonds. Any bonds or interest-bearing warrants issued by authority of law by any county, city, town, school district or other municipality or subdivision, which is now or hereafter may be constituted or organized under the laws of any state in the United States, and which is authorized to issue such bonds and warrants under the Constitution and laws of the state in which it is situated; provided legal provision has been made by a tax to meet said obligations.

5. Bonds of Educational Institutions. Any bonds or interest-bearing warrants issued by authority of law by any educational institution which is now or hereafter may be constituted or organized under the laws of any state in the United States, and which is authorized to issue such bonds and warrants under the Constitution and laws of the state in which it is

situated; provided legal provision has been made by a tax to meet said obligations.

6. Revenue Bonds, etc., of Educational Institutions. The bonds and warrants, including revenue and special obligations, of any educational institution located in any state in the United States when special revenue or income to meet the principal and interest payments as they accrue upon such obligations shall have been appropriated, pledged or otherwise provided by such educational institution.

7. Bonds and Warrants of Municipally Owned Systems. The bonds and warrants payable from designated revenues of any city, county, drainage district, road district, town, township, village or other civil administration, agency, authority, instrumentality, or subdivision which is now or hereafter may be constituted or organized under the laws of any state in the United States, and which is authorized to issue such bonds and warrants under the Constitution and laws of the state in which it is situated; provided special revenue or income to meet the principal and interest payments as they accrue upon such obligations shall have been appropriated, pledged or otherwise provided by such municipality.

8. Paving Certificates. Any paving certificates or other certificates or evidence of indebtedness issued by any city in any state in the United States and secured by a first lien on real estate.

9. Bonds Issued Under Federal Farm Loan Act. Bonds issued under and by virtue of the Federal Farm Loan Act approved July 17, 1916 (12 U.S.C.A. Sec. 641 et seq.), when such bonds are issued against and secured by promissory notes, or obligations, the payment of which is secured by mortgage, deed of trust, or other valid lien upon unencumbered real estate situated in this state.

Revisor's Note

(1) Paragraphs 2, 3, 4, 7, and 8, Section A, Part I, V.T.I.C. Article 3.39, refer to a "city." Paragraphs 4 and 7 refer to a "town" and Paragraph 7 refers to a "township" and a "village." The revised law substitutes the term "municipality" for "city," "town," "township," and "village" for the reason stated in Revisor's Note (6) to Section 425.002.

(2) Paragraphs 4, 5, and 7, Section A, Part I, V.T.I.C. Article 3.39, refer to political subdivisions, educational institutions, and other entities that are "now or hereafter may be constituted or organized" under state law. The revised law omits "now or hereafter may be" for the reason stated in Revisor's Note (1) to Section 425.002. The reference

to "constituted" is omitted from the revised law because "constituted" is included in the meaning of "organized."

(3) Paragraph 9, Section A, Part I, V.T.I.C. Article 3.39, refers to "the Federal Farm Loan Act approved July 17, 1916 (12 U.S.C.A. Sec. 641 et seq.)." That act was repealed by the Farm Credit Act of 1971 (Pub. L. No. 92-181), which is codified as 12 U.S.C. Section 2001 et seq. Section 5.26(a) of Pub. L. No. 92-181 provided in part that "[a]ll references in other legislation, State or Federal, . . . to the Acts repealed hereby, shall be deemed to refer to comparable provisions of this Act." The revised law is drafted accordingly.

Revised Law

Sec. 425.206. AUTHORIZED INVESTMENTS FOR ALL FUNDS: CORPORATE BONDS, NOTES, AND DEBENTURES. (a) Subject to Subsection (e), an insurer may invest any of the insurer's funds and accumulations in a first mortgage bond or first lien note on real or personal property of:

(1) a solvent corporation that has not defaulted in the payment of any debt during the five years preceding the investment;

(2) a solvent corporation that has not been in existence for five consecutive years but whose first mortgage bonds or first lien notes on real or personal property are fully guaranteed by a solvent corporation that has not defaulted in the payment of any debt during the five years preceding the investment;

(3) a solvent corporation that has not been in existence for five consecutive years but whose first mortgage bonds or first lien notes on real or personal property are secured by leases or other contracts executed by a solvent corporation that has not defaulted in the payment of any debt during the five years preceding the investment, if the required rentals or other required

payments under the leases or other contracts are sufficient in all circumstances to pay interest and principal when due on the bonds or notes; or

(4) a solvent corporation that has not been in existence for five consecutive years preceding the investment, if:

(A) the corporation has succeeded to the business and assets and has assumed the liabilities of another corporation; and

(B) neither the successor corporation or the corporation succeeded has defaulted in the payment of any debt during the five years preceding the investment.

(b) Subject to Subsection (e), an insurer may invest any of the insurer's funds and accumulations in a note or debenture of a corporation with a net worth of at least $5 million if:

(1) a prior lien in excess of 10 percent of the net worth of the corporation does not exist against the real or personal property of the corporation at the time the note or debenture is issued; and

(2) under the provisions of the indenture providing for the issuance of the note or debenture, a prior lien that exceeds 10 percent of the net worth of the corporation cannot be created against the real or personal property of the corporation at the time the note or debenture is issued.

(c) Subject to Subsection (e), an insurer may invest any of the insurer's funds and accumulations in a note or debenture of a solvent corporation that has not been in existence for five consecutive years if:

(1) a prior lien does not exist against the real or personal property of the corporation at the time the note or debenture is issued;

(2) under the provisions of the indenture providing for the issuance of the note or debenture, a prior lien cannot be created against the real or personal property of the corporation at the time the note or debenture is issued; and

(3) the note or debenture is:

(A) secured by a lease or other contract executed by a solvent corporation that has a net worth of at least $5 million and has not defaulted in the payment of any debt during the five years preceding the investment, if the required rentals or other required payments under the lease or other contract are sufficient in all circumstances to pay interest and principal when due on the bond or note; or

(B) fully guaranteed by a corporation described by Paragraph (A).

(d) Subject to Subsection (e), an insurer may invest any of the insurer's funds and accumulations in a bond, bill of exchange, or other commercial note or bill of:

(1) a solvent corporation that has not defaulted in the payment of any debt during the five years preceding the investment; or

(2) a solvent corporation that has not been in existence for the five years preceding the investment, if:

(A) the corporation has succeeded to the business and assets and has assumed the liabilities of another corporation;

(B) neither the successor corporation or the corporation succeeded has defaulted in the payment of any debt during the five years preceding the investment;

(C) the corporation has a net worth of at least $50 million; and

(D) the corporation does not have long-term indebtedness that exceeds the corporation's net worth, as evidenced by the corporation's latest published financial statements or other financial data available to the public.

(e) The amount of an insurer's investments in the bonds, notes, debentures, or other obligations of any one corporation may not exceed five percent of the insurer's admitted assets. (V.T.I.C. Art. 3.39, Part I, Sec. A, Para. 10.)

Source Law

[Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively, and none other:

A. ANY OF ITS FUNDS AND ACCUMULATIONS]

10. Corporate First Mortgage Bonds, Notes and Debentures. (1) First mortgage bonds or first lien notes on real estate or personal property: (a) of any solvent corporation which has not defaulted in the payment of any debt within five (5) years next preceding such investment; or (b) of any solvent corporation which has not been in existence for five (5) consecutive years but whose first mortgage bonds or first lien notes on real estate or personal property are fully guaranteed by a solvent corporation which has not defaulted in the payment of any debt within five (5) years next preceding such investment; or (c) of any solvent corporation which has not been in existence for five (5) consecutive years but whose first mortgage bonds or first lien notes on real estate or personal property are secured by leases or other contracts executed by a solvent corporation which has not defaulted in the payment of any debt within five (5) years next preceding such investment, the required rentals or other required payments under which leases or other contracts are sufficient in any and every circumstance to pay interest and principal when due on such bonds or notes; or (d) of any solvent corporation which has not been in existence for five (5) consecutive years next preceding such investment, provided such corporation has succeeded to the business and assets and has assumed the liabilities of another corporation, and which corporation and the corporation so succeeded have not defaulted in the payment of any debt within five (5) years next preceding such investment; or

(2) in the notes or debentures of any such corporation with a net worth of not less than Five Million Dollars ($5,000,000) where no prior lien exists in excess of 10 percent of the net worth of such corporation, and, under the provisions of the indenture providing for the issuance of such notes or debentures, no such prior lien can be created in excess of 10 percent of the net worth of such corporation, against the real or personal property of such corporation at the time the notes or debentures were issued; or (3) in the notes or debentures of any solvent corporation which has not been in existence for five (5) consecutive years where no prior lien exists, and, under the provisions of the indenture providing for the issuance of such notes or debentures, no such prior lien can be created against the real or personal property of such corporation at the time the notes or debentures were issued, but whose notes or debentures are secured by leases or other contracts executed by a solvent corporation which has not defaulted in the payment of any debt within five (5) years next preceding such investment and has a net worth of at least Five Million Dollars ($5,000,000), the required rentals or other required payments under which leases or other contracts are sufficient in any and every circumstance to pay interest and principal when due on such bonds or notes, or whose notes or debentures are fully guaranteed by any such corporation; or (4) in the bonds, bills of exchange, or

other commercial notes or bills of any solvent corporation which has not defaulted in the payment of any debt within five (5) years next preceding such investment, or of any solvent corporation which has not been in existence for five (5) consecutive years next preceding such investment, provided such corporation has succeeded to the business and assets and has assumed the liabilities of another corporation, and which corporation and the corporation so succeeded have not defaulted in the payment of any debt within five (5) years next preceding such investment, and which corporation has a net worth of not less than Fifty Million Dollars ($50,000,000) and has no long-term indebtedness in excess of its net worth, as evidenced by its latest published financial statements or other financial data available to the public; but in no event shall the amount of such investment in the bonds, notes, debentures, or other obligations of any one such corporation exceed five percent (5%) of the admitted assets of the insurance company making such investment.

Revised Law

Sec. 425.207. AUTHORIZED INVESTMENTS FOR ALL FUNDS: SHARES OF SAVINGS AND LOAN ASSOCIATIONS. (a) Subject to this section, an insurer may invest any of the insurer's funds and accumulations in a share, stock, share or savings account, or investment certificate of a savings and loan association engaged in business in this state that is qualified to participate in insurance issued by the Federal Deposit Insurance Corporation.

(b) An insurer's investment in a savings and loan association may not exceed 20 percent of the savings and loan association's total assets. (V.T.I.C. Art. 3.39, Part I, Sec. A, Para. 11.)

Source Law

[Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively, . . . .

A. ANY OF ITS FUNDS AND ACCUMULATIONS]

11. Shares of Savings and Loan Associations. The shares, stock, share accounts or savings accounts, and investment certificates of Savings and Loan Associations doing business in this state where such association has qualified for participation in insurance issued by the Federal Savings and Loan Insurance Corporation; no such investment shall exceed twenty per cent (20%) of the total assets of any such Individual Savings and Loan Association.

Revisor's Note

Paragraph 11, Section A, Part I, V.T.I.C. Article

3.39, refers to a savings and loan association that "qualified for participation in insurance issued by the Federal Savings and Loan Insurance Corporation." The Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (Pub. L. No. 101-73) abolished the Federal Savings and Loan Insurance Corporation and provided for the insurance of the deposits of savings and loan associations by the Federal Deposit Insurance Corporation. The revised law is drafted accordingly.

Revised Law

Sec. 425.208. AUTHORIZED INVESTMENTS FOR ALL FUNDS: BANK AND BANK HOLDING COMPANY STOCKS. (a) Subject to this section, an insurer may invest any of the insurer's funds and accumulations in:

(1) the stock of a state or national bank that is a member of the Federal Deposit Insurance Corporation; and

(2) the stock of a bank holding company as defined by the Bank Holding Company Act of 1956 (12 U.S.C. Section 1841 et seq.), as amended by the Bank Holding Company Act Amendments of 1970 (12 U.S.C. Section 1841 et seq. and Section 1971 et seq.).

(b) An insurer's investment in the stock of a bank or bank holding company may not exceed:

(1) 20 percent of the total outstanding shares of the stock of the bank or bank holding company; or

(2) 10 percent of the insurer's admitted assets. (V.T.I.C. Art. 3.39, Part I, Sec. A, Para. 12.)

Source Law

[Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively, . . . .

A. ANY OF ITS FUNDS AND ACCUMULATIONS]

12. Bank and Bank Holding Company Stocks. The stock of banks, either state or national, that are members of the Federal Deposit Insurance Corporation and the stock of bank holding companies as defined in the Bank Holding Company Act of 1956 (12 U.S.C.A. 1841 et seq.) as amended by the Bank Holding Company Act Amendments of 1970 (12 U.S.C.A. 1841 et seq., 1971 et seq.) enacted by the United States Congress; no such investment shall exceed twenty per cent (20%) of the

total outstanding shares of the stock of any such bank or bank holding company and in no event shall the amount of investment in any such stock exceed ten per cent (10%) of the admitted assets of the insurance company making such investment.

Revised Law

Sec. 425.209. AUTHORIZED INVESTMENTS FOR ALL FUNDS: DEBENTURES OF PUBLIC UTILITY CORPORATIONS. (a) Subject to this section, an insurer may invest any of the insurer's funds and accumulations in:

(1) a debenture of a solvent public utility corporation that:

(A) has not defaulted in the payment of any debt during the five years preceding the investment; and

(B) has not failed in any one of the five years preceding the investment to have earned, after taxes, including income taxes, and after deducting proper charges for replacements, depreciation, and obsolescence, an amount applicable to interest on the corporation's outstanding indebtedness equal to at least two times the amount of interest due for that year, or, in the case of issuance of new debentures, the earnings applicable to interest are equal to at least two times the amount of annual interest on the corporation's obligations after giving effect to the new financing; or

(2) a debenture of a solvent public utility corporation that has not been in existence for the five years preceding the investment, if:

(A) the corporation has succeeded to the business and assets and has assumed the liabilities of another public utility corporation;

(B) neither the successor corporation or the corporation succeeded has defaulted in the payment of any debt during the five years preceding the investment; and

(C) neither the successor corporation or the corporation succeeded have failed in any one of the five years preceding the investment to have earned, after taxes, including

income taxes, and after deducting proper charges for replacements, depreciation, and obsolescence, an amount applicable to interest on the corporation's outstanding indebtedness equal to at least two times the amount of interest due for that year, or in the case of issuance of new debentures, the earnings applicable to interest are equal to at least two times the amount of annual interest on the corporation's obligations after giving effect to the new financing.

(b) The amount of an insurer's investment in debentures under this section may not exceed five percent of the insurer's admitted assets. (V.T.I.C. Art. 3.39, Part I, Sec. A, Para. 13.)

Source Law

> [Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively, . . . .
>
> A. ANY OF ITS FUNDS AND ACCUMULATIONS]
>
> 13. Debentures of Public Utility Corporations. The debentures of any solvent public utility corporation which has not defaulted in the payment of any debt within five (5) years next preceding such investment, or of any solvent public utility corporation which has not been in existence for five (5) consecutive years next preceding such investment provided such corporation has succeeded to the business and assets and has assumed the liabilities of another such corporation, and which public utility corporation and public utility corporation so succeeded have not defaulted in the payment of any debt within five (5) years next preceding such investment; provided further, that such public utility corporation shall not have failed in any one of the five (5) years next preceding such investment to have earned, after taxes, including income taxes, and after deducting proper charges for replacements, depreciation and obsolescence, a sum applicable to interest on its outstanding indebtedness equal at least to two times the amount of interest due for that year, or where, in the case of issuance of new debentures, such earnings applicable to interest are equal to at least two times the amount of annual interest on such public utility corporation's obligations after giving effect to such new financing; or, in the case of a public utility corporation which has not been in existence for five (5) consecutive years next preceding such investment but has succeeded to the business and assets and has assumed the liabilities of another such corporation, and which public utility corporation and the public utility corporation so succeeded have not failed in any one of the five (5) years next preceding such investment to have earned, after taxes, including income taxes, and after deducting proper charges for replacements, depreciation and obsolescence, a sum applicable to interest on the outstanding indebtedness equal to at least two times the amount of interest due for that year, to where in the case of issuance of new

debentures such earnings applicable to interest are equal to at least two times the amount of annual interest on such public utility corporation's obligations after giving effect to such new financing; but in no event shall the amount of such investment in debentures under this Subdivision exceed five per cent (5%) of the admitted assets of the insurance company making the investment.

Revised Law

Sec. 425.210. AUTHORIZED INVESTMENTS FOR ALL FUNDS: PREFERRED STOCK OF PUBLIC UTILITY CORPORATIONS. (a) Subject to this section, an insurer may invest any of the insurer's funds and accumulations in:

(1) preferred stock of a solvent public utility corporation, the bonds and debentures of which are authorized investments for the insurer, and that:

(A) has not defaulted in the payment of any debt during the five years preceding the investment; and

(B) has not failed in any one of the five years preceding the investment to have earned an amount applicable to the dividends on the preferred stock equal to at least three times the amount of dividends due in that year, or, in the case of issuance of new preferred stock, the earnings applicable to dividends are equal to at least three times the amount of the annual dividend requirements after giving effect to the new financing; or

(2) a solvent public utility corporation, the bonds and debentures of which are authorized investments for the insurer, and that has not been in existence for the five years preceding the investment, if:

(A) the corporation has succeeded to the business and assets and has assumed the liabilities of another public utility corporation;

(B) neither the successor corporation or the corporation succeeded has defaulted in the payment of any debt during the five years preceding the investment; and

(C) neither the successor corporation or the corporation succeeded have failed in any one of the five years preceding the investment to have earned an amount applicable to the

dividends on the preferred stock equal to at least three times the amount of dividends due in that year, or, in the case of issuance of new preferred stock, the earnings applicable to dividends are equal to at least three times the amount of the annual dividend requirements after giving effect to the new financing.

(b) Preferred stock purchased under this section must be of an issue entitled to first claim on the net earnings of the public utility corporation, after deducting the amount necessary to service any outstanding bonds and debentures.

(c) The amount of an insurer's investment in preferred stock under this section may not exceed 2-1/2 percent of the insurer's admitted assets. (V.T.I.C. Art. 3.39, Part I, Sec. A, Para. 14.)

Source Law

> [Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively, . . . .
>
> A. ANY OF ITS FUNDS AND ACCUMULATIONS]
>
> 14. Preferred Stock of Public Utility Corporations. The preferred stock of any solvent public utility corporation which has not defaulted in the payment of any debt within five (5) years next preceding such investment, or of any solvent public utility corporation which has not been in existence for five (5) consecutive years next preceding such investment provided such corporation has succeeded to the business and assets and has assumed the liabilities of another corporation, and which public utility corporation and the public utility corporation so succeeded have not defaulted in the payment of any debt within five (5) years next preceding such investment; provided further, that such public utility corporation shall not have failed in any one of the five (5) years next preceding such investment to have earned a sum applicable to dividends on such preferred stock equal to at least three times the amount of dividends due in that year, or, in the case of issuance of new preferred stock such earnings applicable to dividends are equal at least to three times the amount of the annual dividend requirements after giving effect to such new financing, and where the bonds and debentures are eligible investments for such insurance company; or, in the case of a public utility corporation which has not been in existence for five (5) consecutive years next preceding such investment, but has succeeded to the business and assets and has assumed the liabilities of another such corporation, and which public utility corporation and the public utility corporation so succeeded have not failed in any one of the five (5) years next preceding such investment to have earned a sum applicable to the dividends on such preferred stock equal to at least three times the amount of dividends due in that year,

or, in the case of issuance of new preferred stock, such earnings applicable to dividends are equal at least to three times the amount of the annual dividend requirements after giving effect to such new financing, and where the bonds and debentures are eligible investments for such insurance company; provided that any preferred stock so purchased shall be of an issue which is entitled to first claim upon the net earnings of such public utility corporation after deducting such sum as may be necessary to service any outstanding bonds and debentures, but in no event shall the amount of such investment in preferred stock under this Subdivision exceed two and one-half per cent (2 1/2%) of the admitted assets of the insurance company making the investment.

Revised Law

Sec. 425.211. AUTHORIZED INVESTMENTS FOR ALL FUNDS: BONDS ISSUED, ASSUMED, OR GUARANTEED IN INTERNATIONAL MARKET. An insurer may invest any of the insurer's funds and accumulations in bonds issued, assumed, or guaranteed by:

(1) the Inter-American Development Bank;

(2) the International Bank for Reconstruction and Development (the World Bank);

(3) the African Development Bank;

(4) the Asian Development Bank;

(5) the International Finance Corporation; and

(6) the State of Israel. (V.T.I.C. Art. 3.39, Part I, Sec. A, Para. 15A.)

Source Law

[Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively, . . . .

A. ANY OF ITS FUNDS AND ACCUMULATIONS]

15A. Other Bonds. A company may also invest its funds and accumulations in:

(1) bonds issued, assumed, or guaranteed by the Inter-American Development Bank, the International Bank for Reconstruction and Development (the World Bank), the African Development Bank, the Asian Development Bank, and the International Finance Corporation; and

(2) bonds issued, assumed, or guaranteed by the State of Israel.

Revised Law

Sec. 425.212. AUTHORIZED INVESTMENTS FOR ALL FUNDS: SECURITIES OR INVESTMENTS AUTHORIZED OR DESCRIBED BY SPECIFIC STATUTORY PROVISION. An insurer may invest any of the insurer's

funds and accumulations in a security or investment authorized or described by:

(1) Section 65.013, Finance Code;

(2) Sections 435.041-435.047, Government Code;

(3) Subchapter B, Chapter 1505, Government Code;

(4) Chapter 284, Transportation Code;

(5) Section 51.039 or 60.104, Water Code;

(6) Chapter 160, General Laws, Acts of the 43rd Legislature, Regular Session, 1933 (Article 842a, Vernon's Texas Civil Statutes);

(7) Chapter 230, Acts of the 49th Legislature, Regular Session, 1945 (Article 842a-1, Vernon's Texas Civil Statutes);

(8) Chapter 110, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-133, Vernon's Texas Civil Statutes);

(9) Chapter 340, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-137, Vernon's Texas Civil Statutes);

(10) Chapter 398, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-138, Vernon's Texas Civil Statutes); or

(11) Chapter 465, Acts of the 51st Legislature, Regular Session, 1949 (Article 8280-139, Vernon's Texas Civil Statutes). (V.T.I.C. Art. 3.39, Part I, Sec. A, Para. 16.)

Source Law

[Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively, . . . .
A. ANY OF ITS FUNDS AND ACCUMULATIONS]

16. Securities Authorized by Special Acts of the Legislature. Securities authorized under Articles: 842a; 842a-1; 881a-24; 1187a; 5890c; 6795b-1; 7880-19a; 8247a; 8280-133; 8280-134; 8280-137; 8280-138; and 8280-139 of the Revised Civil Statutes of Texas.

Revisor's Note

(1) Paragraph 16, Section A, Part I, V.T.I.C. Article 3.39, refers to securities "authorized under" Articles 842a and 842a-1, Revised Civil Statutes of

Texas, meaning, respectively, Chapter 160, General Laws, Acts of the 43rd Legislature, Regular Session, 1933, and Chapter 230, Acts of the 49th Legislature, Regular Session, 1945. Those articles do not authorize the issuance of securities but provide that certain obligations issued or guaranteed by the United States, specific federal agencies, or the State of Texas are legal and authorized investments for, among other entities, insurers. Accordingly, the revised law refers to securities "described by" those articles.

(2) Paragraph 16, Section A, Part I, V.T.I.C. Article 3.39, refers to "[s]ecurities authorized under" Article 881a-24, Revised Civil Statutes of Texas, meaning Section 25, Chapter 61, General Laws, Acts of the 41st Legislature, 2nd Called Session, 1929. Article 881a-24 provided that an insurer, among other entities, could invest the insurer's funds in share accounts of savings and loan associations and that those investments by insurers were eligible for tax-reducing purposes under Article 7064. Article 881a-24 was repealed by Chapter 113, Acts of the 58th Legislature, Regular Session, 1963. That act enacted the Texas Savings and Loan Act (Article 852a, Vernon's Texas Civil Statutes). The relevant portion of Article 881a-24 became Section 6.14, Texas Savings and Loan Act, and was codified in 1997 as Section 65.013, Finance Code. The revised law is drafted accordingly. The revised law also adds a reference to "investments" under Section 65.013, Finance Code, because share accounts, referred to in Chapter 65, Finance Code, as "savings accounts," are not "securities."

(3) Paragraph 16, Section A, Part I, V.T.I.C. Article 3.39, refers to Article 1187a, Revised Civil Statutes of Texas, meaning Chapter 231, General Laws,

Acts of the 43rd Legislature, Regular Session, 1933. That statute was codified in 1999 as Subchapter B, Chapter 1505, Government Code. The revised law is drafted accordingly.

(4) Paragraph 16, Section A, Part I, V.T.I.C. Article 3.39, refers to Article 5890c, Revised Civil Statutes of Texas, meaning Chapter 3, page 494, General Laws, Acts of the 46th Legislature, Regular Session, 1939. Article 5890c provided that bonds issued by the Texas National Guard Armory Board were legal and authorized investments for insurers, among other entities. Article 5890c was repealed by Chapter 112, Acts of the 58th Legislature, Regular Session, 1963, and by Chapter 690, Acts of the 59th Legislature, Regular Session, 1965. The 1965 act enacted Article 5767, Revised Statutes, relating to the Texas National Guard Armory Board. Section 6(8), Article 5767, contained language similar to Article 5890c. Article 5767 was repealed by Chapter 186, Acts of the 60th Legislature, Regular Session, 1967. That act enacted Title 97A, Revised Statutes, relating to the Texas National Guard Armory Board. Part of that title, Article 5931-5(a)(8), contained language similar to that in Section 6(8), Article 5767. Article 5931-5(a)(8) was codified in 1987 as Sections 435.041-435.047, Government Code. The revised law is drafted accordingly.

(5) Paragraph 16, Section A, Part I, V.T.I.C. Article 3.39, refers to Article 6795b-1, Revised Civil Statutes of Texas, meaning Chapter 304, Acts of the 50th Legislature, Regular Session, 1947. That article was codified in 1995 as Chapter 284, Transportation Code. The revised law is drafted accordingly.

(6) Paragraph 16, Section A, Part I, V.T.I.C.

Article 3.39, refers to Article 7880-19a, Revised Civil Statutes of Texas, meaning Chapter 25, General Laws, Acts of the 39th Legislature, Regular Session, 1925. The relevant portion of that article was codified in 1971 as Section 51.039, Water Code. The revised law is drafted accordingly.

(7) Paragraph 16, Section A, Part I, V.T.I.C. Article 3.39, refers to Article 8247a, Revised Civil Statutes of Texas, meaning Chapter 111, Acts of the 43rd Legislature, 1st Called Session, 1933. The relevant portion of that article was codified in 1971 as Section 60.104, Water Code. The revised law is drafted accordingly.

(8) Paragraph 16, Section A, Part I, V.T.I.C. Article 3.39, refers to Article 8280-134, Revised Civil Statutes of Texas, meaning Chapter 159, Acts of the 51st Legislature, Regular Session, 1949. That article created the Lower Nueces River Water Supply District and authorized the district to issue obligations. Chapter 844, Acts of the 69th Legislature, Regular Session, 1985, dissolved the district and required payment of all outstanding district obligations. On dissolution of the district, Article 8280-134 was repealed. Accordingly, the revised law omits the reference to Article 8280-134.

Revised Law

Sec. 425.213. AUTHORIZED INVESTMENTS FOR ALL FUNDS: OTHER SECURITIES SPECIFICALLY AUTHORIZED BY LAW. An insurer may invest any of the insurer's funds and accumulations in:

(1) an adequately secured equipment trust obligation or certificate or another adequately secured instrument evidencing:

(A) an interest in transportation equipment that is located wholly or partly within the United States; and

(B) a right to receive determined portions of rental, purchase, or other fixed obligatory payments for the use or purchase of the transportation equipment; and

(2) any other security as specifically authorized by law. (V.T.I.C. Art. 3.39, Part I, Sec. A, Para. 17.)

Source Law

> [Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively, . . . .
>
> A. ANY OF ITS FUNDS AND ACCUMULATIONS]
>
> 17. Other Securities Specifically Authorized by Law. (1) Equipment trust obligations or certificates that are adequately secured or other adequately secured instruments evidencing an interest in transportation equipment that is in whole or in part within the United States and a right to receive determined portions of rental, purchase, or other fixed obligatory payments for the use or purchase of the transportation equipment; and
>
> (2) Such other securities as are now or may hereafter be specifically authorized by law.

Revisor's Note

Paragraph 17(2), Section A, Part I, V.T.I.C. Article 3.39, refers to "securities as are now or may hereafter be specifically authorized by law." The revised law omits "as are now or may hereafter be" for the reason stated in Revisor's Note (1) to Section 425.002.

Revised Law

Sec. 425.214. AUTHORIZED INVESTMENTS FOR ALL FUNDS: LOANS SECURED BY REAL PROPERTY. (a) Subject to this section, an insurer may loan any of the insurer's funds and accumulations and take as collateral a first lien on real property to which the title is valid.

(b) The amount of a loan secured by a first lien on real property may exceed 75 percent of the property value only if:

(1) the amount does not exceed 90 percent of the property value and the property contains only a dwelling designed exclusively for occupancy by not more than four families for residential purposes; or

(2) the amount does not exceed 95 percent of the property value and:

(A) the property contains only a dwelling designed exclusively for occupancy by not more than four families for residential purposes; and

(B) the portion of the unpaid balance of the loan that exceeds 80 percent of the property value is guaranteed or insured by a mortgage guaranty insurer authorized to engage in business in this state.

(c) An insurer may not originate a loan that exceeds 75 percent of the value of the real property securing the loan.

(d) The aggregate amount of an insurer's loans secured by first liens on real property to any one corporation, company, partnership, individual, or any affiliated person or group may not exceed 10 percent of the insurer's admitted assets. The amount of any single loan secured by a first lien on real property may not exceed five percent of the insurer's admitted assets.

(e) The limitations imposed by Subsections (b)-(d) do not apply to a first lien on real property if the commissioner finds that:

(1) the making or acquiring of the lien is beneficial to and protects the interest of the insurer; and

(2) no substantial damage to the insurer's policyholders and creditors appears probable from the taking or acquiring of the lien.

(f) Subject to Subsections (g)-(j), an insurer may loan any of the insurer's funds and accumulations and take as collateral a first lien on a leasehold estate in:

(1) real property to which the title is valid; and

(2) improvements located on the property to which the title is valid.

(g) The term of a loan secured by first lien on a leasehold estate in real property may not, as of the date the loan is made, exceed a period equal to four-fifths of the unexpired term of the

leasehold estate. The term of the leasehold estate may not expire sooner than the 10th anniversary of the expiration of the term of the loan.

(h) A loan secured by a first lien on a leasehold estate in real property must be payable in equal monthly, quarterly, semiannual, or annual installments on principal and interest during a period not to exceed four-fifths of the unexpired term, as of the date the loan is made, of the leasehold estate.

(i) The restrictions imposed by this section on the value of the real property securing a loan compared to the amount of the loan, and on the duration of a loan secured by a leasehold estate in real property, do not apply to a loan if:

(1) the entire amount of the indebtedness is insured or guaranteed in any manner by:

(A) the United States;

(B) the Federal Housing Administration under the National Housing Act (12 U.S.C. Section 1701 et seq.), as amended; or

(C) this state; or

(2) the difference between the entire amount of the indebtedness and the portion of the loan insured or guaranteed by an entity described by Subdivision (1) does not exceed the amount of a loan permitted by the applicable restriction.

(j) If any part of the value of buildings is to be included in the value of real property or leasehold estate in real property to attain the minimum authorized value of the security for a loan under this section:

(1) the buildings must be insured against loss by fire by:

(A) an insurer authorized to engage in business in the state in which the real property is located; or

(B) a company recognized as acceptable for that purpose by the insurance regulatory official of the state in which the real property is located;

(2) the amount of insurance coverage may not be less than 50 percent of the value of the buildings, except that the insurance coverage is not required to exceed the outstanding balance owed to the insurer if the outstanding balance of the loan is less than 50 percent of the value of the buildings; and

(3) the loss clause under the insurance must be payable to the insurer. (V.T.I.C. Art. 3.39, Part II (part), Sec. A, Paras. 1, 2, 6, 8.)

Source Law

[Part II. A life insurance company organized under the laws of this state] may loan its several funds [identified as follows,] taking as collateral security for the payment of such loans the securities named below, and [none other.]

A. ANY OF ITS FUNDS ACCUMULATIONS

Such company may loan any of its funds and accumulations on the following securities:

1. First Liens Upon Real Estate. First liens upon real estate, the title to which is valid and provided the amount of the loan does not exceed: (a) seventy-five (75%) per cent of the value of such real estate; or (b) ninety (90%) per cent of the value of such real estate if it contains only a dwelling designed exclusively for occupancy by not more than four families for residential purposes; or (c) ninety-five (95%) per cent of the value of such real estate if it contains only a dwelling designed exclusively for occupancy by not more than four families for residential purposes, and the portion of the unpaid balance of such loan which is in excess of an amount equal to eighty (80%) per cent of such value is guaranteed or insured by a mortgage insurance company qualified to do business in the State of Texas; provided, however, that loans in excess of seventy-five (75%) per cent of the value of such real estate authorized under (b) or (c) hereof shall not be originated by such company; provided, however, that the aggregate amount of loans secured by first liens on real estate to any one corporation, company, partnership, individual, or any affiliated person or group may not exceed ten (10%) per cent of the admitted assets of such insurer, and provided further that the amount of any such single loan secured by a first lien on real estate may not exceed five (5%) per cent of the admitted assets of the insurer. The limitation provided by this subsection shall not apply to any first lien on real estate where the Commissioner of Insurance finds that: (1) the making or acquiring of such lien is beneficial to and protects the interest of the insurer and (2) no substantial damage to the policyholders and creditors of such insurer appears probable from the taking or acquiring of such lien.

2. First Liens Upon Leasehold Estates. First liens upon leasehold estates in real property and improvements situated thereon, the title to which is valid; provided that the duration of any loan upon such leasehold estates shall not exceed a period equal to four-fifths (4/5) of the then unexpired term of such

leasehold estate, provided the unexpired term of the leasehold estate must extend at least ten (10) years beyond the term of the loan, and any such loan shall be payable only in equal monthly, quarterly, semi-annual or annual installments, on principal and interest during a period not exceeding four-fifths (4/5) of the then unexpired term of such leasehold estate.

6. Restrictions as to Value of Real Estate Removed Where Loans Insured by the United States. The foregoing restrictions as to the value of the real estate security compared to the amount loaned thereon and as to the duration of such loans shall not be applied to loans if the entire amount of the indebtedness is insured or guaranteed in any manner by the United States, the Federal Housing Administration pursuant to the National Housing Act of 1934, as amended (12 U.S.C.A. Sec. 1701 et seq.), or by the State of Texas, or, if not wholly insured or guaranteed, the difference between the entire amount of the indebtedness and that portion thereof insured or guaranteed by the United States, the Federal Housing Administration pursuant to the National Housing Act of 1934, as amended, or by the State of Texas, would not exceed the amount of loan permissible under said restrictions.

8. Insurance Requirements. If any part of the value of buildings is required to be included in the value of such real estate to attain the minimum authorized value of the security, such buildings shall be insured against loss by fire in a company authorized to transact business in the state in which such real estate is located, or in a company recognized as acceptable for such purpose by the insurance regulatory official of the state in which such real estate is located, which insurance shall be in an amount of at least fifty per cent (50%) of the value of such buildings; provided, that the insurance coverage need not exceed the outstanding balance owed to the lending company when the outstanding balance falls below fifty per cent (50%) of the value of the buildings. The loss clause shall be payable to such company.

Revisor's Note

Paragraph 1, Section A, Part II, V.T.I.C. Article 3.39, refers to a "mortgage insurance company" that is "qualified" to engage in business. The revised law substitutes "mortgage guaranty insurer" for "mortgage insurance company" and "authorized" for "qualified" for the reasons stated in the revisor's note to Section 425.118.

Revised Law

Sec. 425.215. AUTHORIZED INVESTMENTS FOR ALL FUNDS: LOANS SECURED BY CERTAIN COLLATERAL SECURED BY REAL PROPERTY. An insurer may loan any of the insurer's funds and accumulations and take as

collateral an obligation secured by a first lien on real property or a leasehold estate that is eligible to secure a loan under Section 425.214. (V.T.I.C. Art. 3.39, Part II, Sec. A, Para. 3.)

Source Law

> [Part II. A life insurance company organized under the laws of this state may loan its several funds identified as follows, taking as collateral security for the payment of such loans the securities named below, and none other.
>
> A. ANY OF ITS FUNDS ACCUMULATIONS
>
> Such company may loan any of its funds and accumulations on the following securities:]
>
> 3. Collateral Securities. Upon any obligation secured collaterally by any such first liens on real estate or leasehold estates.

Revised Law

Sec. 425.216. AUTHORIZED INVESTMENTS FOR ALL FUNDS: POLICY LOANS. (a) Subject to Subsection (b), an insurer may loan any of the insurer's funds and accumulations and take as collateral an insurance policy issued by the insurer.

(b) A loan on a policy under this section may not exceed the reserve value of the policy. (V.T.I.C. Art. 3.39, Part II, Sec. A, Para. 4.)

Source Law

> [Part II. A life insurance company organized under the laws of this state may loan its several funds identified as follows, taking as collateral security for the payment of such loans the securities named below, and none other.
>
> A. ANY OF ITS FUNDS ACCUMULATIONS
>
> Such company may loan any of its funds and accumulations on the following securities:]
>
> 4. Policy Loans. Security of Its Own Policies. No loan on any policy shall exceed the reserve values thereof.

Revised Law

Sec. 425.217. AUTHORIZED INVESTMENTS FOR ALL FUNDS: LOANS SECURED BY CERTAIN SECURITIES. An insurer may loan any of the insurer's funds and accumulations and take as collateral for the loan any security described by Sections 425.205-425.213 and 425.218 in which the insurer may invest any of the insurer's funds and accumulations. (V.T.I.C. Art. 3.39, Part II, Sec. A, Para. 5.)

Source Law

[Part II. A life insurance company organized under the laws of this state may loan its several funds identified as follows, taking as collateral security for the payment of such loans the securities named below, and none other.

A. ANY OF ITS FUNDS ACCUMULATIONS

Such company may loan any of its funds and accumulations on the following securities:]

5. Other Securities. It may loan any of its funds and accumulations, taking as collateral to secure the payment of such loan, any of the securities named or referred to in Part 1 of this Article 3.39 above in which it may invest any of its funds and accumulations.

Revised Law

Sec. 425.218. AUTHORIZED INVESTMENTS FOR ALL FUNDS: SECURITIES NOT OTHERWISE SPECIFIED. (a) Notwithstanding any express or implied prohibitions, and subject to this section, an insurer may invest any of the insurer's funds and accumulations in an investment that does not otherwise qualify under any other provision of this chapter.

(b) The amount of any one investment by an insurer under this section may not exceed one percent of the insurer's admitted assets.

(c) The aggregate amount of investments by an insurer under this section may not exceed the lesser of:

(1) five percent of the insurer's admitted assets; or

(2) the amount of the insurer's capital and surplus in excess of $200,000 as shown on the last annual statement filed by the insurer with the department before the date the investment is acquired.

(d) Except as provided by another law of this state, this section does not authorize an insurer to invest any of the insurer's funds or accumulations in real property. (V.T.I.C. Art. 3.39, Part I, Sec. A, Para. 15.)

Source Law

[Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively, . . . .

A. ANY OF ITS FUNDS AND ACCUMULATIONS]

15. Securities Not Otherwise Specified. Notwithstanding any expressed or implied prohibitions, a life insurance company may, after the effective date of this amendment, invest any of its funds and accumulations in investments which do not otherwise qualify under any other provision of Chapter 3 of the Insurance Code; provided, however, that the amount of any one such investment under this Section shall not exceed one per cent (1%) of the admitted assets of any such life insurance company; and provided further, that the investments authorized by this Section shall not exceed the lesser of (a) five per cent (5%) of its admitted assets, or (b) the amount of its capital and surplus in excess of Two Hundred Thousand Dollars ($200,000) as shown on its last annual statement preceding the date of the acquisition of such investment as filed with the State Board of Insurance.

Nothing herein shall be construed or applied so as to authorize any life insurance company to invest any of its funds or accumulations in real property unless already authorized to do so by this Act or some other existing law of the State of Texas. . . .

Revisor's Note

(1) Paragraph 15, Section A, Part I, V.T.I.C. Article 3.39, provides that a life insurance company may, "after the effective date of this amendment," invest any of its funds in investments that do not otherwise qualify under another provision of V.T.I.C. Chapter 3. The revised law omits "after the effective date of this amendment" as unnecessary because the quoted language means that the law is to apply prospectively. Under Section 311.022, Government Code (Code Construction Act), which applies to the revised law, a statute is presumed to operate prospectively unless expressly made retroactive.

(2) Paragraph 15, Section A, Part I, V.T.I.C. Article 3.39, refers to "investments which do not otherwise qualify under any other provision of Chapter 3 of the Insurance Code." V.T.I.C. Chapter 3 is revised in many chapters of this code. The relevant provisions of V.T.I.C. Chapter 3--those that regulate the investments of life insurers--are revised in this chapter. The revised law is drafted accordingly.

Revised Law

Sec. 425.219. AUTHORIZED INVESTMENTS FOR POLICY RESERVES AND SURPLUS: BONDS OF CERTAIN WATER CONTROL AND IMPROVEMENT DISTRICTS. An insurer may invest the insurer's policy reserves and surplus over and above the insurer's capital in municipal bonds issued under Section 51.039, Water Code. (V.T.I.C. Art. 3.39, Part I, Sec. B.)

Source Law

> [Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively,] . . . .
>
> B. POLICY RESERVES AND SURPLUS
>
> 1. Specified Municipal Bonds. It may invest its policy reserves and surplus over and above its capital in "Municipal Bonds" issued under and by virtue of Chapter 280, Acts 1929, 41st Legislature.

Revisor's Note

Section B, Part I, V.T.I.C. Article 3.39, refers to "Chapter 280, Acts 1929, 41st Legislature." Section 18 of that act (originally classified as Article 7880-19a, Vernon's Texas Civil Statutes), which provided for the issuance of bonds by water control and improvement districts that are operating as municipal districts, was codified in 1971 as Section 51.039, Water Code. The revised law is drafted accordingly.

Revised Law

Sec. 425.220. AUTHORIZED INVESTMENTS FOR CAPITAL, SURPLUS, AND CONTINGENCY FUNDS: CAPITAL STOCK, BONDS, AND OTHER CORPORATE OBLIGATIONS. (a) Subject to this section and Section 425.226, an insurer may invest the insurer's capital, surplus, and contingency funds in the capital stock, bonds, bills of exchange, or other commercial notes or bills and securities of:

(1) a solvent corporation that has not defaulted in the payment of any debt during the five years preceding the investment; or

(2) a solvent corporation that has not been in existence for the five years preceding the investment, if:

(A) the corporation has succeeded to the business and assets and has assumed the liabilities of another corporation; and

(B) neither the successor corporation nor the corporation succeeded has defaulted in the payment of any debt during the five years preceding the investment.

(b) An insurer may not invest in the stock of:

(1) a manufacturing corporation with a net worth of less than $25,000; or

(2) an oil corporation with a net worth of less than $500,000.

(c) Except as provided by Subsection (d), an insurer's investment in the insurer's own capital stock or in the stock of a single corporation may not be in an amount exceeding 10 percent of the amount of the insurer's capital, surplus, and contingency funds.

(d) An insurer may own, and the insurer may invest not more than 25 percent of the insurer's capital, surplus, and contingency funds in, the capital stock of a single fire and casualty insurance company if that investment gives the insurer a majority of the outstanding stock of the fire and casualty insurance company.

(e) In addition to the investments authorized by this section and subject to Section 425.226, an insurer may invest in the capital stock, bonds, and other obligations of one or more solvent corporations that portion of the insurer's surplus funds that exceeds the greater of:

(1) 10 percent of the insurer's admitted assets, as determined from the insurer's latest annual statement on file with the department; or

(2) the minimum capital and surplus requirements for incorporating a life insurance company under Chapter 841. (V.T.I.C. Art. 3.39, Part I, Sec. C, Paras. 1, 3.)

Source Law

[Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively,] . . . .

C. CAPITAL, SURPLUS AND CONTINGENCY FUNDS OVER AND ABOVE POLICY RESERVES

It may invest its capital, surplus and contingency funds over and above the amount of its policy reserves in the following securities:

1. Capital Stock, Bonds, and Other Obligations of Corporations. The capital stock, bonds, bills of exchange, or other commercial notes or bills and securities of any solvent corporation which has not defaulted in the payment of any debt within five (5) years next preceding such investment, or of any solvent corporation which has not been in existence for five (5) consecutive years next preceding such investment, provided such corporation has succeeded to the business and assets and has assumed the liabilities of another corporation, and which corporation and the corporation so succeeded have not defaulted in the payment of any debt within five (5) years next preceding such investment.

3. Limitation of Investments. It may not invest in its own capital stock nor in the stock of any one corporation to any extent more than ten per cent (10%) of the amount of its own capital, surplus, and contingent funds, nor in the stock of any manufacturing corporation with a net worth of less than Twenty-Five Thousand Dollars ($25,000), nor in the stock of any oil corporation with a net worth of less than Five Hundred Thousand Dollars ($500,000); provided, however, that it may own and invest not more than twenty-five per cent (25%) of its capital, surplus and contingency funds in the capital stock of one fire and casualty insurance company, provided such investment gives it a majority of the outstanding stock of such fire and casualty insurance company; and provided further, it may additionally invest that portion of its surplus funds which is in excess of the greater amount of either (a) ten per cent (10%) of its admitted assets as determined from its latest annual statement on file with the State Board of Insurance or (b) the minimum capital and surplus requirements for incorporating a life insurance company under Chapter 3 of the Insurance Code, as amended, as it may be amended, in the capital stock, bonds and other obligations of any one or more solvent corporations.

Revisor's Note

(1) Paragraphs 1 and 3, Section C, Part I, V.T.I.C. Article 3.39, provide that an insurer may invest its capital, surplus, and contingency funds in capital stock, bonds, and other corporate obligations, subject to limitations in those paragraphs. Paragraph 4, Section F, Part I, V.T.I.C. Article 3.39, which is

revised in this chapter as Section 425.226, contains an additional limitation on investment of those funds in corporate obligations. For the reader's convenience, the revised law includes a reference to the limitations in Section 425.226.

(2) Paragraph 3, Section C, Part I, V.T.I.C. Article 3.39, refers to "the minimum capital and surplus requirements for incorporating a life insurance company under Chapter 3 of the Insurance Code, as amended." The relevant requirements from V.T.I.C. Chapter 3 are revised in Chapter 841 of this code, and the revised law is drafted accordingly. The revised law omits the reference to "as amended" for the reason stated in Revisor's Note (2) to Section 425.058.

Revised Law

Sec. 425.221. AUTHORIZED INVESTMENTS FOR CAPITAL, SURPLUS, AND CONTINGENCY FUNDS: BONDS OR NOTES OF EDUCATIONAL OR RELIGIOUS CORPORATIONS. Subject to Section 425.226, an insurer may invest the insurer's capital, surplus, and contingency funds in a bond or note of an educational or religious corporation that has provided for the payment of a sufficient amount of the first weekly or monthly revenues of the corporation to an interest and sinking fund account in a bank or trust company as an independent paying agent. (V.T.I.C. Art. 3.39, Part I, Sec. C, Para. 2.)

Source Law

[Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively,] . . . .

[C. CAPITAL, SURPLUS AND CONTINGENCY FUNDS OVER AND ABOVE POLICY RESERVES

It may invest its capital, surplus and contingency funds over and above the amount of its policy reserves in the following securities:]

2. Bonds or Notes of Educational or Religious Corporations. The bonds or notes of any educational or religious corporation where provision has been made for the payment of a sufficient amount of the first weekly or monthly revenues thereof to an interest and sinking fund account in a bank or trust company as an

independent paying agent.

Revisor's Note

Paragraph 2, Section C, Part I, V.T.I.C. Article 3.39, provides that an insurer may invest its capital, surplus, and contingency funds in bonds or notes of educational or religious corporations. The revised law includes a reference to the limitations in Section 425.226 for the reason stated in Revisor's Note (1) to Section 425.220.

Revised Law

Sec. 425.222. AUTHORIZED INVESTMENTS FOR CAPITAL, SURPLUS, AND CONTINGENCY FUNDS: LIFE INCOME INTERESTS IN QUALIFIED TRUSTS. (a) Subject to this section, an insurer may invest the insurer's capital, surplus, and contingency funds in a life income interest in a qualified irrevocable express testamentary trust.

(b) For purposes of this section, a trust is a qualified trust if:

(1) each fee simple recipient of any part of the corpus of the trust:

(A) is a public charity, church, educational institution, or scientific institution;

(B) is located in this state; and

(C) is recognized by the United States Internal Revenue Service as exempt from payment of income taxes;

(2) the corpus of the trust is wholly or partly composed of interests in real estate, stocks, bonds, debentures, and other securities of an aggregate total value of at least $5 million; and

(3) the corpus of the trust produces annual income of at least $100,000.

(c) An insurer's life income interest in a qualified trust may not exceed 10 percent of the insurer's admitted assets.

(d) Before an insurer may acquire a life income interest in a qualified trust, the insurer must present evidence satisfactory

to the commissioner that shows:

(1) the interest is subject to transfer and is recognized as transferable;

(2) the interest is capable of reasonable valuation;

(3) a market for the sale of the interest exists; and

(4) the interest is supported by life insurance in:

(A) an amount not less than the admitted value of the interest; and

(B) a form approved by the commissioner.

(e) In valuing a life income interest in a qualified trust on the insurer's books, the insurer may value the interest only on the basis of the lesser of:

(1) the recognized market established in accordance with Subsection (d)(3); or

(2) the ratio that the fractional life income interest in the income of the trust bears to the total market value of the properties held by the trust that are of a type of property an insurer may lawfully acquire under the investment statutes of this state. (V.T.I.C. Art. 3.39, Part I, Sec. C, Para. 4.)

Source Law

[Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively,] . . . .

[C. CAPITAL, SURPLUS AND CONTINGENCY FUNDS OVER AND ABOVE POLICY RESERVES

It may invest its capital, surplus and contingency funds over and above the amount of its policy reserves in the following securities:]

4. Certain Life Income Interests. (a) Life income interest in an irrevocable express testamentary trust that has as the fee simple recipient of all the corpus of the trust one or more Texas public charities, Texas churches, Texas educational institutions or Texas scientific institutions; provided each recipient is recognized by the Internal Revenue Service of the United States as exempt from payment of income taxes and provided further that (1) the corpus of any such trust is in whole or in part composed of interests in real estate, stocks, bonds, debentures and other securities of an aggregate total value of not less than $5,000,000; and (2) the corpus of any such trust produces annual income of not less than $100,000.

(b) No life insurance company's interest in any

such trust shall exceed ten per cent (10%) of its admitted assets.

(c) Before such interest shall be acquired, satisfactory evidence shall be presented to the Commissioner of Insurance as follows:

(1) That the interest is subject to and recognized as transferable,

(2) That the interest is capable of reasonable valuation,

(3) That a market for sale of such interest exists,

(4) That the life income interest is supported by life insurance in an amount not less than its admitted value and in form approved by the Commissioner of Insurance.

(d) In valuing such interest on its books, the life insurance company shall value the interest only on the basis of the lesser of, (1) the recognized market established in accordance with Section (c)(3) above, or (2) the ratio that such fractional life income interest in the income of the trust bears to the total market value of the properties held by the trust that are of the type of property a life insurance company can lawfully acquire under the investment statutes of the State of Texas.

Revised Law

Sec. 425.223. AUTHORIZED INVESTMENTS FOR CAPITAL, SURPLUS, AND CONTINGENCY FUNDS: CAPITAL STOCK OF REINSURER. (a) Subject to Subsection (b), an insurer may invest the insurer's capital, surplus, and contingency funds in not more than 20 percent of the capital stock of any other insurance company organized under Chapter 841 whose principal business is the reinsurance, either wholly or partly, of risks ceded to that insurer by other life insurance companies.

(b) The aggregate amount of an insurer's investments under this section may not exceed 10 percent of the insurer's capital, surplus, and contingency funds.

(c) The investment authorized by this section may be made by purchase of stock issued and outstanding or by subscription to and payment for the increase in the capital stock of the reinsurer. (V.T.I.C. Art. 3.39, Part I, Sec. D.)

Source Law

[Part I. A life insurance company organized under the laws of this state may invest its several funds, identified as follows, in the following securities, respectively,] . . . .

D. CAPITAL, SURPLUS AND CONTINGENCY FUNDS NOT TO EXCEED 10%

1. Capital Stock of Other Insurance

Corporations. It may invest not to exceed ten per cent (10%) of its capital, surplus, and contingency funds, in not more than twenty per cent (20%) of the capital stock of any other insurance company, now or hereafter organized under this Chapter, whose principal business is the reinsurance, either partially or wholly, of risks ceded to it by other life insurance companies. The investment herein authorized may be made by purchase of stock then issued and outstanding or by subscription to and payment for the increase in the capital stock of such reinsurance corporation.

Revisor's Note

Paragraph 1, Section D, Part I, V.T.I.C. Article 3.39, refers to an "insurance company . . . organized under this Chapter," meaning V.T.I.C. Chapter 3. The revised law refers to Chapter 841 of this code for the reason stated in Revisor's Note (2) to Section 425.220.

Revised Law

Sec. 425.224. AUTHORIZED INVESTMENTS FOR CAPITAL, SURPLUS, AND CONTINGENCY FUNDS: LOANS SECURED BY CORPORATE STOCK. (a) Subject to this section, an insurer may loan the insurer's capital, surplus, and contingency funds and take as collateral the capital stock, bonds, bills of exchange, or other commercial notes or bills or the securities of:

(1) a solvent corporation that has not defaulted in the payment of any debt during the five years preceding the investment; or

(2) a solvent corporation that has not been in existence for the five years preceding the investment, if:

(A) the corporation has succeeded to the business and assets and has assumed the liabilities of another corporation; and

(B) neither the successor corporation nor the corporation succeeded has defaulted in the payment of any debt during the five years preceding the investment.

(b) Subject to this section, an insurer may loan the insurer's capital, surplus, and contingency funds and take as collateral the bonds or notes of an educational or religious corporation that has provided for the payment of a sufficient

amount of the first weekly or monthly revenues of the corporation to an interest and sinking fund account in a bank or trust company as an independent paying agent.

(c) The market value of the stock, bills of exchange, other commercial notes or bills, or securities must be at all times during the continuance of the loan at least 50 percent more than the amount loaned on the securities or obligations.

(d) An insurer may not take as collateral for any loan:

(1) the insurer's capital stock;

(2) the stock of a single corporation in an amount that exceeds 10 percent of the amount of the insurer's own capital, surplus, and contingency funds;

(3) the stock of a manufacturing corporation with a net worth of less than $25,000;

(4) the stock of an oil corporation with a net worth of less than $500,000; or

(5) any stock, the holder or owner of which is or may become liable for any assessment other than taxes. (V.T.I.C. Art. 3.39, Part II, Sec. B.)

Source Law

[Part II. A life insurance company organized under the laws of this state may loan its several funds identified as follows, taking as collateral security for the payment of such loans the securities named below, and none other.]

B. CAPITAL, SURPLUS AND CONTINGENCY FUNDS OVER AND ABOVE POLICY RESERVES

1. Capital Stock, Bonds, and Other Obligations of Solvent Corporations, and Educational or Religious Corporations. It may loan its capital, surplus, and contingency funds, or any part thereof over and above the amount of its policy reserves, taking as security therefor the capital stock, bonds, bills of exchange, or other commercial notes or bills and the securities of any solvent corporation which has not defaulted in the payment of any debt within five (5) years next preceding such investment; or of any solvent corporation which has not been in existence for five (5) consecutive years next preceding such investment, provided such corporation has succeeded to the business and assets and has assumed the liabilities of another corporation, and which corporation and the corporation so succeeded have not defaulted in the payment of any debt within five (5) years next preceding such investment; or in the bonds or notes of any Educational or Religious Corporation where

provision has been made for the payment of a sufficient amount of the first weekly or monthly revenues thereof to an interest and sinking fund account in a bank or trust company as an independent paying agent; provided, the market value of such stock, bills of exchange, or other commercial notes or bills and securities shall be at all times during the continuance of such loan at least fifty per cent (50%) more than the sum loaned thereon; provided that it shall not take as collateral security for any loan its own capital stock, nor shall it take as collateral security for any loan the stock of any one corporation to any extent more than ten per cent (10%) of the amount of its own capital, surplus, and contingency funds, nor shall it take as collateral security for any loan the stock of any manufacturing corporation with a net worth of less than Twenty-Five Thousand Dollars ($25,000), nor the stock of any oil corporation with a net worth of less than Five Hundred Thousand Dollars ($500,000); and provided further, that it shall not take as collateral security for any such loan any stock on account of which the holder or owner thereof may in any event be or become liable to any assessment except for taxes.

Revised Law

Sec. 425.225. INVESTMENT IN FOREIGN SECURITIES. (a) An insurer authorized to engage in business in a foreign country may invest in securities of that country that are the same kind of securities as those in the United States in which an insurer is authorized by this subchapter to invest.

(b) The aggregate amount of an insurer's investments under this section may not exceed the amount of the insurer's reserves on the business in force in the foreign country. (V.T.I.C. Art. 3.39, Part I, Sec. F, Para. 1.)

Source Law

F. GENERAL

1. Investment in Foreign Securities. Any such company legally authorized to transact business in a foreign country may invest in the same kind of securities of said country as hereinbefore authorized in the United States of America for an aggregate amount not exceeding the reserve on the business in force in said country.

Revisor's Note

Paragraph 1, Section F, Part I, V.T.I.C. Article 3.39, refers to an insurer that is "legally authorized to transact business in a foreign country." The revised law omits "legally" as unnecessary. A company that is "authorized" to transact business in a foreign

country is "legally authorized" to do so.

Revised Law

Sec. 425.226. INVESTMENT IN STOCK SUBJECT TO ASSESSMENT PROHIBITED. An insurer may not invest any of the insurer's funds in a stock, the holder or owner of which is or may become liable for any assessment other than taxes. (V.T.I.C. Art. 3.39, Part I, Sec. F, Para. 4.)

Source Law

> 4. Not to Invest in Stock Subject to Assessment. No such insurance company shall invest any of its funds in any stock on account of which the holder or owner thereof may in any event be or become liable to any assessment except for taxes.

Revised Law

Sec. 425.227. CERTAIN INVESTMENT POWERS NOT A RESTRICTION. The investment powers granted by Sections 425.207 and 425.208 may not be construed as restricting the powers granted by Sections 425.220 and 425.221. (V.T.I.C. Art. 3.39, Part I, Sec. F, Para. 5.)

Source Law

> 5. Certain Investment Privileges Are Cumulative. The investment powers conferred by Paragraphs Nos. 11 and 12, Section A, are in addition to those conferred by Paragraphs Nos. 1, 2 and 3, Section C, and are not to be construed as restricting the powers already granted by said Paragraphs Nos. 1, 2 and 3 of Section C and Paragraphs Nos. 11 and 12, Section A, and the powers conferred herein are cumulative with respect to Paragraphs Nos. 1, 2 and 3, Section C, and the powers conferred therein.

Revisor's Note

Paragraph 5, Section F, Part I, V.T.I.C. Article 3.39, provides that the "investment powers conferred by Paragraphs Nos. 11 and 12, Section A, are in addition to those conferred by Paragraphs Nos. 1, 2 and 3, Section C," and that "the powers conferred herein are cumulative with respect to Paragraphs Nos. 1, 2 and 3, Section C, and the powers conferred therein." The revised law omits the quoted language 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.

Revised Law

Sec. 425.228. INVESTMENTS OF CEDING INSURER. (a) Subject to this section, if a domestic insurer assumes the business and takes over the assets of another domestic or a foreign insurer, all investments of the ceding insurer that were authorized, when made, by the laws of the state in which the ceding insurer was organized as proper securities for investment of the funds of an insurer and that are taken over by the assuming insurer are considered to be valid securities of the assuming insurer under the laws of this state.

(b) The commissioner must approve investments described by Subsection (a) and the terms on which those investments are taken over. The commissioner may require the assuming insurer to dispose of any of the investments on notice the commissioner considers reasonable. (V.T.I.C. Art. 3.39, Part I, Sec. F, Para. 3.)

Source Law

> 3. Investments of Companies Reinsured. In any case in which a life insurance company organized under the laws of this state shall reinsure the business and take over the assets of another life insurance company, either domestic or foreign, all investments of such reinsured company that were authorized, when made, by the laws of the state in which it was organized, as proper securities for investment of the funds of a life insurance company, and which are taken over by such reinsuring company, shall be considered as valid securities of such reinsuring company under the laws of this state, provided such investments are approved by the Board of Insurance Commissioners of this state, and the same are taken over on terms satisfactory to said Board; and upon the condition that the Board of Insurance Commissioners shall have the power to require the reinsuring company to dispose of such investments upon such notice as it may deem reasonable.

Revised Law

Sec. 425.229. AUTHORIZED INVESTMENTS: REAL ESTATE FOR INSURER'S OFFICES. (a) Subject to this section, an insurer may secure, hold, and convey the following real property:

(1) one building site and office building for the

insurer's accommodation in the transaction of the insurer's business and for lease;

(2) branch office buildings in this state and elsewhere within the United States in which the insurer is authorized to engage in business as necessary for the insurer's convenient accommodation in the transaction of the insurer's business and for lease; and

(3) parking facilities adjacent to or in the vicinity of each office building owned by the insurer as reasonably necessary for the insurer and the building tenants.

(b) An office building described by Subsection (a)(1) may be on ground on which the insurer owns a lease the term of which expires not sooner than the 50th anniversary of the date the insurer acquires the lease. The insurer must own, or be entitled to the use of, all the improvements on the leased ground. The value of the improvements must be at least equal to the value of the ground and at least 20 times the annual average ground rentals payable under the lease. The office building must have an annual average net rental of at least twice the annual ground rental. The insurer must be liable for and shall pay all state and local taxes imposed against the ground and improvements. For purposes of taxation, the ground and improvements are considered to be real property owned by the insurer. The commissioner must approve the acquisition of an office building on leased ground before the insurer makes the investment.

(c) The insurer must use at least 50 percent of the space in each branch office building under Subsection (a)(2) that is available for occupancy for business purposes for the transaction of the insurer's business and not for lease to others.

(d) An insurer may make an investment under Subsection (a)(2) or (3) only in a municipality that has a population of 15,000 or more.

(e) An insurer may not make an investment under this section if, after making the investment, the insurer's aggregate

investments under this section would exceed 33-1/3 percent of the insurer's admitted assets as of December 31 preceding the date of the investment, except that an insurer's aggregate investments under this section may be increased to an amount not to exceed 50 percent of the insurer's admitted assets if the commissioner approves the investment in advance, and the investment may be further increased if the additional increase is paid for only from surplus funds and is not included as an admitted asset of the insurer.

(f) The value of each investment under this section is subject to the approval of the commissioner. The commissioner may, at the time the investment is made or any time when an examination of the insurer is being made, have an investment under this section appraised by an appraiser appointed or approved by the commissioner. The insurer shall pay the reasonable expense of the appraisal. The expense of the appraisal is considered to be an expense of the examination of the insurer. An insurer may not make any increase in the valuation of real property described by Subsection (a) unless the increase in valuation is approved by the commissioner, subject to the conditions imposed by Subsection (e). (V.T.I.C. Art. 3.40 (part).)

Source Law

Art. 3.40. Every such insurance company may secure, hold and convey real property only for the following purposes and in the following manner:

1(a). One building site and office building for its accommodation in the transaction of its business and for lease and rental; and such office building may be on ground on which the company owns a lease having not less than fifty (50) years to run from the date of its acquisition by the company, provided that the company shall own, or be entitled to the use of, all the improvements thereon, and that the value of such improvements shall at least equal the value of the ground, and shall be not less than twenty (20) times the annual average ground rentals payable under such lease; and provided such office building shall have an annual average net rental of at least twice such annual ground rental; and provided further, that such company shall be liable for and shall pay all state and local taxes levied and assessed against such ground and the improvements thereon, which for the purposes of taxation shall be deemed real estate owned by the company. Provided that an acquisition of such an office building on leased ground shall be approved by

the State Board of Insurance before such investment.

Branch office buildings in the State of Texas and elsewhere within the United States wherein such company is authorized to do business as shall be requisite for its convenient accommodation in the transaction of its business and for lease and rental and also parking facilities adjacent to or in the vicinity of each office building owned by such insurance company as shall be reasonably requisite for such insurance company and tenants of the buildings; however, at least fifty per cent (50%) of the space in each such branch office building which is available for occupancy for business purposes shall be used by such insurance company for the transaction of its business and not for lease and rental to others; provided, however, that such investments in the properties described in this paragraph shall only be made in towns or cities having a population of fifteen thousand (15,000) or more according to the last Federal Census.

1(b). No such company shall make any investment in the properties described in Subdivision 1(a) above if, after making such investment, the total investment of the company in such properties is in excess of thirty-three and one-third per cent (33 1/3%) of its admitted assets as of December 31st next preceding the date of such investment; provided, however, that such investment may be increased to as much as fifty per cent (50%) of the company's admitted assets upon advance approval by the State Board of Insurance; provided further, that such investment may be further increased if the amount of such additional increase is paid for only from surplus funds and is not included as an admitted asset of the company.

1(c). The value of each such investment in the properties described in Subdivision 1(a) shall be subject to the approval by the State Board of Insurance; and the Board may, in its discretion, at the time such investment is made or any time when an examination of the company is being made, cause any such investment to be appraised by an appraiser appointed or approved by the Board, and the reasonable expense of such appraisal shall be paid by such insurance company and shall be deemed to be a part of the expense of examination of such company. No such insurance company may hereafter make any increase in the valuation of any of the properties described in Subdivision 1(a) unless and until such increased valuation shall be likewise approved by the Board, subject to the limitations and conditions set out in Subdivision 1(b);

. . .

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 3.40, refers to securing and holding an office building "for lease and rental." The revised law omits the reference to "rental" as unnecessary because the meaning of that term is included in the meaning of "lease."

(2) Section 1(a), V.T.I.C. Article 3.40, refers to taxes "levied and assessed" against ground and

improvements used as an insurer's office building. Such taxes would be ad valorem taxes subject to Title 1, Tax Code. The revised law substitutes "imposed" for "levied and assessed" because "impose" is the term generally used in Title 1, Tax Code, and includes both the levy and assessment of an ad valorem tax.

(3) Section 1(a), V.T.I.C. Article 3.40, refers to "towns or cities." The revised law substitutes "municipality" for "town or city" for the reason stated in Revisor's Note (6) to Section 425.002.

(4) Section 1(a), V.T.I.C. Article 3.40, describes a population number that is to be determined according to "the last Federal Census." The revised law omits the reference to the federal census as unnecessary. Section 311.005(3), Government Code (Code Construction Act), defines "population" as population according to the most recent federal decennial census. That definition applies to the revised law.

(5) Section 1(c), V.T.I.C. Article 3.40, refers to the "limitations and conditions" of Section 1(b) of that article. The revised law omits the reference to "limitations" as unnecessary because the meaning of that term is included in the meaning of "conditions."

Revised Law

Sec. 425.230. AUTHORIZED INVESTMENTS: OIL, GAS, AND MINERALS. (a) In this section and Section 425.231:

(1) "Producing" means producing oil, gas, or other minerals in paying quantities. A well that has been shut in is considered to be producing oil, gas, or other minerals in paying quantities if shut-in royalties are being paid.

(2) "Production payment" means a right to oil, gas, or other minerals in place or as produced that entitles the owner of the right to a specified fraction of production until the owner

receives a specified amount of money, or a specified number of units of oil, gas, or other minerals.

(3) "Royalty" or "overriding royalty" means a right to oil, gas, and other minerals in place or as produced that entitles the owner of the right to a specified fraction of production without limitation to a specified amount of money or a specified number of units of oil, gas, or other minerals.

(b) Subject to this section, in addition to and without limitation on the purposes for which real property may be acquired, secured, held, or retained under Section 425.229 or 425.231, an insurer may secure, hold, retain, and convey production payments, producing royalties, and producing overriding royalties as an investment for the production of income.

(c) The aggregate amount of an insurer's investments under this section, plus the aggregate amount of the insurer's investments in home office and branch office properties under Section 425.229, may not exceed the total amount permitted by and is subject to all of the limitations imposed by Sections 425.229(e) and (f). For purposes of this subsection, an investment in production payments, producing royalties, or producing overriding royalties is considered to be an investment in property described by Section 425.229.

(d) For the purposes of Section 425.229(f), the commissioner may establish a value of a production payment, producing royalty, or producing overriding royalty as the maximum amount that the insurer purchasing the production payment, producing royalty, or producing overriding royalty could loan against a first lien on the production payment, producing royalty, or producing overriding royalty under Sections 425.214(f)-(h).

(e) An insurer may not make an investment in production payments, producing royalties, or producing overriding royalties solely for the production of income if, after making the investment, the insurer's total investment at cost in the production payments, producing royalties, or producing overriding

royalties would exceed 10 percent of the insurer's admitted assets as of December 31 preceding the date of the investment.

(f) If production in paying quantities from a royalty interest or overriding royalty interest held by an insurer ends, the insurer shall sell and dispose of the royalty or overriding royalty not later than the second anniversary of the date the production ends, unless:

(1) production in paying quantities has resumed; or

(2) the insurer obtains from the commissioner a certificate stating that the insurer's interests will suffer materially by the forced sale of the interest.

(g) The commissioner shall state in a certificate under Subsection (f)(2) the amount of time by which the period for sale is extended under that subsection. (V.T.I.C. Art. 3.40 (part).)

Source Law

Art. 3.40. . . .

In addition to, and without limitation on, the purposes for which real property may be acquired, secured, held or retained pursuant to other provisions of this Article, every such insurance company may secure, hold, retain and convey production payments, producing royalties and producing overriding royalties as an investment for the production of income; provided, however, that the total amount of all such investments in production payments, producing royalties and producing overriding royalties plus the total amount of investments in home office and branch office properties under Subdivision 1(a) of this Article shall not exceed the total amount permitted by and shall be subject to all of the limitations and restrictions of Subdivisions 1(b) and 1(c) of this Article and for this purpose all investments in production payments, producing royalties and producing overriding royalties pursuant to the provisions of this paragraph shall be deemed to be "properties described in Subdivision 1(a)" of this Article; and provided further, that in valuing each such production payment, producing royalty and producing overriding royalty for the purposes of Subdivision 1(c) of this Article the State Board of Insurance may establish such value as being the maximum amount which the company purchasing such production payment, producing royalty and producing overriding royalty could loan against a first lien on such production payment, producing royalty and producing overriding royalty under the provisions of Part II, Section A, Subsection 2 of Article 3.39 of the Insurance Code; and provided further, no such company shall make any investment in such production payments, producing royalties and producing overriding royalties solely as an investment for the production of income if, after making such investment, the total

investment of the company at cost in such production payments, producing royalties and producing overriding royalties is in excess of ten per cent (10%) of its admitted assets as of December 31st next preceding the date of such investment. For the purposes of this paragraph, a production payment is defined to mean a right to oil, gas or other minerals in place or as produced that entitles its owner to a specified fraction of production until a specified sum of money, or a specified number of units of oil, gas or other minerals, has been received; a royalty and an overriding royalty are each defined to mean a right to oil, gas and other minerals in place or as produced that entitles the owner to a specified fraction of production without limitation to a specified sum of money, or a specified number of units of oil, gas or other minerals; "producing" is defined to mean producing oil, gas or other minerals in paying quantities, provided that it shall be deemed that oil, gas or other minerals are being produced in paying quantities if a well has been "shut in" and "shut in royalties" are being paid. In the event production in paying quantities should cease from any such royalty interest or overriding royalty interest held by any insurance company, such royalty or overriding royalty shall be sold and disposed of within two (2) years after such production shall have ceased, unless production in paying quantities shall have been resumed, or unless such Insurance Company shall have procured a certificate from the Board that its interests will suffer materially by the forced sale thereof; in which event the sale may be extended to such time as the Board shall direct in such certificate.

Revisor's Note

V.T.I.C. Article 3.40 refers to "the limitations and restrictions" of Sections 1(b) and (c) of that article. The revised law omits the reference to "restrictions" as unnecessary because the meaning of that term is included in the meaning of "limitations."

Revised Law

Sec. 425.231. AUTHORIZED INVESTMENTS: REAL PROPERTY ACQUIRED UNDER CERTAIN CIRCUMSTANCES. (a) Subject to this section, an insurer may secure, hold, and convey the following real property:

(1) real property acquired in good faith as security for a loan previously contracted or for money due;

(2) real property conveyed to the insurer to satisfy a debt previously contracted in the course of the insurer's dealings; and

(3) real property purchased at a sale under a

judgment, court decree, or mortgage or other lien held by the insurer.

(b) An insurer shall sell and dispose of all property described by Subsection (a) that is not necessary for the insurer's accommodation in the convenient transaction of the insurer's business, other than an interest in minerals or royalties reserved on the sale of land acquired under Subsection (a) or an interest in producing royalties or producing overriding royalties otherwise acquired, not later than the fifth anniversary of:

(1) the date the insurer acquires title to the property; or

(2) the date the property ceases to be necessary for the accommodation of the insurer's business.

(c) An insurer may hold property acquired under Subsection (a) for a period longer than that specified by Subsection (b) if the insurer obtains a certificate from the commissioner stating that the insurer's interests will suffer materially by the forced sale of the property. The commissioner shall state in the certificate the amount of time by which the period for sale is extended under this subsection. (V.T.I.C. Art. 3.40 (part).)

Source Law

> Art. 3.40. Every such insurance company may secure, hold and convey real property only for the following purposes and in the following manner:
>
> . . .
>
> 2. Such as have been acquired in good faith by way of security for loans previously contracted or for moneys due;
>
> 3. Such as have been conveyed to it in the satisfaction of debts previously contracted in the course of its dealings;
>
> 4. Such as have been purchased at sales under judgment or decrees of court, or mortgage or other liens held by such companies.
>
> 5. All such real property specified in Subdivisions 2, 3, and 4 of this Article which shall not be necessary for its accommodation in the convenient transactions of its business, except interests in minerals and royalties reserved upon the sale of land acquired under such Subdivisions 2, 3, and 4 hereof, and further excepting interests in producing royalties and producing overriding royalties otherwise acquired, shall be sold and disposed of within five (5) years after the company shall have acquired title to the same, or within five (5) years after the same shall have ceased to be necessary for

the accommodation of its business. It shall not hold such property for a longer period, unless it shall procure a certificate from the Board that its interests will suffer materially by the forced sale thereof; in which event the time for the sale may be extended to such time as the Board shall direct in such certificate.

. . .

Revised Law

Sec. 425.232. AUTHORIZED INVESTMENTS: IMPROVED INCOME-PRODUCING REAL PROPERTY. (a) In this section, "improved income-producing real property" includes all commercial and industrial real property, a substantial portion of which has been materially enhanced in value by the construction of durable, permanent-type buildings and other improvements costing an amount at least equal to the value of the real property, excluding the buildings and improvements, that is held or acquired by purchase, lease, or otherwise for the production of income. The term does not include agricultural, horticultural, farm and ranch, or residential property, or single or multiunit family dwelling property.

(b) Notwithstanding Sections 425.229, 425.230, and 425.231, subject to this section, a domestic insurer may:

(1) invest any of the insurer's funds and accumulations in improved income-producing real property or any interest in improved income-producing real property; and

(2) hold, improve, maintain, manage, lease, sell, or convey improved income-producing real property or an interest in improved income-producing real property.

(c) The aggregate amount of an insurer's investments in all income-producing real property, including improvements, may not exceed 15 percent of the insurer's admitted assets. The amount of an insurer's investment in a single piece of improved income-producing real property, including improvements, may not exceed five percent of the insurer's admitted assets. For purposes of this subsection, an insurer's admitted assets are determined from the insurer's annual statement as of the preceding December 31 and filed with the department as required by law. Section

425.229(f) applies to the value of any investment made under this section.

(d) The investment authority granted by this section is in addition to that granted by Sections 425.229, 425.230, and 425.231, except that an insurer may not make an investment in improved income-producing real property that, when added to the insurer's investments under Section 425.229, would exceed the limitations imposed by Section 425.229(e).

(e) This section does not permit an insurer to purchase undeveloped real property for the purpose of development or subdivision. (V.T.I.C. Art. 3.40-1, Secs. 1, 3.)

Source Law

Art. 3.40-1

Sec. 1. Notwithstanding any provision or limitation of Article 3.40 of this Code, any life insurance company organized under the laws of this state may invest any of its funds and accumulations in improved income producing real estate or any interest therein, and may hold, improve, maintain, manage, lease, sell or convey such property or interest therein, subject to the following terms, conditions and limitations:

(1) The term "improved income producing real estate" as used in this Article shall include all commercial and industrial real property, a substantial portion of which has been materially enhanced in value by the construction of durable, permanent-type buildings and other improvements costing an amount at least equal to the value of such real estate exclusive of building and improvements, as may be held or acquired by purchase or lease, or otherwise, for the production of income, excepting any agricultural, horticultural, farm and ranch property, residential property, single or multiunit family dwelling property, which is expressly excluded.

(2) The total amount invested by any such company in all such income producing property and improvements thereof shall not exceed fifteen per centum of its admitted assets, provided, however, that the amount invested in any one such property and its improvements shall not exceed five per centum of its admitted assets. The admitted assets of the company at any time shall be determined from its annual statement made as of the last preceding December 31 and filed with the State Board of Insurance as required by law. The value of any investment made under this Article shall be subject to Subdivision 1(c) of Article 3.40 of this Code.

(3) The investment authority granted by this Article 3.40-1 is in addition to and separate and apart from that granted by Article 3.40 of this Code, provided, however, that no such company shall make any investment in the properties described in this Article 3.40-1 which when added to those described in subdivision 1(a) of Article 3.40 of this Code would be

in excess of the limitations provided by subdivision 1(b) of Article 3.40 of this Code.

Sec. 3. Nothing contained in this Article shall permit such a life insurance company to purchase undeveloped real estate for the purpose of development or subdivision.

Revisor's Note

(1) Section 1, V.T.I.C. Article 3.40-1, refers to any "provision or limitation" of V.T.I.C. Article 3.40. The revised law omits the reference to "limitation" for the reason stated in the revisor's note to Section 425.130.

(2) Section 2, V.T.I.C. Article 3.40-1, provides that improved income-producing real estate owned by a life insurance company will not "be classified as 'Texas Securities.'" The revised law omits this provision as obsolete and unnecessary. Former V.T.I.C. Article 3.33, which required life insurance companies to invest a specific portion of their assets in "Texas securities," was repealed by Chapter 332, Acts of the 58th Legislature, Regular Session, 1963. The omitted law reads:

> Sec. 2. The property owned by such life insurance company pursuant to this Article shall not be classified as "Texas Securities".

(3) Section 4, V.T.I.C. Article 3.40-1, limits the amount of a life insurance company's investments in improved income-producing real estate "during the first seven years after the effective date of this Act." The revised law omits this provision as expired. Article 3.40-1 was enacted by Chapter 660, Acts of the 60th Legislature, Regular Session, 1967, and took effect August 28, 1967. The omitted law reads:

> Sec. 4. No life insurance company may invest more than one per centum of its admitted assets in income producing real estate in any one year during the first seven years after the effective date of this Act, provided, however, if a life insurance company invests less than one per centum of

its admitted assets in income producing real estate during any one year such life insurance company may thereafter, at any time, invest the difference between the percentage of admitted assets invested and one per centum of admitted assets and such percentage shall be in addition to and cumulative of the amount of income producing real estate in which such life insurance company may invest in any particular year hereunder.

Revisor's Note
(End of Subchapter)

Section E, Part I, V.T.I.C. Article 3.39, prescribes authorized investments, at the time of incorporation, for the capital and surplus of stock life insurance companies "organized under Article 3.02 of this Code" and of mutual life insurance companies "organized under Article 11.01 of this Code." Section E also contains provisions relating to the investment of those companies' capital and surplus after incorporation. The revised law omits Section E as unnecessary. As to stock life insurance companies, Section E duplicates requirements of Sections 841.054(c) (capital and surplus requirements on incorporation) and 841.201 of this code (investment of capital and surplus after a charter is granted) (both sections were formerly part of V.T.I.C. Article 3.02). As to mutual life insurance companies, Section E duplicates Section 882.055 of this code (surplus requirements on incorporation) and Sections 882.301 and 882.304 of this code (investment of surplus after a charter is granted) (all three sections were formerly part of V.T.I.C. Article 11.01). The omitted law reads:

E. MINIMUM CAPITAL AND SURPLUS

1. Requirement as to Investment of Minimum Capital and Surplus. Notwithstanding other provisions of this Article 3.39 of this Code, the capital and surplus of a company hereafter organized under Article 3.02 of this Code and the free surplus of a company hereafter organized under Article 11.01 of this Code shall, at

the time of incorporation, consist only of lawful money of the United States, or bonds of the United States, or of this state, or of any county or incorporated municipality thereof, or government insured mortgage loans which are otherwise authorized by this Chapter, and shall not include any real estate; provided, however, that fifty per cent (50%) of the minimum capital may be invested in first mortgage real estate loans; and the minimum capital of a company hereafter organized under said Article 3.02 and the minimum free surplus of a company hereafter organized under said Article 11.01 at all times shall be maintained in cash or in the same classes of investments. After the granting of charter the surplus in excess of such One Hundred Thousand Dollars ($100,000) may be invested as otherwise provided in this Code for Stock Companies.

CHAPTER 426. RESERVES FOR WORKERS' COMPENSATION INSURANCE COMPANIES

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Sec. 426.002. COMPUTATION OF RESERVES . . . . . 407

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CHAPTER 426. RESERVES FOR WORKERS' COMPENSATION INSURANCE COMPANIES

Revised Law

Sec. 426.001. RESERVES REQUIRED. A workers' compensation insurance company engaged in business in this state shall maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses and claims incurred, whether reported or unreported. The company may not maintain reserves in an amount that is greater than reasonably necessary for that purpose. (V.T.I.C. Art. 5.61, Sec. (a) (part).)

Source Law

Art. 5.61. (a) Each workers' compensation insurer transacting business in this state shall maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses and claims incurred, whether reported or unreported, but not in an amount greater than reasonably required for those purposes. . . .

Revisor's Note

V.T.I.C. Article 5.61 refers to a "workers' compensation insurer." Throughout this chapter, the

revised law substitutes "insurance company" for "insurer" for consistency with the terminology used in the Labor Code with respect to workers' compensation insurance.

Revised Law

Sec. 426.002. COMPUTATION OF RESERVES. Reserves required by Section 426.001 must be computed in accordance with any rules adopted by the commissioner to adequately protect insureds, secure the solvency of the workers' compensation insurance company, and prevent unreasonably large reserves. (V.T.I.C. Art. 5.61, Sec. (a) (part).)

Source Law

> (a) . . . The reserves shall be computed in accordance with any rules adopted by the commissioner for the purpose of adequately protecting the insureds, securing the solvency of the insurer, and preventing unreasonably large reserves.

Revised Law

Sec. 426.003. MAINTENANCE OF RESERVES; NOTICE OF NONCOMPLIANCE. (a) If a workers' compensation insurance company's reserves are determined under this chapter to be:

(1) inadequate, the commissioner shall notify the company and require the company to establish and maintain reasonable additional reserves; or

(2) unreasonably large, the commissioner shall notify the company and require the company to reduce the amount of reserves to a reasonable amount.

(b) Not later than the 60th day after the date of notification of noncompliance under Subsection (a), the company shall:

(1) restore compliance as required by Subsection (a); and

(2) file a statement of restored compliance, accompanied by any documentation required by the commissioner. (V.T.I.C. Art. 5.61, Secs. (b), (c).)

Source Law

(b) If the reserves are determined to be inadequate, the commissioner shall notify the insurer and require the insurer to establish and maintain reasonable additional reserves. If the reserves are determined to be unreasonably large, the commissioner shall notify the insurer and require the insurer to reduce its reserves to a reasonable amount.

(c) Not later than the 60th day after the date of the notification by the commissioner that its reserves have been determined not to be in compliance with the requirements of this article, the insurer shall restore compliance and file a statement of restored compliance, together with such documentation as the commissioner may require.

CHAPTER 427. SUBORDINATED INDEBTEDNESS

SUBCHAPTER A. GENERAL PROVISIONS

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[Sections 427.003-427.050 reserved for expansion]

SUBCHAPTER B. LOAN, ADVANCE, AND OTHER INDEBTEDNESS

Sec. 427.051. LOAN OR ADVANCE PERMITTED . . . . . 409

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CHAPTER 427. SUBORDINATED INDEBTEDNESS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 427.001. APPLICABILITY OF CHAPTER. This chapter applies to an insurer or health maintenance organization as defined by Section 401.001. (V.T.I.C. Art. 1.39, Sec. (a).)

Source Law

Art. 1.39. (a) This article applies to an insurer as that term is defined by Article 1.15A of this code.

Revisor's Note

Section (a), V.T.I.C. Article 1.39, refers to an insurer "as that term is defined by Article 1.15A" of the Insurance Code. Section 3(5), V.T.I.C. Article 1.15A, revised in this code as Section 401.001,

defines "insurer" to mean an insurer authorized to do business under the law of this state, including, among certain listed entities, "health maintenance organizations." For accuracy, Section 401.001 omits "health maintenance organization" from the listed entities and substitutes a separate definition of that term, because a "health maintenance organization" is not a traditional insurer. Consequently, the revised law refers to both an insurer and a health maintenance organization as defined by Section 401.001, and similar changes are made throughout this chapter.

Revised Law

Sec. 427.002. RULES. The commissioner shall adopt rules necessary to implement this chapter. (V.T.I.C. Art. 1.39, Sec. (f).)

Source Law

(f) The commissioner shall adopt rules as necessary to implement this article.

[Sections 427.003-427.050 reserved for expansion]

SUBCHAPTER B. LOAN, ADVANCE, AND OTHER INDEBTEDNESS

Revised Law

Sec. 427.051. LOAN OR ADVANCE PERMITTED. An insurer or health maintenance organization may obtain a loan or an advance, repayable with interest, of:

(1) cash;

(2) cash equivalents; or

(3) other assets that have a readily determinable value and are satisfactory to the commissioner. (V.T.I.C. Art. 1.39, Sec. (b) (part).)

Source Law

(b) An insurer may obtain a loan or an advance of cash, cash equivalents, or other assets that have a readily determinable value and are satisfactory to the commissioner, repayable with interest, and . . . .

Revised Law

Sec. 427.052. SUBORDINATED LIABILITY PERMITTED. (a) An

insurer or health maintenance organization may assume a subordinated liability for repayment of a loan or advance described by Section 427.051 and payment of interest on the loan or advance if the insurer or health maintenance organization and the creditor execute a written agreement stating that the creditor may be paid only out of that portion of the insurer's or health maintenance organization's surplus that exceeds the greater of:

(1) a minimum surplus amount set in the agreement; or

(2) a minimum surplus amount of $500,000.

(b) The department or commissioner may not require the agreement to provide a minimum surplus amount that is different from the amount described by this section. (V.T.I.C. Art. 1.39, Sec. (b) (part).)

Source Law

(b) An insurer [may obtain a loan or an advance of cash, cash equivalents, or other assets that have a readily determinable value and are satisfactory to the commissioner, repayable with interest, and] may assume a subordinated liability for repayment of the advance and payment of interest on the advance if the insurer and creditor execute a written agreement stating that the creditor may be paid only out of that portion of the insurer's surplus that exceeds the greater of a minimum surplus stated and fixed in the agreement or a minimum surplus of $500,000 for that insurer. The department or the commissioner may not require the agreement to provide another minimum surplus amount.

Revisor's Note

(1) Section (b), V.T.I.C. Article 1.39, provides that an insurer or health maintenance organization may obtain "a loan or an advance" and subsequently authorizes the insurer or health maintenance organization to assume a subordinated liability for repayment of "the advance" and payment of interest on "the advance." The revised law substitutes a reference to a "loan or advance" for references to "the advance" because, in context, the authorization to assume a subordinated liability and repayment of interest and other language throughout the article clearly applies to both a loan and an

advance. Similar changes are made throughout this chapter.

(2) Section (b), V.T.I.C. Article 1.39, refers to a minimum surplus amount that is "stated and fixed" in an agreement. The revised law substitutes "set" for the quoted language because, in context, "set" is synonymous with "fixed," and an amount that is "set" in the agreement is necessarily "stated."

Revised Law

Sec. 427.053. APPROVAL OF AGREEMENT REQUIRED. (a) An insurer or health maintenance organization must submit the written agreement under Section 427.052 to the commissioner for approval of the form and content of the agreement.

(b) The commissioner must approve or disapprove the agreement not later than the 30th day after the date the insurer or health maintenance organization submits the agreement. If the commissioner fails to act as required by this subsection, the agreement is considered approved.

(c) An insurer or health maintenance organization may assume a subordinated liability only after the commissioner has approved the agreement under this chapter or Subchapter C, Chapter 823. (V.T.I.C. Art. 1.39, Sec. (e) (part).)

Source Law

(e) An agreement entered into under Subsection (b) of this article must be submitted to the commissioner for approval as to form and content; provided, however, that the commissioner must give his decision of either approval or disapproval within 30 days after the written filing by the insurer, and his failure to so act within such 30 days shall constitute approval of the transaction. An insurer may not assume a subordinated liability until the commissioner has approved the agreement under either Section 4, Article 21.49-1, or this article. . . .

Revisor's Note

(1) Section (e), V.T.I.C. Article 1.39, refers to the approval of the commissioner of insurance of a "transaction." The revised law substitutes "agreement" for "transaction" for consistency of

terminology throughout this chapter.

(2) Section (e), V.T.I.C. Article 1.39, refers to approval of an agreement under Section 4, V.T.I.C. Article 21.49-1. Section 4, V.T.I.C. Article 21.49-1, was revised as Sections 823.008 and 823.053(e) of this code and Subchapter C, Chapter 823, of this code. The revised law substitutes a reference to Subchapter C, Chapter 823, of this code because it is clear from the context that is the relevant part of Section 4, V.T.I.C. Article 21.49-1, to which this section refers.

Revised Law

Sec. 427.054. LIABILITY. (a) A loan or advance made under this chapter, including any interest accruing on the loan or advance, is a legal liability of the insurer or health maintenance organization, and a liability with respect to the insurer's or health maintenance organization's financial statement, only to the extent provided by the terms of the loan or advance agreement.

(b) Notwithstanding Subsection (a), if the loan or advance agreement provides for a sinking fund out of which the loan or advance is to be repaid, the loan or advance is a legal liability of the insurer or health maintenance organization, and a liability with respect to the insurer's or health maintenance organization's financial statement, only to the extent of the amounts accumulated and held in the sinking fund. By agreement of the parties, any portion of the amounts accumulated in the sinking fund may be returned to the surplus of the insurer or health maintenance organization at any time and any amount returned may not be a legal liability of the insurer or health maintenance organization or a liability with respect to the insurer's or health maintenance organization's financial statement. (V.T.I.C. Art. 1.39, Secs. (c), (d).)

Source Law

(c) A loan or advance made under this article,

and any interest accruing on the loan or advance, is a legal liability and financial statement liability of the insurer only to the extent provided by the terms and conditions of the loan or advance agreement, and the loan or advance may not otherwise be a legal liability or financial statement liability of the insurer.

(d) If the loan or advance agreement provides for a sinking fund out of which the loan or advance is to be repaid, then the loan or advance shall be a legal liability and financial statement liability of the insurer only to the extent of those funds accumulated and held in the sinking fund, and the loan or advance may not otherwise be a legal liability or financial statement liability of the insurer. By mutual agreement of the parties to the agreement, any portion of the accumulated funds in the sinking fund may be returned to the surplus of the insurer at any time and from time to time and thereafter may not be considered as a legal liability or financial statement liability of the insurer.

Revisor's Note

(1) Section (c), V.T.I.C. Article 1.39, refers to "terms and conditions" of a loan or advance agreement. The revised law omits "conditions" because "conditions" is included within the meaning of "terms."

(2) Sections (c) and (d), V.T.I.C. Article 1.39, provide that certain loans or advances are a legal liability or financial statement liability of an insurer or health maintenance organization only to the extent specified by the section, "and the loan or advance may not otherwise be a legal liability or financial statement liability of the insurer." The revised law omits the quoted language as unnecessarily repetitive.

(3) Section (d), V.T.I.C. Article 1.39, states that certain funds may be returned to the surplus of an insurer or health maintenance organization "at any time and from time to time." The revised law omits the reference to "from time to time" because "from time to time" is included within the meaning of "at any time."

Revised Law

Sec. 427.055. PAYMENT OF PRINCIPAL OR INTEREST ON CERTAIN

LIABILITIES. (a) An insurer or health maintenance organization may not pay principal or interest on a subordinated liability assumed under Section 427.052 or Subchapter C, Chapter 823, on or after September 1, 1995, unless:

(1) the payment complies with a schedule of payments contained in the agreement approved by the commissioner in accordance with Section 427.052 or Subchapter C, Chapter 823; or

(2) if the payment does not comply with the schedule of payments contained in the agreement or the agreement does not contain a payment schedule, the insurer or health maintenance organization provides written notice to the commissioner not later than the 15th day before the scheduled payment date.

(b) A loan, debenture, revenue bond, or advance agreement issued to an insurer or health maintenance organization before September 1, 1995, and any subsequent payment of principal or interest on the indebtedness are governed by the law in effect on the date of issuance. (V.T.I.C. Art. 1.39, Sec. (e) (part).)

Source Law

(e) . . . An insurer may not repay principal or pay interest on a subordinated liability assumed under either Section 4, Article 21.49-1, or this article on or after September 1, 1995, unless either (i) such payment or repayment complies with a specific schedule of payments contained within the terms of the previously approved agreement, or (ii) written notice is provided to the commissioner at least 15 days before the date scheduled for any payment or repayment if either a schedule of payments is not contained within the terms of the previously approved agreement, or such payment or repayment does not comply with the specific schedule of payments contained within the terms of the previously approved agreement. A loan, debenture, revenue bond, or advance agreement issued before September 1, 1995, and any subsequent payment of interest or repayment of principal are governed by the law in effect on the date of issuance.

Revisor's Note

Section (e), V.T.I.C. Article 1.39, refers to a subordinated liability assumed under Section 4, V.T.I.C. Article 21.49-1. The revised law substitutes a reference to Subchapter C, Chapter 823, of this code for the reason stated in Revisor's Note (2) to Section

427.053.
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CHAPTER 441. SUPERVISION AND CONSERVATORSHIP

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 441.001. FINDINGS AND PURPOSE. (a) An insurer delinquency, or the state's inability to properly proceed in a threatened delinquency, directly or indirectly affects other insurers by creating a lack of public confidence in insurance and insurers. Insurer delinquencies destroy public confidence in the state's ability to regulate insurers. The harmful results of insurer delinquencies, including those described by this subsection, are properly minimized by laws designed to protect and assist insureds, creditors, and owners.

(b) Placing an insurer in receivership often destroys or diminishes, or is likely to destroy or diminish, the value of the insurer's assets, including:

(1) the insurer's insurance account or in-force business;

(2) the insurer as a going concern; and

(3) the insurer's agency force.

(c) The value of the assets described by Subsection (b) should be preserved if the circumstances of the insurer's financial condition warrant an attempt to rehabilitate or conserve the insurer and the rehabilitation or conservation is otherwise feasible.

(d) It is a proper concern of this state and proper policy to attempt to correct or remedy insurer misconduct, ineptness, or

misfortune.

(e) The purpose of this chapter is to:

(1) provide for the rehabilitation and conservation of insurers by authorizing and requiring supervision and conservatorship by the commissioner;

(2) authorize action to determine whether an attempt should be made to rehabilitate and conserve an insurer;

(3) avoid, if possible and feasible, the necessity of placing an insurer under temporary or permanent receivership;

(4) provide for the protection of an insurer's assets pending determination of whether the insurer may be successfully rehabilitated; and

(5) alleviate concerns regarding insurance and insurers.

(f) Rehabilitation of an insurer might not be accomplished in every case, but this chapter facilitates and directs an attempt to rehabilitate an insurer without immediate resort to the harsher remedy of receivership. If receivership becomes necessary, the preliminary supervision and conservatorship may prevent a dissipation of assets, which will benefit policyholders, creditors, and owners.

(g) For the reasons stated by this section, the substance and procedures of this chapter are the public policy of this state and are necessary to the public welfare. That policy and welfare require the availability of this chapter and the application of this chapter if circumstances warrant.

(h) This chapter provides, in conjunction with other law, a generally ordered sequence, and provides for review at each step, of supervision, concurrent conservatorship and rehabilitation, including reinsurance, and cessation of the conservatorship by rehabilitation or by receivership and liquidation if at any time that cessation is indicated or determined to be appropriate. (V.T.I.C. Art. 21.28-A, Sec. 1 (part).)

Source Law

Sec. 1. . . . The Legislature finds and determines that the placing of an insurer in receivership often destroys or diminishes, or is likely to destroy or diminish, one or more of the following values or assets: (a) the value of the insurance account or in-force business of the insurer, (b) the value of the insurer as a going concern, (c) the value of its agency force, and (d) the value of other of its assets. The Legislature declares that such values and assets should be preserved if the circumstances of the insurer's financial condition warrant an attempt to conserve or rehabilitate such insurer and such rehabilitation or conservation is otherwise feasible, but . . . . It is the purpose of the Legislature to provide for rehabilitation and conservation of insurers by authorizing and requiring the additional facility of supervision and conservatorship by the commissioner, to authorize action to resolve whether an attempt be made to rehabilitate and conserve an insurer, and to avoid, if possible and feasible, the necessity of temporary or permanent receivership. It is the further purpose of this Act to provide for protection of the assets of an insurer pending determination of whether or not an insurer can be successfully rehabilitated. It is not the sense of the Legislature that rehabilitation will be accomplished in every case, but it is the purpose of this Article to provide a facility and direction for attempting the rehabilitation without immediate resort to the harsher remedy of receivership. . . . In the event that receivership ultimately becomes necessary, it is nevertheless the belief and finding of the Legislature that the preliminary supervision and conservatorship is preventive of a dissipation of assets and will thus benefit policyholders, creditors and owners; and the commissioner is directed, in its discretion, to the use of this authorization. The Legislature further finds that an insurer delinquency, or the state's incapacity to properly proceed in a threatened delinquency, directly or indirectly affects other insurers by creating a lack of public confidence in insurance and in insurance companies. As respects the state, insurer delinquencies are destructive of public confidence in the capacity of the state to regulate insurers. These and other harmful results of insurer delinquency are properly minimized by a further enactment designed to protect and in aid of insureds, creditors and owners. The Legislature intends and expects that the inappropriate as well as the appropriate concerns in respect of insurance and insurers will be reduced by the existence and operation of this law. The Legislature declares that it is a proper concern of this state and proper policy to attempt to correct or remedy insurer misconduct, ineptness or misfortune. . . . In consequence of the foregoing, the substance and procedure of this Article is here declared to be the public policy of this state and necessary to the public welfare. Such policy and welfare requires the availability of this law and the application of this law whenever circumstances warrant; and . . . . And in conjunction with existing law, the rationale is effected in the provision herein for a generally ordered sequence, and review at each such step, of supervision, concurrent conservation and rehabilitation (including reinsurance), and, as may at

any time or ultimately be indicated or determined, cessation of the conservation by accomplishment of rehabilitation or by receivership and liquidation.

Revisor's Note

(1) Section 1, V.T.I.C. Article 21.28-A, describes the need for enacting Article 21.28-A and refers to the "sense of the Legislature" that laws in existence before the enactment of Article 21.28-A were inadequate or inappropriate to remedy the financial condition of, and that a void exists in the law with respect to the rehabilitation of, certain insurers. The revised law omits these provisions as executed. The omitted law reads:

> Art. 21.28-A
>
> Sec. 1. It is the sense of the Legislature that existing provisions and conditions of law and the ordered procedures of law are sometimes not adequate, nor appropriate under all circumstances, in respect of a need to remedy the financial condition and the management of certain insurers. Neither are the laws adequate for the rehabilitation of insurers who voluntarily request rehabilitation. A void exists in the laws with respect to those insurers most susceptible to rehabilitation or the regaining of solvency. . . .

(2) Section 1, V.T.I.C. Article 21.28-A, contains findings made by the legislature in enacting that article. The findings are introduced with various phrases, including "[t]he Legislature finds," "[t]he Legislature declares," "[i]t is the purpose of the Legislature," and "it is . . . the belief and finding of the Legislature." The revised law omits each of the references to findings being made "by the legislature" as unnecessary. Because only the legislature may enact statutes, it is implicit in the revision of the substance of each of the findings that the finding was made by the legislature.

(3) Section 1, V.T.I.C. Article 21.28-A, describes the necessity and benefits of supervision

and conservatorship of an insurer before the insurer is placed in receivership and provides that "the commissioner is directed, in its discretion, to the use of this authorization." The revised law omits the quoted phrase as duplicative of other provisions revised in this chapter that explicitly provide the duties and authority of the commissioner of insurance regarding insurer delinquencies.

(4) Section 1, V.T.I.C. Article 21.28-A, refers to "the inappropriate as well as the appropriate" concerns with respect to insurance and insurers. The revised law omits as unnecessary the reference to the descriptions of these concerns as "inappropriate" and "appropriate."

(5) Section 1, V.T.I.C. Article 21.28-A, refers to "concurrent conservation and rehabilitation." The revised law substitutes "conservatorship" for "conservation" for consistency with the terminology used in this chapter.

(6) Section 1, V.T.I.C. Article 21.28-A, refers to "at any time or ultimately." The revised law omits the reference to "ultimately" because, in context, "ultimately" is included within the meaning of "at any time."

Revised Law

Sec. 441.002. DEFINITION. In this chapter, unless the purposes of this chapter clearly require or the context clearly indicates another meaning, "insurer" means a person, organization, or company, regardless of whether the person or entity is authorized or admitted, that engages in the business of insurance or that acts as a principal or agent of a person, organization, or company engaged in the business of insurance. The term includes a stock insurance company, reciprocal or interinsurance exchange, Lloyd's plan, fraternal benefit society, stipulated premium

company, title insurance company, and mutual insurance company of any kind, including a statewide mutual assessment company, local mutual aid association, burial association, county mutual insurance company, and farm mutual insurance company. (V.T.I.C. Art. 21.28-A, Secs. 2 (part), (a).)

Source Law

> Sec. 2. As used in this Article, the following words, terms and phrases . . . include the meanings, significance or application described in this Section, except as another meaning is clearly requisite from the purposes or is otherwise clearly indicated by the context.
>
> (a) "Insurance Company" (used interchangeably with "insurer") is any person, organization, association or company, (authorized or unauthorized, admitted or non-admitted) acting as an insurer, or as principal or agent of an insurer, including stock companies, reciprocals or interinsurance exchanges, Lloyds associations, fraternal benefit societies, stipulated premium companies, title insurance companies, and mutual companies of all kinds, including state-wide mutual assessment corporations, local mutual aids, burial associations, and county mutual insurance companies and farm mutual insurance companies.

Revisor's Note

(1) Section 2, V.T.I.C. Article 21.28-A, describes the manner in which the terms defined in that section may appear in other parts of that article. The revised law omits the description as unnecessary. The omitted law reads:

> Sec. 2. [As used in this Article, the following words, terms and phrases] (in single quotes in this Section of the Article but not in quotes in other Sections) [include the meanings, significance or application described in this Section] . . . .

(2) Section 2(a), V.T.I.C. Article 21.28-A, defines "insurance company" and provides that the term is "used interchangeably with 'insurer.'" The revised law uses the defined term "insurer" and substitutes that term for "insurance company" in this section and throughout this chapter because the terms have the same meaning and the former term is more commonly used in this code.

(3) Section 2(a), V.T.I.C. Article 21.28-A, refers to a "person, organization, association or company." The revised law omits as unnecessary the reference to "association" because, in context, that term is included within the meaning of "organization."

(4) Section 2(a), V.T.I.C. Article 21.28-A, refers to "Lloyds associations," "state-wide mutual assessment corporations," and "local mutual aids," meaning entities operating under Chapters 941, 881, and 886, respectively. The terms most frequently used to refer to those entities are "Lloyd's plan," "statewide mutual assessment company," and "local mutual aid association." For consistent use of terminology in this code, the revised law substitutes "Lloyd's plan," "statewide mutual assessment company," and "local mutual aid association" for "Lloyds associations," "state-wide mutual assessment corporations," and "local mutual aids," respectively.

Revised Law

Sec. 441.003. APPLICABILITY OF AND COMPLIANCE WITH CHAPTER. Compliance with this chapter is a condition of engaging in the business of insurance in this state. This chapter applies to, and is a consequence of, any other transaction with respect to an insurer or insurance. (V.T.I.C. Art. 21.28-A, Sec. 1 (part).)

Source Law

> Sec. 1. . . . [Such policy and welfare requires the availability of this law and the application of this law whenever circumstances warrant; and] it is therefore a condition of doing an insurance business in this state; and it is made applicable and is a consequence of any other transactions in respect of an insurer or insurance. . . .

Revised Law

Sec. 441.004. ACTIONS OF COMMISSIONER. (a) In the event of an insurer's delinquency or suspected delinquency, the commissioner, in the commissioner's administrative discretion, may act under this chapter, another applicable law, or a combination of

this chapter and another applicable law.

(b) If the commissioner determines to act under this chapter or is directed by a court to act under this chapter, the commissioner shall comply with the requirements of this chapter. (V.T.I.C. Art. 21.28-A, Secs. 10, 12(a) (part).)

Source Law

> Sec. 10. (a) If the Commissioner determines to act under authority of this Article, or is directed by the State Board of Insurance or a court of competent jurisdiction to act under this Article, the sequence of his acts and proceedings shall be as set forth herein. However, it is a purpose and substance of this Article to authorize administrative discretion--to allow the State Board of Insurance and the Commissioner administrative discretion in the event of insurance company delinquencies--and in furtherance of that purpose, the Commissioner is hereby authorized in respect of insurance company delinquencies or suspected delinquencies to proceed and administer either under this Article or under any other applicable law, or under this law in conjunction with other law, either as such law is now existing or as is hereafter enacted, and it is so provided.
>
> Sec. 12. (a) . . . Also authorized for use, in conjunction with this Article, in delinquency proceedings or threatened insolvencies of insurers, are any other statutes or laws possible of application with this Act or in the procedures of this Act, or in augmentation of this Act whether or not directed as applicable by such other statute; but . . . .

Revisor's Note

(1) Section 10, V.T.I.C. Article 21.28-A, 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 State Board of Insurance or "the board" have been changed appropriately.

(2) Section 10, V.T.I.C. Article 21.28-A, refers to a court "of competent jurisdiction." The revised law omits the quoted language as unnecessary in this section and in similar provisions throughout this chapter 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.

(3) Section 10, V.T.I.C. Article 21.28-A, provides that the commissioner of insurance may take action under that article or other applicable law "either as such law is now existing or as is hereafter enacted." The revised law omits the quoted language as unnecessary because any applicable law in effect at the time of an action of the commissioner applies by its own terms, and the commissioner may take the action as authorized by that law.

(4) Section 12(a), V.T.I.C. Article 21.28-A, provides that Section 14, V.T.I.C. Article 17.25, and V.T.I.C. Articles 14.33 and 22.22 may be used in conjunction with the law revised in this chapter. The revised law omits the provision because the specified laws were repealed by Chapter 1419, Acts of the 77th Legislature, Regular Session, 2001, as being completely subsumed and replaced by the enactment in 1967 of Article 21.28-A, revised in relevant part as this chapter. The omitted law reads:

> Sec. 12. (a) Other statutes authorized for use and application in conjunction with this Article are Section 14 of Article 17.25, and Articles 14.33 and 22.22 of the Insurance Code. . . .

Revised Law

Sec. 441.005. RULES; AUTHORITY FOR ADMINISTRATIVE ACTION. (a) The commissioner may:

(1) adopt reasonable rules as necessary to implement and supplement this chapter and the purposes of this chapter; and

(2) take any administrative action required by the findings of Section 441.001.

(b) The authority granted by this section may be inferred from the context of this chapter. (V.T.I.C. Art. 21.28-A, Secs. 1

(part), 11.)

Source Law

> Sec. 1. . . . It is the purpose of the Legislature to express, or to imply from context when not expressed, an authorization, provision and enabling of the promulgation of rules and regulations by the board as directed in these legislative findings and in the augmentation of this law; and to provide also for any other requisite administrative action. . . .
>
> Sec. 11. The State Board of Insurance shall be empowered to adopt and promulgate such reasonable rules and regulations as may be necessary for the augmentation and accomplishment of this Act, including its purposes.

Revisor's Note

Sections 1 and 11, V.T.I.C. Article 21.28-A, refer to the adoption of "rules and regulations." The revised law omits the 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.

Revised Law

Sec. 441.006. RULES AND PROCEDURES FOR MERGER OF INSURERS. (a) The commissioner shall adopt rules that encourage the merger of insurers in weak financial condition with insurers in strong financial condition in cases in which rehabilitation or conservation of an insurer would be inefficient or impracticable.

(b) The rules and procedures for conservatorship may not be used unless the rules and procedures adopted to promote the merger of insurers in weak financial condition are followed. (V.T.I.C. Art. 21.28-A, Sec. 1 (part).)

Source Law

> Sec. 1. . . . in cases in which rehabilitation or conservation would be inefficient or impracticable, the board is directed to promulgate rules that encourage the merger of insurers in weak financial condition with insurers in strong financial condition. . . . The rules and procedures authorized for conservatorship may not be employed without following the rules and procedures promulgated to promote the merger of insurers in weak financial condition. . . .

Revised Law

Sec. 441.007. CONFLICT WITH OTHER LAWS. If this chapter conflicts with any other law, this chapter prevails. (V.T.I.C. Art. 21.28-A, Sec. 12(a) (part).)

Source Law

> (a) . . . in the event of conflict between this Article and any other Article, the provisions of this Article shall govern.

Revised Law

Sec. 441.008. INAPPLICABILITY OF CERTAIN ADMINISTRATIVE PROCEDURE PROVISIONS. Section 2001.062, Government Code, does not apply to a hearing conducted under this chapter. (V.T.I.C. Art. 21.28-A, Sec. 3 (part).)

Source Law

> Sec. 3. . . . Section 15, Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes), does not apply to hearings held by the Commissioner or his representative under this Article.

Revisor's Note

(1) Section 3, V.T.I.C. Article 21.28-A, refers to Section 15, Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes). That section was codified in 1993 as Section 2001.062, Government Code, and the revised law is drafted accordingly.

(2) Section 3, V.T.I.C. Article 21.28-A, refers to a hearing "held by the Commissioner or his representative under this Article." Chapter 40 of this code provides that certain administrative hearings required to be held under this code or another insurance law of this state be conducted by the State Office of Administrative Hearings. Therefore, the revised law omits the reference to the hearing being conducted by the commissioner or the commissioner's representative.

[Sections 441.009-441.050 reserved for expansion]

SUBCHAPTER B. DETERMINATION AND NOTICE

Revised Law

Sec. 441.051. CIRCUMSTANCES CONSTITUTING INSOLVENCY OR DELINQUENCY. For the purposes of this chapter, the circumstances in which an insurer is considered insolvent, delinquent, or threatened with delinquency include circumstances in which the insurer:

(1) has required surplus, capital, or capital stock that is impaired to an extent prohibited by law;

(2) continues to write new business when the insurer does not have the surplus, capital, or capital stock that is required by law to write new business;

(3) conducts the insurer's business fraudulently; or

(4) attempts to dissolve or liquidate without first having made provisions satisfactory to the commissioner for liabilities arising from insurance policies issued by the insurer. (V.T.I.C. Art. 21.28-A, Secs. 2 (part), (b).)

Source Law

Sec. 2. As used in this Article, the following words, terms and phrases . . . include the meanings, significance or application described in this Section, except as another meaning is clearly requisite from the purposes or is otherwise clearly indicated by the context.

(b) In respect of an insurance company or insurer, "insolvent" or "insolvency" and the phrases in further identity of insurer delinquency and threatened insurer delinquency, mean and include, and the conditions to which this Article is applicable include, but are not limited to, any one or more of the following circumstances or conditions.

(1) if an insurance company's required surplus, capital, or capital stock is impaired to an extent prohibited by law, or

(2) if an insurance company continues to write new business when it is not possessed of the surplus, capital or capital stock which is required of it by law to permit it to do so, or

(3) if the business of any such insurance company is being conducted fraudulently, or

(4) if any such insurance company attempts to dissolve or liquidate without first having made provisions, satisfactory to the Commissioner of Insurance, for liabilities arising from policies of insurance issued by such company.

Revisor's Note

(1) Section 2, V.T.I.C. Article 21.28-A, provides that the terms and phrases in that section have certain meanings for purposes of Article 21.28-A, "except as another meaning is clearly requisite from the purposes or is otherwise clearly indicated by the context." The revised law omits the quoted phrase as unnecessary with respect to the terms "insolvent" and "insolvency" and phrases describing a similar condition that are defined in Section 2(b), Article 21.28-A. That section defines those terms and phrases by referring to conditions "including" certain specified conditions. The term "including" is a term of enlargement and not of limitation as explained in Revisor's Note (3) to this section. Because the list of conditions contained in Section 2(b) is a nonexclusive list, the definition provided by that section by its terms allows for the application of a different meaning with respect to the terms and phrases that section defines.

(2) Section 2(b), V.T.I.C. Article 21.28-A, states that certain conditions "mean and include" certain circumstances. The revised law omits "mean" as inaccurate because that section clearly provides a nonexclusive description of the circumstances in which an insurer is considered to be in a particular condition.

(3) Section 2(b), V.T.I.C. Article 21.28-A, states that certain conditions "include, but are not limited to" certain circumstances. The revised law omits "but are 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 sections apply to the revised law.

(4) Section 2(b), V.T.I.C. Article 21.28-A, refers to the "Commissioner of Insurance." 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. Throughout this chapter, the revised law is drafted accordingly.

Revised Law

Sec. 441.052. CIRCUMSTANCES CONSTITUTING INSURER EXCEEDING POWERS. For the purposes of this chapter, the circumstances in which an insurer is considered to have exceeded the insurer's powers include circumstances in which the insurer:

(1) refuses to permit the commissioner, the commissioner's deputy, or an examiner appointed by the department to examine the insurer's books, papers, accounts, records, or affairs;

(2) is organized in this state and removes from the state books, papers, accounts, or records that are necessary to examine the insurer;

(3) fails to promptly answer inquiries authorized by Section 38.001;

(4) fails to comply with an order of the commissioner to remedy, within the time prescribed by law, a prohibited deficiency in the insurer's capital, capital stock, or surplus;

(5) without obtaining the commissioner's prior written approval:

(A) totally reinsures the insurer's entire outstanding business; or

(B) merges or consolidates substantially all of the insurer's property or business with another insurer;

(6) continues to write business after the insurer's certificate of authority has been revoked or suspended; or

(7) is in a condition that makes the insurer's continuation in business hazardous to the public or to the insurer's policyholders or certificate holders. (V.T.I.C. Art. 21.28-A, Secs. 2 (part), (c).)

Source Law

Sec. 2. As used in this Article, the following words, terms and phrases . . . include the meanings, significance or application described in this Section, except as another meaning is clearly requisite from the purposes or is otherwise clearly indicated by the context.

(c) "Exceeded its Powers" includes and means but is not limited to the following circumstances:

(1) if an insurance company has refused to permit examination of its books, papers, accounts, records, or affairs by the Commissioner of Insurance, his deputy, or duly commissioned examiners; or if any insurance company, organized in the State of Texas, has removed from the state such books, papers, accounts or records necessary for an examination of such insurance company, or

(2) if an insurance company has failed to promptly answer inquiries authorized by Article 1.24 of this Code, or

(3) if an insurance company has neglected or refused to observe an order of the Commissioner to make good, within the time prescribed by law, any prohibited deficiency in its capital, capital stock, or surplus, or

(4) if an insurance company without first having obtained written approval of the Commissioner has by contract or otherwise: (i) totally reinsured its entire outstanding business, or (ii) merged or consolidated substantially its entire property or business with another insurer; or

(5) if any insurance company is continuing to write business after its license has been revoked or suspended; or

(6) if an insurance company is in a condition that renders the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance.

Revisor's Note

(1) Section 2, V.T.I.C. Article 21.28-A, provides that the terms and phrases in that section have certain meanings for purposes of Article 21.28-A, "except as another meaning is clearly requisite for the purposes or is otherwise clearly indicated by the context." The revised law omits the quoted phrase as

unnecessary with respect to the phrase "exceeded its powers" that is defined in Section 2(c), Article 21.28-A, which defines the phrase by referring to circumstances that include certain specified circumstances, for the reason stated in Revisor's Note (1) to Section 441.051.

(2) Section 2(c), V.T.I.C. Article 21.28-A, provides that a certain action by an insurer "includes and means but is not limited to" the circumstances specified by that section. The revised law omits "means" as inaccurate because that section clearly provides a nonexclusive description of the circumstances under which an insurer is considered to have exceeded the insurer's powers. The revised law omits "but is not limited to" for the reason stated in Revisor's Note (3) to Section 441.051.

(3) Section 2(c)(1), V.T.I.C. Article 21.28-A, refers to "duly commissioned examiners." The substance of Section 2(c)(1), Article 21.28-A, was originally enacted by Chapter 281, Acts of the 60th Legislature, Regular Session, 1967, and included the reference to "commissioned" examiners. V.T.I.C. Article 1.04A, enacted by Chapter 1082, Acts of the 71st Legislature, Regular Session, 1989, and revised in this code in relevant part as Section 401.101, provides that the department may use a salaried department examiner or the services of any qualified person or firm to examine an insurer. Therefore, the revised law omits the reference to the requirement that an examiner be "commissioned" as impliedly repealed by Article 1.04A, and substitutes a reference to an examiner "appointed" by the department. The revised law also omits the reference to "duly" in this section and throughout this chapter as unnecessary

because the word does not add to the clear meaning of the law. In this context, an examiner purporting to be commissioned is not commissioned if that commission was not properly granted.

(4) Section 2(c)(4), V.T.I.C. Article 21.28-A, refers to certain actions by an insurer "by contract or otherwise." The revised law omits the quoted phrase as unnecessary because it does not provide a limitation on how the action may be taken.

(5) Section 2(c)(5), V.T.I.C. Article 21.28-A, refers to an insurer's "license." The revised law substitutes "certificate of authority" for "license" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 441.053. NOTICE TO INSURER. (a) If at any time the commissioner determines that an insurer is insolvent, has exceeded the insurer's powers, or has otherwise failed to comply with the law, the commissioner shall:

(1) notify the insurer of that determination;

(2) provide to the insurer a written list of the commissioner's requirements to abate the conditions on which that determination was based; and

(3) if the commissioner determines that the insurer requires supervision, notify the insurer that the insurer is under the commissioner's supervision and that the commissioner is invoking this chapter.

(b) The commissioner may provide the notice and information to an insurer that agrees to supervision.

(c) The insurer shall comply with the commissioner's requirements. (V.T.I.C. Art. 21.28-A, Secs. 2 (part), (d) (part), 3 (part).)

Source Law

Sec. 2. As used in this Article, the following words, terms and phrases . . . include the meanings, significance or application described in this Section, except as another meaning is clearly requisite from the purposes or is otherwise clearly indicated by the context.

(d) "Consent," as used in this Act, includes and means agreement to either supervision or . . . by the insurance company.

Sec. 3. If upon examination or at any other time it appears to or is the opinion of the Commissioner of Insurance that any insurance company is insolvent, or its condition is such as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance, or if such company appears to have exceeded its powers (as defined herein) or has failed to comply with the law, or if such insurance company gives its consent (as defined herein), then the Commissioner of Insurance shall upon his determination (a) notify the insurance company of his determination, and (b) furnish to the insurance company a written list of the Commissioner's requirements to abate his determination, and (c) if the Commissioner makes a further determination to supervise he shall notify the insurance company that it is under the supervision of the Commissioner of Insurance and that the Commissioner is applying and effecting the provisions of this Article. Such insurance company shall comply with the lawful requirements of the Commissioner of Insurance. . . .

Revisor's Note

(1) Section 2, V.T.I.C. Article 21.28-A, provides that the terms and phrases in that section have certain meanings for purposes of Article 21.28-A, "except as another meaning is clearly requisite from the purposes or is otherwise clearly indicated by the context." Section 2(d), Article 21.28-A, defines "consent" by providing that the term "means and includes" agreement to certain specified actions. The revised law incorporates the applicable substance of the definition in the revised law derived from Section 3, Article 21.28-A, and omits the quoted exception and the reference to "includes," despite that term being a term of enlargement and not of limitation for the reason stated in Revisor's Note (3) to Section 441.051, as unnecessary because the context of Section 3 does not require, clearly indicate, or allow for a meaning

contrary to the definition provided by Section 2(d).

(2) Section 3, V.T.I.C. Article 21.28-A, refers to a determination made "upon examination or at any other time." The revised law omits "upon examination" because, in context, "upon examination" is included within the meaning of "at any time."

(3) Section 3, V.T.I.C. Article 21.28-A, refers to several determinations made by the commissioner of insurance, including a determination that an insurer is in a "condition . . . such as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance" or that the insurer has exceeded its powers. The revised law omits the quoted phrase because that condition is specified by Section 2(c)(6), Article 21.28-A, revised in this chapter as Section 441.052(7), as a circumstance under which an insurer has exceeded the insurer's powers.

(4) Section 3, V.T.I.C. Article 21.28-A, refers to an insurer that "appears to have exceeded its powers (as defined herein)." The revised law omits the reference to "as defined herein" as unnecessary. Section 2(c), V.T.I.C. Article 21.28-A, revised in this chapter as Section 441.052, defines "exceeded its powers" to include a list of circumstances in which an insurer appears to have exceeded the insurer's powers. That section applies by its own terms to the law revised in this section. Similar changes are made throughout this chapter.

(5) Section 3, V.T.I.C. Article 21.28-A, provides that an insurer is required to comply with the "lawful requirements" of the commissioner of insurance. The revised law omits as unnecessary in this section and in similar provisions throughout this

chapter the reference to the requirements being "lawful." An insurer is not required to comply with any requirement of the commissioner that is unlawful.

[Sections 441.054-441.100 reserved for expansion]

SUBCHAPTER C. SUPERVISION

Revised Law

Sec. 441.101. APPOINTMENT OF SUPERVISOR. The commissioner may appoint a supervisor to supervise an insurer. (V.T.I.C. Art. 21.28-A, Sec. 4(a) (part).)

Source Law

> Sec. 4. (a) . . . the Commissioner may appoint a supervisor to supervise such insurance company and . . . .

Revisor's Note

Section 4(a), V.T.I.C. Article 21.28-A, provides that the commissioner of insurance may appoint a supervisor for an insurer, and Section 4(b) of that article provides that the "Liquidator of the State Board of Insurance, or his duly appointed deputy," may be appointed to serve as the supervisor. The position of liquidator was a position provided for by V.T.I.C. Article 21.28, revised as Chapter 442 of this code, before that article was amended by Chapter 12, Acts of the 72nd Legislature, 2nd Called Session, 1991. The functions performed by the liquidator are now performed by the receiver, who may be the commissioner or a special deputy receiver, in accordance with Section 2(a), V.T.I.C. Article 21.28, revised in relevant part as Section 442.051. The revised law omits Section 4(b) because, given that the position of liquidator no longer exists, it is no longer necessary or accurate to state that the liquidator or the liquidator's deputy may serve as supervisor. The omitted law reads:

(b) The Liquidator of the State Board

of Insurance, or his duly appointed deputy, may be appointed to serve as the supervisor.

Revised Law

Sec. 441.102. TIME FOR COMPLIANCE WITH REQUIREMENTS OF SUPERVISION. An insurer under supervision must comply with the commissioner's requirements under Section 441.053 not later than the 180th day after the date of the commissioner's notice of supervision. (V.T.I.C. Art. 21.28-A, Sec. 3 (part).)

Source Law

> Sec. 3. . . . If placed under supervision, the insurance company shall have not more than one hundred-eighty (180) days from the date of the Commissioner's notice of supervision to comply with the requirements of the Commissioner. . . .

Revised Law

Sec. 441.103. PAYMENT OF CLAIMS. An insurer under supervision shall continue to pay claims under an insurance policy according to the terms of the policy. (V.T.I.C. Art. 21.28-A, Sec. 3 (part).)

Source Law

> Sec. 3. . . . During the period of supervision, the insurance company shall continue to pay claims according to terms of the insurance policy, and . . . .

Revised Law

Sec. 441.104. PROHIBITED ACTS DURING SUPERVISION. During supervision, the commissioner may prohibit the insurer from taking any of the following actions without the prior approval of the commissioner or supervisor:

(1) disposing of, conveying, or encumbering any of the insurer's assets or business in force;

(2) withdrawing money from the insurer's bank accounts;

(3) lending or investing the insurer's money;

(4) transferring the insurer's property;

(5) incurring a debt, obligation, or liability;

(6) merging or consolidating with another company;

(7) entering into a new reinsurance contract or treaty;

(8) terminating, surrendering, forfeiting, converting, or lapsing an insurance policy, except for nonpayment of premiums due; or

(9) releasing, paying, or refunding premium deposits, accrued cash or loan values, unearned premiums, or other reserves on an insurance policy. (V.T.I.C. Art. 21.28-A, Sec. 4(a) (part).)

Source Law

(a) During the period of supervision, the Commissioner . . . may provide that the insurance company may not do any of the following things, during the period of supervision, without the prior approval of the Commissioner or his supervisor:

(1) Dispose of, convey or encumber any of its assets or its business in force;

(2) Withdraw any of its bank accounts;

(3) Lend any of its funds;

(4) Invest any of its funds;

(5) Transfer any of its property;

(6) Incur any debt, obligation or liability;

(7) Merge or consolidate with another company;

(8) Enter into any new reinsurance contract or treaty; or

(9) Terminate, surrender, forfeit, convert, or lapse any policy or contract of insurance, except for nonpayment of premiums due, or to release, pay, or refund premium deposits, accrued cash or loan values, unearned premiums, or other reserves on any insurance policy or contract.

Revisor's Note

(1) Section 4(a), V.T.I.C. Article 21.28-A, refers to the lending and investing of "funds." The revised law substitutes "money" for "funds" because, in context, the terms are synonymous and the former is more commonly used.

(2) Section 4(a), V.T.I.C. Article 21.28-A, refers to a "policy or contract" of insurance. The revised law omits the references to "contract" in this section and throughout this chapter because, in context, an insurance policy and insurance contract are synonymous, and the term "insurance policy" is more commonly used in Article 21.28-A, revised as this chapter.

Revised Law

Sec. 441.105. HEARING ON SUPERVISION; TERMINATION BY CONSERVATION OR RELEASE. (a) On the commissioner's own motion or the motion of a party of record, a hearing may be scheduled relating to an insurer under supervision after at least 10 days' written notice to each party of record. Notice may be waived by the parties of record.

(b) The commissioner shall place the insurer in conservatorship if, after the hearing, it is determined that the insurer:

(1) failed to comply with the commissioner's requirements;

(2) has not been rehabilitated;

(3) is insolvent; or

(4) appears to have exceeded the insurer's powers.

(c) The commissioner may release the insurer from supervision if, after the hearing, it is determined that the insurer:

(1) has been rehabilitated; or

(2) is no longer in a condition that makes the insurer's continuation in business hazardous to the public or to the insurer's policyholders or certificate holders. (V.T.I.C. Art. 21.28-A, Sec. 3 (part).)

Source Law

> Sec. 3. . . . the Commissioner may schedule a hearing relating to the insurance company in supervision with not less than ten (10) days' written notice to all parties of record on his own motion or that of any party of record. However, notice may be waived by the parties of record. If after hearing it is determined that the insurance company has failed to comply with the lawful requirements of the Commissioner, it has not been rehabilitated, it is insolvent, or it is otherwise in such a condition as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance, or if the company appears to have exceeded its powers as defined in this Article, the Commissioner of Insurance, acting for himself, or through a conservator appointed by the Commissioner of Insurance for that purpose, shall take charge as conservator of the insurance company and all of the property and effects thereof. If after hearing it is

determined that the insurance company has been rehabilitated or its condition has otherwise been remedied such that the continuance of its business is no longer hazardous to the public or to holders of its policies or certificates of insurance, the Commissioner may release that insurance company from supervision. . . .

Revisor's Note

(1) Section 3, V.T.I.C. Article 21.28-A, provides that "the Commissioner [of insurance] may schedule" a hearing on at least 10 days' notice. The revised law omits the reference to the commissioner scheduling the hearing for the reason stated in Revisor's Note (2) to Section 441.008.

(2) Section 3, V.T.I.C. Article 21.28-A, refers to several determinations made by the commissioner of insurance, including a determination that an insurer is in "such a condition as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance" or that the insurer has exceeded its powers. The revised law omits the quoted phrase for the reason stated in Revisor's Note (3) to Section 441.053.

(3) Section 3, V.T.I.C. Article 21.28-A, refers to the commissioner of insurance taking charge of an insurer by "acting for himself, or through a conservator appointed by the Commissioner of Insurance for that purpose," placing the insurer in conservatorship. The revised law omits the provision as unnecessary because it duplicates the duties of the conservator under Section 5, Article 21.28-A, revised in relevant part in this chapter as Section 441.153.

[Sections 441.106-441.150 reserved for expansion]

SUBCHAPTER D. CONSERVATORSHIP

Revised Law

Sec. 441.151. APPOINTMENT OF CONSERVATOR. (a) The commissioner may appoint a conservator for an insurer:

(1) if:

(A) after notice and opportunity for hearing, it is determined that the insurer:

(i) is insolvent;

(ii) appears to have exceeded the insurer's powers; or

(iii) has failed to comply with any requirement of the commissioner; or

(B) the insurer agrees to the appointment of a conservator; and

(2) if it is determined that supervision is inadequate to rehabilitate the insurer.

(b) The commissioner may appoint a conservator. (V.T.I.C. Art. 21.28-A, Secs. 2 (part), (d) (part), 5 (part).)

Source Law

> Sec. 2. As used in this Article, the following words, terms and phrases . . . include the meanings, significance or application described in this Section, except as another meaning is clearly requisite from the purposes or is otherwise clearly indicated by the context.
>
> (d) "Consent," as used in this Act, includes and means agreement to . . . conservatorship by the insurance company.
>
> Sec. 5. If, after notice and opportunity for hearing, it is determined that such insurance company is insolvent, or its condition is such as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance, or if the company appears to have exceeded its powers as defined in this Article, or has failed to comply with any lawful requirements of the Commissioner, or upon consent by an insurance company, and if it is determined that supervision is inadequate to accomplish the rehabilitation of the company, the Commissioner in his discretion may appoint a conservator, . . . .

Revisor's Note

(1) Section 2, V.T.I.C. Article 21.28-A, provides that the terms and phrases in that section have certain meanings for purposes of Article 21.28-A, "except as another meaning is clearly requisite from the purposes or is otherwise clearly indicated by the

context." Section 2(d), Article 21.28-A, defines "consent" by providing that the term "means and includes" agreement to certain specified actions. The revised law incorporates the applicable substance of the definition in the revised law derived from Section 5, Article 21.28-A, and omits the quoted exception and the reference to "includes" for the reason stated in Revisor's Note (1) to Section 441.053.

(2) Section 5, V.T.I.C. Article 21.28-A, refers to a determination that an insurer's "condition is such as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance" or that the insurer has exceeded its powers. The revised law omits the quoted phrase for the reason stated in Revisor's Note (3) to Section 441.053.

(3) Section 5, V.T.I.C. Article 21.28-A, provides that the commissioner of insurance may appoint a conservator and that "[t]he liquidator of the State Board of Insurance, or his duly appointed deputy," may be appointed to serve as the conservator. For the reasons stated in the revisor's note to Section 441.101, the revised law omits that provision because it is no longer necessary or accurate. The omitted law reads:

> Sec. 5. . . . The liquidator of the State Board of Insurance, or his duly appointed deputy, may be appointed to serve as the conservator. . . .

<u>Revised Law</u>

Sec. 441.152. NOTICE OF CONSERVATORSHIP. (a) Not later than the seventh day after the date the commissioner enters an order appointing a conservator for an insurer as provided by Section 441.151 or Subchapter F, the commissioner shall publish notice of the conservatorship in at least one newspaper of general

circulation in each county with a population of at least 100,000.

(b) The notice must include:

(1) the name of the insurer placed in conservatorship;

(2) the date the insurer was placed in conservatorship in this state;

(3) the reasons for placing the insurer in conservatorship;

(4) any action with respect to the insurer that is available to a policyholder; and

(5) any requirement with which a policyholder must comply. (V.T.I.C. Art. 21.28-A, Sec. 5A.)

Source Law

Sec. 5A. (a) On appointment of a conservator as provided by Sections 5 and 6 of this Article, the Commissioner of Insurance shall publish notice of the conservatorship in at least one newspaper with general circulation in each county that has a population of at least 100,000 according to the most recent federal decennial census.

(b) The notice must include:

(1) the name of the insurer placed in conservatorship;

(2) the date on which the insurer was placed in conservatorship in this state;

(3) the reasons for placing the insurer in conservatorship; and

(4) any courses of action with relation to the insurer available to policyholders and any duties with which the policyholders may be required to comply.

(c) The Commissioner of Insurance must publish the notice required by this section not later than the seventh day after the date the Commissioner enters an order placing the insurer in conservatorship.

Revisor's Note

Section 5A(a), V.T.I.C. Article 21.28-A, describes a population number that is to be determined "according to the most recent federal decennial census." The revised law omits the quoted language as unnecessary. Section 311.005(3), Government Code (Code Construction Act), and Section 312.011(20), Government Code, define "population" as population according to the most recent federal decennial census. That definition applies to the revised law.

Revised Law

Sec. 441.153. POWERS AND DUTIES OF CONSERVATOR. (a) The conservator appointed for an insurer under Section 441.151 shall immediately take charge of the insurer and all of the insurer's property, books, records, and effects, conduct the insurer's business, and act to remove the causes and conditions that made the conservatorship order necessary, as directed by the commissioner.

(b) During the conservatorship, the conservator shall provide reports to the commissioner as required by the commissioner and may:

(1) take all necessary measures in the conservator's own name as conservator to preserve, protect, or recover any asset or property of the insurer, including a claim or cause of action that the insurer may assert; and

(2) file a suit, or prosecute and defend a suit filed by or against the insurer, as the conservator considers necessary to protect all of the interested parties or any property affected by the suit. (V.T.I.C. Art. 21.28-A, Sec. 5 (part).)

Source Law

> Sec. 5. . . . [the Commissioner in his discretion may appoint] a conservator, who shall immediately take charge of such insurance company and all of the property, books, records, and effects thereof, and conduct the business thereof, and take such steps toward the removal of the causes and conditions, which have necessitated such order, as the Commissioner may direct. During the pendency of conservatorship, the conservator shall make such reports to the Commissioner from time to time as may be required by the Commissioner, and shall be empowered to take all necessary measures to preserve, protect, and recover any assets or property of such insurance company, including claims or causes of action belonging to or which may be asserted by such insurance company, and to deal with the same in his own name as conservator, and shall be empowered to file, prosecute, and defend any suit or suits which have been filed or which may thereafter be filed by or against such insurance company which are deemed by the conservator to be necessary to protect all of the interested parties or any property affected thereby. . . .

Revisor's Note

(1) Section 5, V.T.I.C. Article 21.28-A, provides that a conservator shall provide reports to

the commissioner of insurance "from time to time" as required by the commissioner. The revised law omits the quoted language because the duty to provide reports as required by the commissioner implies the duty to do so from time to time.

(2) Section 5, V.T.I.C. Article 21.28-A, refers to a claim or cause of action "belonging to or which may be asserted by" an insurer. The revised law omits as unnecessary the reference to "belonging to" because, in context, a claim or cause of action that "belongs to" an insurer is a claim or cause of action that the insurer may assert.

Revised Law

Sec. 441.154. PAYMENT OF CLAIMS. An insurer under conservatorship shall continue to pay claims under an insurance policy according to the terms of the policy. (V.T.I.C. Art. 21.28-A, Sec. 9 (part).)

Source Law

> Sec. 9. . . . During the period of conservatorship, the insurance company shall continue to pay claims according to the terms of the insurance policy. . . .

Revised Law

Sec. 441.155. REINSURANCE DURING CONSERVATORSHIP. (a) If during a conservatorship it appears that the interest of the insurer's policyholders or certificate holders is best protected by reinsuring the policies or certificates, the conservator may, with the approval of or at the direction of the commissioner:

(1) reinsure all or part of the insurer's policies or certificates with a solvent insurer authorized to engage in business in this state; and

(2) to the extent that the insurer has reserves attributable to the reinsured policies or certificates, transfer to the reinsurer reserves in an amount sufficient to reinsure the policies or certificates.

(b) A transfer of reserves under this section may not be considered a preference of a creditor. (V.T.I.C. Art. 21.28-A, Sec. 5 (part).)

Source Law

> Sec. 5. . . . If at the time of appointment of a conservator or at any time during the pendency of such conservatorship it appears that the interest of the policy holders or certificate holders of such insurance company can best be protected by reinsuring the same, the conservator may, with the approval of or at the direction of the Commissioner: (1) reinsure all or any part of such insurance company's policies or certificates of insurance with some solvent insurance company authorized to transact business in this state, and (2) to the extent that such insurance company in conservatorship is possessed of reserves attributable to such policies or certificates of insurance, the conservator may transfer to the reinsuring company such reserves or any portion thereof as may be required to consummate the reinsurance of such policies, and any such reserves so transferred shall not be deemed a preference of creditors. . . .

Revised Law

Sec. 441.156. HEARINGS DURING CONSERVATORSHIP. (a) On the commissioner's own motion or the motion of a party of record, a hearing relating to an insurer in conservatorship may be scheduled after at least 10 days' written notice to each party of record.

(b) The notice required by this section may be waived by the parties of record. (V.T.I.C. Art. 21.28-A, Sec. 5 (part).)

Source Law

> Sec. 5. . . . During the pendency of a conservatorship, the Commissioner may schedule a hearing relating to the insurance company in conservatorship with not less than ten (10) days' written notice to all parties of record on his own motion or that of any party of record; provided, however, that notice may be waived by the parties of record. . . .

Revisor's Note

> Section 5, V.T.I.C. Article 21.28-A, provides that "the Commissioner [of insurance] may schedule" a hearing on at least 10 days' notice. The revised law omits the reference to the commissioner scheduling the hearing for the reason stated in Revisor's Note (2) to Section 441.008.

Revised Law

Sec. 441.157. IMMUNITY. A conservator and the conservator's agents and employees are not liable, and a cause of action does not arise against the conservator or an agent or employee, for an action taken or not taken by the conservator, agent, or employee in connection with the adjustment, negotiation, or settlement of a claim. (V.T.I.C. Art. 21.28-A, Sec. 5 (part).)

Source Law

> Sec. 5. . . . A conservator and his agents and employees are not liable for and a cause of action may not be brought against any of them for an action taken or not taken by them relating to the adjustment, negotiation, or settlement of claims.

Revised Law

Sec. 441.158. VENUE. (a) A suit against an insurer in conservatorship or against the conservator may be filed only in Travis County unless the cause of action is based on the terms of an insurance policy issued by the insurer.

(b) A conservator appointed under this chapter may file suit in Travis County against any person to preserve, protect, or recover any asset or property of the insurer, including a claim or cause of action that may be asserted by the insurer. (V.T.I.C. Art. 21.28-A, Sec. 8.)

Source Law

> Sec. 8. Except for causes of action based upon terms of an insurance policy or policy or policies issued by an insurance company placed in conservatorship, any suit filed against an insurance company or its conservator, after the entrance of an order by the Commissioner of Insurance placing such insurance company in conservatorship and while such order is in effect, shall be brought in a court of competent jurisdiction in Travis County, Texas, and not elsewhere. The conservator appointed hereunder for such company may file suit in any court of competent jurisdiction in Travis County, Texas, against any person for the purpose of preserving, protecting, or recovering any assets or property of such insurance company including claims or causes of action belonging to or which may be asserted by such insurance company.

Revisor's Note

(1) Section 8, V.T.I.C. Article 21.28-A, refers to a suit filed in "a court of competent jurisdiction."

The revised law omits the references to "a court" because a suit may only be brought in a court. The revised law omits the references to "competent jurisdiction" for the reason stated in Revisor's Note (2) to Section 441.004.

(2) Section 8, V.T.I.C. Article 21.28-A, refers to a claim or cause of action "belonging to or which may be asserted by" an insurer. The revised law omits the reference to "belonging to" for the reason stated in Revisor's Note (2) to Section 441.153.

Revised Law

Sec. 441.159. DURATION OF CONSERVATORSHIP. (a) Except as provided by Subsection (b), a conservator appointed under this chapter shall complete the conservator's duties as required by this chapter not later than the 90th day after the date of appointment.

(b) If the commissioner issues written findings that there is a substantial likelihood of rehabilitation of the insurer in conservatorship, the commissioner may extend the conservatorship for additional successive 30-day periods. The total period of extensions may not exceed 180 consecutive days. A hearing is not required before the commissioner issues the findings. (V.T.I.C. Art. 21.28-A, Sec. 9 (part).)

Source Law

> Sec. 9. The conservator shall complete his duties and responsibilities as required by this Act not later than the ninetieth (90th) day after the date on which he is appointed conservator. The Commissioner of Insurance may extend the conservatorship for additional successive periods of thirty (30) days each for a total period of extensions not to exceed one hundred and eighty (180) successive days, if the Commissioner determines and issues written findings that there is a substantial likelihood of rehabilitation and no hearing is required before the Commissioner makes his determination. . . .

Revisor's Note

(1) Section 9, V.T.I.C. Article 21.28-A, refers to the "duties and responsibilities" of a conservator. The revised law omits the reference to

"responsibilities" as unnecessary because that term is included within the meaning of "duties."

(2) Section 9, V.T.I.C. Article 21.28-A, refers to circumstances in which the commissioner of insurance "determines and issues" certain findings. The revised law omits as unnecessary the reference to "determines" because the commissioner necessarily must determine the findings before issuing the findings.

Revised Law

Sec. 441.160. RETURN TO MANAGEMENT. An insurer that is rehabilitated shall be returned to management or placed under new management under reasonable conditions that best tend to prevent defeat of the purposes of the conservatorship. (V.T.I.C. Art. 21.28-A, Sec. 9 (part).)

Source Law

> Sec. 9. . . . If rehabilitated, the rehabilitated insurance company shall be returned to management or new management under such reasonable conditions as will best tend to prevent the defeat of the purposes for which it was placed in conservatorship.

[Sections 441.161-441.200 reserved for expansion]

SUBCHAPTER E. PROVISIONS APPLYING TO SUPERVISION AND CONSERVATORSHIP

Revised Law

Sec. 441.201. CONFIDENTIALITY. (a) Hearings and orders, notices, correspondence, reports, records, and other information in the department's possession relating to the supervision or conservatorship of an insurer are confidential during the supervision or conservatorship. On termination of the supervision or conservatorship, the information in the department's custody that relates to the supervision or conservatorship is public information.

(b) This section does not prohibit access by the department to hearings or orders, notices, correspondence, reports, records,

or other information.

(c) The provisions of Chapter 2001, Government Code, relating to discovery apply to the parties of record in a proceeding under this chapter.

(d) The commissioner may open a proceeding under this chapter or disclose information that is confidential under this section to a department, agency, or instrumentality of this state, another state, or the United States if the commissioner determines that opening the proceeding or disclosing the information is necessary or proper to enforce the laws of this state, another state, or the United States.

(e) An officer or employee of the department is not liable for a release of information that is confidential under this section unless it is shown that the release was accomplished with actual malice.

(f) This section does not apply to information:

(1) if the insurer's insureds are not protected by Chapter 462, 463, or 2602, or substantially similar statutes; or

(2) on the appointment by a court of a receiver for the insurer. (V.T.I.C. Art. 21.28-A, Sec. 3A.)

Source Law

Sec. 3A. (a) All hearings, orders, notices, correspondence, reports, records, and other information in the possession of the Texas Department of Insurance relating to the supervision or conservatorship of any insurance company are confidential during the period of supervision and conservatorship. On termination of the supervision and conservatorship, the information in the custody of the department that relates to the supervision and conservatorship becomes public information.

(b) This section does not prohibit access to hearings, orders, notices, correspondence, reports, records, and other information by the State Board of Insurance.

(c) The provisions of the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes) relating to discovery apply to the parties of record in these proceedings.

(d) The Commissioner of Insurance or the State Board of Insurance may open the proceedings or disclose the information to a department, agency, or instrumentality of this or another state or the United States if the Commissioner of Insurance or the State Board of Insurance determines that the disclosure is necessary or proper for the enforcement of the laws of

this or another state or the United States.

(e) An officer or employee of the Texas Department of Insurance is not liable for release of information without a showing that the release of information was accomplished with actual malice.

This section does not apply to information (1) if the insureds of the insurance company are not protected by Article 9.48, 21.28-C, or 21.28-D of this code or by statutes substantially similar to those Articles, or (2) on the appointment of a receiver for the insurance company by a court of competent jurisdiction.

Revisor's Note

(1) Section 3A(a), V.T.I.C. Article 21.28-A, refers to the "Texas Department of Insurance." The revised law substitutes a reference to "department" for "Texas Department of Insurance" because Section 31.001 of this code defines "department" for purposes of this code and the other insurance laws of this state to mean the Texas Department of Insurance.

(2) Section 3A(c), V.T.I.C. Article 21.28-A, refers to the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes). The relevant part of that statute was codified in 1993 as Chapter 2001, Government Code, and the revised law is drafted accordingly.

Revised Law

Sec. 441.202. COSTS OF SUPERVISION AND CONSERVATORSHIP. The commissioner shall determine the costs related to services provided by a supervisor or conservator under this chapter. Subject to Section 442.551, the costs shall be charged against the insurer's assets and paid as determined by the commissioner. (V.T.I.C. Art. 21.28-A, Sec. 5 (part).)

Source Law

Sec. 5. . . . The cost incident to the supervisor's and conservator's service shall be fixed and determined by the Commissioner of Insurance and, subject to Subsection (a) of Section 8 of Article 21.28 of this code, shall be a charge against the assets and funds of the insurance company to be allowed and paid as the Commissioner of Insurance may determine.

. . .

Revisor's Note

(1) Section 5, V.T.I.C. Article 21.28-A, refers to costs being "fixed and determined" by the commissioner. The revised law omits as unnecessary the reference to "fixed" because, in the context in which that term is used, "fixed" is included within the meaning of "determined."

(2) Section 5, V.T.I.C. Article 21.28-A, refers to a charge against the "assets and funds" of an insurer. The revised law omits as unnecessary the reference to "funds" because, in the context in which the term is used, "funds" is included within the meaning of "assets."

(3) Section 5, V.T.I.C. Article 21.28-A, refers to certain charges being "allowed and paid" as determined by the commissioner of insurance. The revised law omits as unnecessary the reference to "allowed" because the charge would be paid only if the commissioner determined that the charge was an "allowed" charge.

Revised Law

Sec. 441.203. COLLECTION OF FEES FROM REHABILITATED INSURER. (a) The commissioner may collect fees from an insurer described by Section 82.002 that is successfully rehabilitated by the commissioner. The fees must be in amounts sufficient to cover the cost of rehabilitating the insurer, but may not exceed that cost.

(b) The department may use fees collected under this section only for the rehabilitation of the insurer from which the fees are collected.

(c) Fees collected under this section shall be deposited in and expended through the Texas Department of Insurance operating account.

(d) The commissioner may determine the terms of the

collection or repayment of the fees. (V.T.I.C. Art. 21.28-A, Secs. 17(a) (part), (b).)

Source Law

> Sec. 17. (a) The State Board of Insurance may collect fees from any entity that is regulated by the board as provided by Subsection (h) of Section 7 of Article 1.10 of this code and that is successfully rehabilitated by the board. The fees shall be in amounts sufficient to cover but not exceed the costs of rehabilitation of that entity. The board shall use the fees for the sole purpose of the rehabilitation of the entity from which they are collected. Fees collected under this subsection shall be deposited in and expended through the State Board of Insurance Operating Fund. . . .
>
> (b) The Commissioner may determine the terms of the collection or repayment of the fees from any successfully rehabilitated entity.

Revisor's Note

(1) Section 17(a), V.T.I.C. Article 21.28-A, refers to "Subsection (h) of Section 7 of Article 1.10 of this code." Section 7(h), V.T.I.C. Article 1.10, was relettered as Section 7(g) by Section 1.07, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993. Section 7(g), Article 1.10, was revised in 1999 in Section 82.002 of this code. The revised law is drafted accordingly.

(2) Section 17(a), V.T.I.C. Article 21.28-A, requires fees to be deposited in 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 has been drafted accordingly.

Revised Law

Sec. 441.204. REVIEW AND STAY OF CERTAIN ACTS OF SUPERVISOR OR CONSERVATOR. (a) An insurer under supervision or conservatorship may request the commissioner or, in the commissioner's absence, the commissioner's appointed deputy to

review an action taken or proposed to be taken by the supervisor or conservator.

(b) A request for review under this section must specify the manner in which the action is believed to not be in the insurer's best interests.

(c) A request for review under this section stays the specified action pending review by the commissioner or the commissioner's deputy. (V.T.I.C. Art. 21.28-A, Sec. 7 (part).)

Source Law

> Sec. 7. During the period of supervision and during the period of conservatorship, the insurance company may request the Commissioner of Insurance or in his absence, the duly appointed deputy for such purpose, to review an action taken or proposed to be taken by the supervisor or conservator, specifying wherein the action complained of is believed not to be in the best interests of the insurance company, and such request shall stay the action specified pending review of such action by the Commissioner or his duly appointed deputy. . . .

Revised Law

Sec. 441.205. APPEAL OF CERTAIN ORDERS. The following orders of the commissioner may be appealed under Subchapter D, Chapter 36:

(1) an order appointing a supervisor and providing that the insurer may not engage in certain acts as provided by Section 441.104;

(2) an order appointing a conservator; and

(3) an order following the review under Section 441.204 of an action of a supervisor or conservator. (V.T.I.C. Art. 21.28-A, Sec. 7 (part).)

Source Law

> Sec. 7. . . . Any order entered by the Commissioner appointing a supervisor and providing that the insurance company shall not do certain acts as provided in Section 4 of this Article, any order entered by the Commissioner appointing a conservator, and any order by the Commissioner following the review of an action of the supervisor or conservator as hereinabove provided may be appealed under Article 1.04 of this code. . . .

Revisor's Note

Section 7, V.T.I.C. Article 21.28-A, provides for

judicial review of certain orders issued by the commissioner of insurance under V.T.I.C. Article 1.04, revised in 1999 as Subchapter D, Chapter 36, of this code, and provides for an appeal to an appellate court. The revised law omits the provisions for appeal to an appellate court as unnecessary because the provisions duplicate Section 36.205 of this code. The omitted law reads:

> Sec. 7. . . . [Any order entered by the Commissioner . . . may be appealed under Article 1.04 of this code.] Either party to said action may appeal to the Appellate Court having jurisdiction of said cause and said appeal shall be at once returnable to said Appellate Court having jurisdiction of said cause and said action so appealed shall have precedence in said Appellate Court over all causes of a different character therein pending.

Revised Law

Sec. 441.206. EX PARTE MEETING WITH COMMISSIONER. Notwithstanding any other law, the commissioner may, at the time of any proceeding or while a proceeding is pending under this chapter, meet with a supervisor or conservator appointed under this chapter and with the attorney or other representative of the supervisor or conservator, without another person present, to implement the commissioner's duties under this chapter or for the supervisor or conservator to implement that person's duties under this chapter. (V.T.I.C. Art. 21.28-A, Sec. 12(b).)

Source Law

> (b) Notwithstanding any other provision of law, the Commissioner may meet with a supervisor or conservator appointed under this Article and with the attorney or other representative of the supervisor or conservator, without the presence of any other person, at the time of any proceeding or during the pendency of any proceeding held under authority of this Article to carry out his duties under this Article or for the supervisor or conservator to carry out his duties under this Article.

Revised Law

Sec. 441.207. INSURER EMPLOYEES DURING SUPERVISION OR CONSERVATORSHIP. (a) Notwithstanding any other provision of this

chapter, an insurer may employ an attorney, actuary, and accountant of the insurer's choice to assist the insurer during supervision. The supervisor shall authorize payment from the insurer for the reasonable fees and expenses of the attorney, actuary, or accountant.

(b) The supervisor, conservator, or commissioner shall, to the maximum extent possible, use the insurer's employees instead of outside consultants, actuaries, attorneys, accountants, and other personnel or department employees to minimize the expense of rehabilitation or the necessity of fees to cover the cost of rehabilitation. (V.T.I.C. Art. 21.28-A, Secs. 13, 17(a) (part).)

Source Law

> Sec. 13. (a) Notwithstanding any other provision of this article, during a supervision proceeding, the insurer may employ an attorney, actuary, and accountant of the insurer's choice to assist the insurer during the supervision.
>
> (b) The supervisor shall authorize the payment of reasonable fees and expenses from the insurer for the attorney, actuary, or accountant.

> Sec. 17. (a) . . . The supervisor, conservator, or commissioner shall use the employees of the entity being rehabilitated, to the maximum extent possible, instead of outside consultants, actuaries, attorneys, accountants, other personnel or departmental employees, in order to minimize the expense of rehabilitation or the necessity of fees for rehabilitation.

[Sections 441.208-441.250 reserved for expansion]

SUBCHAPTER F. OUT-OF-STATE INSURERS

Revised Law

Sec. 441.251. APPLICABILITY. This chapter applies to an insurer engaged in the business of insurance in this state but not domiciled in this state, regardless of whether the insurer is authorized to engage in the business of insurance in this state. (V.T.I.C. Art. 21.28-A, Sec. 6 (part).)

Source Law

> Sec. 6. This Article shall apply to insurance companies doing an insurance business but not domiciled in the State of Texas, whether authorized to do business in this state or not. . . .

Revised Law

Sec. 441.252. APPOINTMENT OF ANCILLARY SUPERVISOR OR CONSERVATOR. (a) The commissioner may appoint an ancillary supervisor or ancillary conservator for the assets located in this state of an insurer described by Section 441.251 in the same manner as the commissioner appoints a supervisor or conservator for an insurer domiciled in this state as provided by this chapter if:

(1) the commissioner makes a determination described by Section 441.053 with regard to the insurer;

(2) the commissioner determines that the insurer does not have the minimum surplus, capital, or capital stock required by this code for similar domestic insurers; or

(3) the insurer agrees to the appointment.

(b) Subject to Section 441.205, the commissioner may immediately, without prior notice and hearing, appoint an ancillary conservator for the assets, property, books, and records located in this state of an insurer described by Section 441.251 if a conservator, rehabilitator, receiver, liquidator, or equivalent official is appointed in the state in which the insurer is domiciled. (V.T.I.C. Art. 21.28-A, Secs. 2 (part), (d), 6 (part).)

Source Law

> Sec. 2. As used in this Article, the following words, terms and phrases . . . include the meanings, significance or application described in this Section, except as another meaning is clearly requisite from the purposes or is otherwise clearly indicated by the context.
>
> (d) "Consent," as used in this Act, includes and means agreement to either supervision or conservatorship by the insurance company.
>
> Sec. 6. . . . In the event that the Commissioner of Insurance makes any of the findings provided for in Section 3 of this Article concerning any such insurance company or finds that any such insurance company is not possessed of the minimum surplus or capital or capital stock required by the Insurance Code of the State of Texas for similar type domestic companies, or if the insurance company gives its consent as defined herein, the Commissioner of Insurance shall have the same power and jurisdiction to appoint an ancillary supervisor or ancillary conservator as to the assets of such out of state insurer located in this state as provided herein for domestic insurance companies. . . . In addition, if a

conservator, rehabilitator, receiver, or liquidator or his equivalent has been appointed in the state of domicile with respect to the insurance company, the Commissioner of Insurance in his discretion may immediately and without prior notice and hearing appoint an ancillary conservator for the assets, property, and books and records of the out of state insurer located in this state subject to Section 7 of this Article. . . .

Revisor's Note

(1) Section 2, V.T.I.C. Article 21.28-A, provides that the terms and phrases in that section have certain meanings for purposes of Article 21.28-A, "except as another meaning is clearly requisite from the purposes or is otherwise clearly indicated by the context." Section 2(d), Article 21.28-A, defines "consent" by providing that the term "means and includes" agreement to certain specified actions. The revised law incorporates the substance of the definition into the revised law derived from Section 6, Article 21.28-A, and omits the quoted exception and the reference to "includes" for the reason stated in Revisor's Note (1) to Section 441.053.

(2) Section 6, V.T.I.C. Article 21.28-A, provides that the commissioner of insurance may take certain actions "subject to Section 7 of this Article." The relevant part of Section 7, Article 21.28-A, is revised in this chapter as Section 441.205. The revised law is drafted accordingly.

Revised Law

Sec. 441.253. POWERS AND DUTIES OF ANCILLARY SUPERVISOR OR CONSERVATOR. (a) An ancillary supervisor or ancillary conservator appointed under this subchapter has all the powers provided by Sections 441.153 and 441.155 with respect to the insurer's assets, property, books, and records located in this state.

(b) An ancillary conservator appointed under this subchapter may:

(1) reinsure all or part of the insurer's policies or

certificates in this state with a solvent insurer authorized to engage in business in this state; and

(2) transfer to the reinsurer as reserves any assets in the ancillary conservator's possession in an amount sufficient to reinsure the policies or certificates.

(c) A transfer of assets under this section is not considered a preference of a creditor. (V.T.I.C. Art. 21.28-A, Sec. 6 (part).)

Source Law

> Sec. 6. . . . Any ancillary supervisor or ancillary conservator appointed with respect to assets, property, and books and records located in this state belonging to an out of state insurance company shall have all of the powers and authority provided for in Section 5 of this Article with respect to such assets, property, and books and records located in this state and, in addition, any ancillary conservator so appointed may reinsure all or any part of such insurance company's policyholders or certificate holders located within this state with some solvent insurance company authorized to transact business in this state and may transfer to the reinsuring company, as reserve funds, assets or any portion thereof in his possession as may be required to consummate the reinsurance of such policies and any of such assets transferred as reserve funds shall not be deemed a preference of creditors. . . .

Revisor's Note

(1) Section 6, V.T.I.C. Article 21.28-A, refers to the "powers and authority" of an ancillary supervisor or conservator. The revised law omits as unnecessary the reference to "authority" because, in context, "authority" is included within the meaning of "powers."

(2) Section 6, V.T.I.C. Article 21.28-A, authorizes an ancillary conservator to reinsure all or part of an insurer's "policyholders or certificate holders" in this state and refers to the reinsurance of "such policies." The revised law substitutes "policies or certificates" for "policyholders or certificate holders" because policies and certificates, rather than the holders of the policies

and certificates, are reinsured. In addition, the revised law substitutes "the policies or certificates" for "such policies" for clarity and consistent use of terminology within this section.

Revised Law

Sec. 441.254. FAILURE TO COMPLY WITH REQUIREMENTS OF SUPERVISION. The failure of an insurer described by Section 441.251 to comply during supervision with the requirements of Section 441.104 with respect to any asset or policy located in this state is grounds for the immediate revocation of the insurer's certificate of authority to engage in business in this state and for the immediate appointment of an ancillary conservator to take charge of the insurer's assets located in this state. (V.T.I.C. Art. 21.28-A, Sec. 6 (part).)

Source Law

> Sec. 6. . . . In the event that any such out of state insurance company shall fail to comply with the provisions of Section 4 of this Article with respect to any of its assets or policies located within this state during any period of supervision, such act or violation shall constitute sufficient grounds for the immediate revocation of its certificate of authority to do business in this state and for the immediate appointment of an ancillary conservator to take charge of its assets located within this state. . . .

Revised Law

Sec. 441.255. REFERRAL FOR REMEDIAL ACTION. The commissioner may refer an insurer described by Section 441.251 to the attorney general for remedial action, including application for appointment of a receiver under Chapter 442, on any grounds on which an insurer domiciled in this state may be referred to the attorney general for remedial action. The commissioner may refer the insurer at any time, and action against the insurer in the insurer's state of domicile is not a prerequisite. (V.T.I.C. Art. 21.28-A, Sec. 6 (part).)

Source Law

> Sec. 6. . . . The Commissioner of Insurance, on any grounds permitting referral to the Attorney General for remedial action against a domestic insurance company, may at any time and without prior

action having been taken in the state of domicile, report an out of state insurance company for remedial action including, without limitation, making application for appointment of a receiver under Article 21.28 of this code.

Revisor's Note

Section 6, V.T.I.C. Article 21.28-A, refers to remedial action, "including, without limitation," applying for appointment of a receiver. The revised law omits the reference to "without limitation" for the reason stated in Revisor's Note (3) to Section 441.051.

[Sections 441.256-441.300 reserved for expansion]

SUBCHAPTER G. POWERS AND DUTIES OF ATTORNEY GENERAL

Revised Law

Sec. 441.301. REMEDIAL ACTION BY ATTORNEY GENERAL. (a) The commissioner may, at any time and regardless of whether an insurer is under supervision or conservatorship, determine that the insurer is not in a condition to continue business in the interest of the insurer's policyholders or certificate holders. The commissioner shall give notice of that determination to the attorney general.

(b) On receipt of notice under Subsection (a), the attorney general shall file suit in the nature of quo warranto in a court in Travis County to:

(1) forfeit the insurer's charter; or

(2) require the insurer to comply with the law or prove to the commissioner that the insurer is solvent, and satisfy the requirement that the insurer's condition does not make the continuation of the insurer's business hazardous to the public or to the insurer's policyholders or certificate holders.

(c) The commissioner may at any time refer an insurer to the attorney general for the purpose of taking any remedial action, including applying for the appointment of a receiver under Chapter 442.

(d) Supervision or conservatorship of the insurer is not required before the attorney general may take remedial action under

this section. (V.T.I.C. Art. 21.28-A, Sec. 5 (part).)

Source Law

> Sec. 5. . . . If the Commissioner of Insurance is satisfied at any time and regardless of the presence or absence of any state of supervision or conservatorship, that such insurance company is not in condition to continue business in the interest of its policy or certificate holders, the Commissioner of Insurance shall give notice to the Attorney General who shall thereupon apply to any Court in Travis County, Texas, having jurisdiction thereof for leave to file a suit in the nature of quo warranto to forfeit the charter of such insurance company or to require it to comply with the law or to satisfy the Commissioner of Insurance as to its solvency, and to satisfy the requirement that its condition is such as to render the continuance of its business not hazardous to the public or to the holders of its policies or certificates of insurance. It shall be in the discretion of the Commissioner of Insurance to [determine at any time whether or not the insurance company] . . . report it to the Attorney General for the purpose of taking any remedial action including, without limitation, applying for appointment of a receiver under Article 21.28 of this code. No period of supervision or conservatorship is necessary as a prerequisite for the Attorney General to take that remedial action. . . .

Revisor's Note

(1) Section 5, V.T.I.C. Article 21.28-A, directs the attorney general to "apply to [a Travis County court] for leave to file a suit in the nature of quo warranto." Under Rules 780 and 781, Texas Rules of Civil Procedure, the remedy available through a suit in the nature of quo warranto is sought by filing an information, as in civil actions, and the procedures for the suit are the same as in civil actions. Leave from the court to file the information is not required. Therefore, the revised law omits the reference to the attorney general applying for leave to file the suit.

(2) Section 5, V.T.I.C. Article 21.28-A, provides that the commissioner of insurance has discretion whether to place an insurer under supervision or conservatorship or to take other action. The revised law omits the reference to the commissioner's discretion to order supervision or

conservatorship because that provision duplicates other provisions revised in this chapter that more explicitly provide for the commissioner's authority to take those actions. The omitted law reads:

> Sec. 5. . . . [It shall be in the discretion of the Commissioner of Insurance to] determine at any time whether or not the insurance company is placed in supervision or he will operate the insurance company through a conservator, as provided above, or . . . .

(3) Section 5, V.T.I.C. Article 21.28-A, refers to taking remedial action, "including, without limitation," applying for appointment of a receiver. The revised law omits the reference to "without limitation" for the reason stated in Revisor's Note (3) to Section 441.051.

Revised Law

Sec. 441.302. FORFEITURE AND CANCELLATION OF CHARTER ON CONCLUSION OF BUSINESS. (a) Once all an insurer's policies are reinsured or terminated and the insurer's affairs are concluded as provided by this chapter, the commissioner shall report that fact to the attorney general. On receipt of the report, the attorney general shall take action necessary to forfeit or cancel the insurer's charter.

(b) The commissioner shall report to the attorney general the commissioner's approval of the merger or consolidation of an insurer with another insurer or the reinsurance of the insurer's policies. On receipt of the report, the attorney general shall take action to forfeit or cancel the insurer's charter in the manner provided for the forfeiture or cancellation of the charter of an insurer that is totally reinsured or liquidated. (V.T.I.C. Art. 21.28-A, Sec. 5 (part).)

Source Law

> Sec. 5. . . . When all the policies of an insurance company are reinsured or terminated, and all of its affairs concluded, as herein provided, the Commissioner of Insurance shall report the same to the Attorney General, who shall take such action as may be

necessary to effect the forfeiture or cancellation of the charter of the insurance company so reinsured and liquidated. Where the Commissioner of Insurance lends his approval to the merger, consolidation or reinsurance of all the policies of one insurance company with that of another, the same shall be reported to the Attorney General who shall proceed to effect the forfeiture or cancellation of the charter of the insurance company from which the policies were merged, consolidated or reinsured, in the same manner as is provided for the charters of companies totally reinsured or liquidated. . . .

[Sections 441.303-441.350 reserved for expansion]

SUBCHAPTER H. AGENTS OF RECORD FOR CERTAIN INSUREDS

Revised Law

Sec. 441.351. AGENTS OF RECORD. (a) Unless otherwise prohibited, the supervisor, conservator, or receiver of an insurer shall provide to the insured's agent of record a copy of each communication provided to an insured if, in the judgment of the supervisor, conservator, or receiver, providing the copy will serve to materially protect the interests of policyholders. The supervisor, conservator, or receiver may also request the assistance of any statewide association of insurance agents in providing to the association's members information that, in the judgment of the supervisor, conservator, or receiver, may serve to materially protect policyholders' interests.

(b) If the supervisor, conservator, or receiver sells a delinquent insurer's policies to another insurer, the purchaser shall:

(1) recognize the pecuniary interest of the agent of record in the policies being sold, regardless of whether the purchaser customarily conducts the purchaser's business through insurance agents;

(2) conduct the purchaser's business with the insured through the agent of record; and

(3) provide to the agent of record a written limited agency contract providing the terms that apply to the conduct of their business together.

(c) A limited agency contract provided under Subsection (b) must provide a level of commission that is reasonable, adequate,

and nonconfiscatory.

(d) This subchapter does not prohibit the agent of record from renewing with another insurer an insurance policy purchased by an insurer from a delinquent insurer.

(e) This section does not apply to:

(1) a life, accident, or health insurance policy or contract delivered or issued for delivery by an insurer that is subject to any provision of a law specified in Section 841.002 or any provision of Chapter 882, 884, 887, 888, or 982;

(2) a contract or certificate delivered or issued for delivery by a group hospital service corporation organized under Chapter 842; or

(3) a contract or evidence of coverage delivered or issued for delivery by a health maintenance organization operating under a certificate of authority issued under Chapter 843. (V.T.I.C. Art. 21.28-A, Sec. 4A.)

Source Law

Sec. 4A. (a) Unless otherwise prohibited, the supervisor, conservator, or receiver shall furnish the agent of record with a copy of each communication provided to the insured, if in the judgment of the supervisor, conservator, or receiver, furnishing such copy will serve to materially protect the interests of policyholders. The supervisor, conservator, or receiver may also request the assistance of any statewide associations of insurance agents to furnish their members with information that in the judgment of the supervisor, conservator, or receiver may serve to materially protect the interests of policyholders.

(b) In the event the supervisor, conservator, or receiver sells the insurance policies of a delinquent insurer to another insurer, the pecuniary interest of the agent of record in the insurance policies being sold shall be recognized by the purchaser, whether or not the purchaser customarily conducts its business through insurance agents.

(c) The insurer purchasing such insurance policies shall conduct its business with the insured through the agent of record and shall furnish the agent of record with a written limited agency contract providing for the terms and conditions that shall serve to guide the conduct of their business together. Such limited agency contract shall provide a level of commission that shall be reasonable, adequate, and nonconfiscatory.

(d) Nothing contained in this Act shall be construed to prohibit the agent of record from renewing insurance policies purchased by the insurer from a delinquent insurer with another insurer.

(e) This section does not apply to:

(1) any life, accident, or health insurance policy or contract delivered or issued for delivery by an insurer that is subject to any provision of Chapter 3, 11, 14, or 22 of this code;

(2) any contract or certificate that is delivered or issued for delivery by a group hospital service corporation organized under Chapter 20 of this code; or

(3) any contract or evidence of coverage delivered or issued for delivery by a health maintenance organization operating under a certificate of authority issued under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

Revisor's Note

Section 4A(c), V.T.I.C. Article 21.28-A, refers to the "terms and conditions" of a contract. The revised law omits as unnecessary the reference to "conditions" because, in context, "conditions" is included within the meaning of "terms."

CHAPTER 442. LIQUIDATION, REHABILITATION, REORGANIZATION, OR CONSERVATION OF INSURERS

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CHAPTER 442. LIQUIDATION, REHABILITATION, REORGANIZATION, OR CONSERVATION OF INSURERS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 442.001. DEFINITIONS. (a) In this chapter:

(1) "Assets" means all property, whether specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons. The term includes all deposits and funds of a special or trust nature.

(2) "Delinquency proceeding" means a proceeding initiated in a court of this state against an insurer to liquidate, rehabilitate, reorganize, or conserve the insurer.

(3) "Insurer" means any organization, corporation, or person that engages in the business of insurance, other than an organization, corporation, or person that is specifically made

exempt from the application of this chapter by another statute that references this chapter. The term includes:

(A) a capital stock company;

(B) a reciprocal or interinsurance exchange;

(C) a Lloyd's plan;

(D) a fraternal benefit society;

(E) a mutual or mutual assessment company of any kind, including:

(i) a statewide mutual assessment company;

(ii) a local mutual aid association;

(iii) a burial association;

(iv) a county mutual insurance company; and

(v) a farm mutual insurance company; and

(F) a fidelity, guaranty, or surety company.

(4) "Person" means an individual, association, corporation, partnership, or other private legal entity.

(5) "Receiver" means a person appointed to act as receiver under Section 442.051. The term includes the commissioner or a person appointed by the commissioner to act as special deputy receiver.

(b) For purposes of this chapter, "court" means the court in which a delinquency proceeding is pending, unless the context clearly indicates otherwise. (V.T.I.C. Art. 21.28, Secs. 1(a) (part), (b), (c), (d), (f), (g); New.)

Source Law

Art. 21.28

Sec. 1. For the purposes of this Article:

(a) "Insurer" means and includes capital stock companies, reciprocal or interinsurance exchanges, Lloyd's associations, fraternal benefit societies, mutual and mutual assessment companies of all kinds and types, state-wide assessment associations, local mutual aids, burial associations, county and farm mutual associations, fidelity, guaranty and surety companies, . . . all other organizations, corporations, or persons transacting an insurance business, unless such insurers are by statute specifically, by naming this Article, exempted from the operation of this Article.

(b) "Delinquency proceeding" means any proceeding commenced in any court of this State against an insurer for the purpose of liquidating,

rehabilitating, reorganizing or conserving such insurer.

(c) "Assets" means all property, real or personal, whether specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons, or a limited class or classes of persons. The word "assets," as used in this Article, includes all deposits and funds of a special or trust nature.

(d) "Liquidator" means "receiver." The term includes the commissioner of insurance or the person designated by the commissioner of insurance to act as special deputy receiver.

(f) "Court," unless the same clearly appears to the contrary from the text of this article, means the court in which the delinquency proceeding is pending.

(g) "Person" means an individual, association, corporation, partnership, or other private legal entity.

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 21.28, refers to "Lloyd's associations," "state-wide assessment associations," "local mutual aids," and "county and farm mutual associations," meaning entities operating under Chapter 941, 881, 886, 912, or 911, respectively, of this code. The terms most frequently used to refer to those entities are "Lloyd's plan," "statewide mutual assessment company," "local mutual aid association," "county mutual insurance company," and "farm mutual insurance company." For consistent use of terminology in this code, the revised law substitutes "Lloyd's plan," "statewide mutual assessment company," "local mutual aid association," "county mutual insurance company," and "farm mutual insurance company" for "Lloyd's associations," "state-wide assessment associations," "local mutual aids," and "county and farm mutual associations," respectively.

(2) Section 1(a), V.T.I.C. Article 21.28, defines "insurer" to include "trust companies organized under the provisions of Chapter 7 of Texas Insurance Code of 1951." The revised law omits the

reference to "trust companies" because Section 1, Chapter 388, Acts of the 55th Legislature, Regular Session, 1957, repealed Chapter 7. The remainder of Chapter 388 enacted new requirements applicable to the creation and organization of trust companies, some of which were added to Vernon's Texas Civil Statutes as Article 1513a. That article was repealed by Chapter 168, Acts of the 70th Legislature, Regular Session, 1987, which added the substance of Article 1513a to the law on the organization of trust companies contained in Chapter XI, The Texas Banking Code of 1943 (Article 342-1101 et seq., Vernon's Texas Civil Statutes). That chapter was repealed by Chapter 769, Acts of the 75th Legislature, Regular Session, 1997, which enacted the Texas Trust Company Act (Article 342a-1.001 et seq., Vernon's Texas Civil Statutes). That act was codified as Subtitle F, Title 3, Finance Code, by Chapter 62, Acts of the 76th Legislature, Regular Session, 1999. To the extent that any trust companies organized under Chapter 7 of this code still exist and operate as insurers, they are included in the reference under Subdivision (3) of the revised law to "any organization, corporation, or person that engages in the business of insurance." The omitted law reads:

> (a) . . . trust companies organized under the provisions of Chapter 7 of Texas Insurance Code of 1951, and . . . .

(3) Section 1(c), V.T.I.C. Article 21.28, defines "assets" to mean "all property, real or personal." Throughout this chapter, references to "real or personal" are omitted from the revised law in this context 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.

(4) Section 1(d), V.T.I.C. Article 21.28, defines "liquidator" to mean "receiver" and provides that the term includes the commissioner of insurance or the person "designated" by the commissioner to act as special deputy receiver. Former Section 12, V.T.I.C. Article 21.28, provided for the appointment of a liquidator by the State Board of Insurance, and former Section 2 of that article required the liquidator to act as receiver if a court found that a receiver should take charge of the assets of an insurer. Chapter 12, Acts of the 72nd Legislature, 2nd Called Session, 1991, amended Article 21.28 to require the commissioner of insurance or a person designated by the commissioner to act as receiver if a court finds that a receiver should take charge of the assets of an insurer and to authorize the commissioner to appoint one or more special deputy receivers to act as receiver for the commissioner. Because the position of liquidator within the Texas Department of Insurance has effectively been abolished, the terms "liquidator" and "receiver" are synonymous, and the source law for this chapter generally uses the term "receiver" rather than "liquidator," the revised law defines the term "receiver" and substitutes "receiver" for "liquidator" throughout this chapter. In addition, for the convenience of the reader the revised law defines "receiver" to mean a person appointed to act as receiver under Section 442.051 because the substantive duty giving rise to the defined term is imposed by that section. Finally, throughout this chapter the revised law substitutes "appointed" for "designated" in the context of the selection of a special deputy receiver by the commissioner for consistency in use of

terminology.

(5) Section 1(e), V.T.I.C. Article 21.28, defines "board" as the State Board of Insurance of the State of Texas or the commissioner of insurance, as applicable. 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. For this reason, the revised law omits the definition of "board." The omitted law reads:

> (e) "Board" means the State Board of Insurance of the State of Texas, or the Commissioner of Insurance as applicable under Article 1.02 of this code.

Revised Law

Sec. 442.002. LIQUIDATION OVERSIGHT DIVISION EMPLOYEES. The employees of the commissioner acting as receiver are employees of the department for the purposes of:

(1) reporting payroll information to the uniform statewide accounting system; and

(2) submitting vouchers to the comptroller for the payment of the employees' salaries. (V.T.I.C. Art. 21.28, Sec. 12A(b).)

Source Law

> (b) The Liquidator and the employees working for the Liquidator or in the liquidation division of the State Board of Insurance are employees of the State Board of Insurance for the purpose of:
>
> (1) reporting payroll information to the uniform statewide accounting system; and
>
> (2) submitting vouchers to the comptroller for the payment of the salaries of the Liquidator and the employees.

Revisor's Note

Section 12A(b), V.T.I.C. Article 21.28, provides that the liquidator and the employees working for the liquidator or in the liquidation division of the State

Board of Insurance, meaning the Texas Department of Insurance, are employees of the department for certain purposes. As explained in Revisor's Note (4) to Section 442.001, Chapter 12, Acts of the 72nd Legislature, 2nd Called Session, 1991, abolished the position of liquidator within the department. The commissioner of insurance or a special deputy receiver appointed by the commissioner acts as a receiver and performs the functions formerly performed by the liquidator. In general, the revised law codifies "liquidator" as "receiver." However, unlike the former liquidator, neither the commissioner nor the special deputy receivers appointed by the commissioner are department employees for any purpose, including those enumerated by Section 12A(b). The commissioner is an officer appointed by the governor with the advice and consent of the senate under Subchapter B, Chapter 31, of this code, and a special deputy receiver is appointed by the commissioner under contract under Section 2(a), Article 21.28, revised in pertinent part in this chapter as Section 442.051, and is therefore an independent contractor. Furthermore, the liquidation division of the department has been redesignated as the liquidation oversight division. Accordingly, the revised law substitutes a reference to the employees of the commissioner in the commissioner's role as receiver for the reference to the liquidator and the employees working for the liquidator or in the liquidation division.

Revised Law

Sec. 442.003. OVERSIGHT OF SPECIAL DEPUTY RECEIVERS AND GUARANTY ASSOCIATIONS. The commissioner shall oversee special deputy receivers and guaranty associations. (V.T.I.C. Art. 21.28, Sec. 2(a) (part).)

Source Law

(a) . . . It is the intent of the legislature that oversight of the special deputy receivers and guaranty associations shall be conducted by the commissioner. . . .

Revisor's Note

Section 2(a), V.T.I.C. Article 21.28, provides that "[i]t is the intent of the legislature" that oversight of certain persons and entities be conducted by the commissioner of insurance. The revised law omits the quoted language as unnecessary because it is implied that a statute expresses the intent of the legislature.

Revised Law

Sec. 442.004. CONFLICT WITH OTHER LAW. If this chapter conflicts with any other law, this chapter prevails. (V.T.I.C. Art. 21.28, Secs. 12A(a-1) (part), 16 (part).)

Source Law

Sec. 12A. (a-1) [The provisions of this Act are cumulative of existing law and] in the event of conflict the provisions of this Act shall govern.

Sec. 16. In the event of conflict between the provisions of this Article and the provisions of any existing law, the provisions of this Article shall prevail, . . . .

Revisor's Note
(End of Subchapter)

Section 12A(a-1), V.T.I.C. Article 21.28, provides that "this Act," meaning Chapter 661, Acts of the 59th Legislature, Regular Session, 1965, which amended V.T.I.C. Article 21.28 by adding Section 12A, is cumulative of existing law. Similarly, Section 16, V.T.I.C. Article 21.28, provides that in the event of a conflict between a provision of Article 21.28 and a provision of any existing law, all laws in conflict with Article 21.28 are repealed to the extent of the conflict. The revised law omits those provisions 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. In addition, under general rules of statutory construction, a statute automatically has the effect of repealing prior conflicting enactments. The omitted law reads:

> Sec. 12A. (a-1) The provisions of this Act are cumulative of existing law and . . . .
>
> Sec. 16. . . . and all laws, or parts of law, in conflict with the provisions of this Article, are hereby repealed to the extent of such conflict.

[Sections 442.005-442.050 reserved for expansion]

SUBCHAPTER B. GENERAL PROVISIONS REGARDING RECEIVER

Revised Law

Sec. 442.051. RECEIVER. If, under a law of this state, a court of competent jurisdiction finds that a receiver should take charge of the assets of an insurer domiciled in this state, the commissioner or a person appointed as a special deputy receiver by the commissioner under a contract shall act as receiver. (V.T.I.C. Art. 21.28, Sec. 2(a) (part).)

Source Law

> Sec. 2. (a) Receiver Taking Charge; Commissioner and Powers and Duties. Whenever under the law of this State a court of competent jurisdiction finds that a receiver should take charge of the assets of an insurer domiciled in this State, the commissioner of insurance or a person designated by the commissioner under contract shall act as receiver. . . .

Revised Law

Sec. 442.052. APPOINTMENT OF SPECIAL DEPUTY RECEIVER. (a) The commissioner may appoint, set the compensation of, and contract with one or more qualified special deputy receivers to act for the commissioner under this code.

(b) The commissioner shall:

(1) specify requirements for the position of special deputy receiver; and

(2) use a competitive bidding process to select special deputy receivers.

(c) In making an appointment under this section, the commissioner shall attempt to reflect the ethnic, racial, and geographic diversity of the state.

(d) A special deputy receiver serves at the pleasure of the commissioner. (V.T.I.C. Art. 21.28, Secs. 2(a) (part), 12(b) (part), (h) (part).)

Source Law

[Sec. 2]

(a) . . . The commissioner shall use a competitive bidding process in the selection of special deputy receivers and shall establish specifications for the position of special deputy receiver. . . .

[Sec. 12]

(b) Appointments, Expenses. The commissioner may appoint, set the compensation of, and contract with one or more qualified special deputy receivers to act for the commissioner under this code. In making an appointment under this section, the commissioner shall attempt to reflect the ethnic, racial, and geographic diversity of the state. . . .

(h) Authority of Special Deputy Receiver. A special deputy receiver appointed by the commissioner serves at the pleasure of the commissioner. . . .

Revised Law

Sec. 442.053. PERFORMANCE BOND REQUIRED. A special deputy receiver must file with the commissioner a bond that is:

(1) in an amount established by the commissioner;

(2) payable to the commissioner for the benefit of injured parties; and

(3) conditioned on:

(A) the faithful performance of the special deputy receiver's duties; and

(B) the proper accounting for all money and property received or administered by the special deputy receiver. (V.T.I.C. Art. 21.28, Sec. 12(a).)

Source Law

Sec. 12. (a) Special Deputy Receiver, Bond. A special deputy receiver appointed by the commissioner under this article shall file with the commissioner a

bond in an amount established by the commissioner, payable to the commissioner for the benefit of injured parties, and conditioned on the faithful performance of the special deputy receiver's duties and the proper accounting for all moneys and properties received or administered by the special deputy receiver.

Revised Law

Sec. 442.054. POWERS OF SPECIAL DEPUTY RECEIVER. (a) Unless restricted by the commissioner, a special deputy receiver has all the powers of a receiver granted under this code and may perform any act on behalf of the commissioner as receiver.

(b) If expressly authorized by the commissioner, a special deputy receiver may employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants, and other personnel the special deputy receiver considers necessary to assist in the performance of the receiver's duties. The expenses of employing those persons are expenses of the receivership payable out of money or other assets of the insurer. (V.T.I.C. Art. 21.28, Secs. 12(b) (part), (h) (part).)

Source Law

(b) . . . A special deputy receiver has all the powers of the receiver granted by this code, unless limited by the commissioner. . . .

(h) . . . Unless restricted by the commissioner, a special deputy receiver may perform any act on behalf of the commissioner. If expressly authorized by the commissioner, a special deputy receiver may employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants, and other personnel as the special deputy receiver considers necessary to assist in the performance of the receiver's duties. The expenses of employing those persons are expenses of the receivership payable out of funds or assets of the insurer.

Revisor's Note

(1) Section 12(b), V.T.I.C. Article 21.28, grants a special deputy receiver "all the powers of the receiver granted by this code." Section 12(h) provides that a special deputy receiver may perform "any act on behalf of the commissioner." It is clear from the context of the source law that the special deputy receiver is authorized to perform on behalf of

the commissioner only the acts that the commissioner would be authorized to perform in the commissioner's role as receiver. The revised law is drafted accordingly.

(2) Section 12(h), V.T.I.C. Article 21.28, refers to "funds" of an insurer. Throughout this chapter, the revised law substitutes "money" for "funds" because, in this context, the terms are synonymous and the former is more commonly used.

Revised Law

Sec. 442.055. RECEIVER CONSIDERED TO ACT ON BEHALF OF RECEIVERSHIP ESTATE. (a) In performing the duties of receiver under this chapter, the commissioner, a special deputy receiver, or an agent or employee of the commissioner or special deputy receiver is considered to act on behalf of the receivership estate.

(b) Chapter 105, Civil Practice and Remedies Code, does not apply to an action taken under this chapter. (V.T.I.C. Art. 21.28, Sec. 2(l).)

Source Law

(l) Actions by Receiver. When performing the duties of receiver under this Article, the commissioner, a special deputy receiver, or an agent or employee of the commissioner, or a special deputy receiver shall be considered to be acting on behalf of the receivership estate, and the provisions of Chapter 105, Civil Practice and Remedies Code, shall not apply to any actions taken pursuant to this Article.

Revised Law

Sec. 442.056. IMMUNITY. (a) The following persons are not liable, and a cause of action does not arise against any of the following persons, for a good faith action or failure to act in exercising powers and performing duties under this chapter:

(1) the commissioner or an agent or employee of the commissioner; or

(2) a special deputy receiver or an agent or employee of the special deputy receiver.

(b) The attorney general shall defend an action to which

Subsection (a) applies that is brought against a person described by that subsection, including an action brought after the defendant's service with the commissioner, a special deputy receiver, or the department has terminated, or after the close of the receivership out of which the action arises. This subsection does not require the attorney general to defend a person with respect to an issue other than the applicability or effect of the immunity provided by Subsection (a). (V.T.I.C. Art. 21.28, Secs. 2(j), (k).)

Source Law

> (j) Immunity. There is no liability on the part of, and a cause of action does not arise against, the receiver, a special deputy receiver, the commissioner, or an agent or employee of the receiver, a special deputy receiver, or the commissioner for a good faith action or failure to act in the performance of powers and duties under this article.
>
> (k) Representation by Attorney General. The attorney general shall defend an action to which Subsection (j) of this section applies that is brought against the receiver, a special deputy receiver, the commissioner, or an agent or employee of the receiver, a special deputy receiver, or the commissioner. This subsection continues to apply to an action that is brought after the defendant's service with the receiver, a special deputy receiver, the commissioner, or the department has terminated or after the close of the receivership out of which the action arises. This subsection does not require the attorney general to defend any person with respect to an issue other than the applicability or effect of the judicial immunity codified by Subsection (j) of this section.

Revisor's Note

(1) Sections 2(j) and (k), V.T.I.C. Article 21.28, refer to "the receiver," "a special deputy receiver," and "the commissioner." The revised law omits the references to "receiver" as unnecessary because under Section 2(a), V.T.I.C. Article 21.28, revised in pertinent part in this chapter as Section 442.051, only the commissioner or a person appointed as a special deputy receiver may act as receiver.

(2) Section 2(k), V.T.I.C. Article 21.28, refers to the "judicial immunity" in Section 2(j), Article 21.28, revised as Subsection (a) of this

section. Section 2(j) refers to "immunity" rather than "judicial immunity." Accordingly, the revised law substitutes "immunity" for "judicial immunity" for consistency in use of terminology.

Revisor's Note
(End of Subchapter)

Section 2(a), V.T.I.C. Article 21.28, provides that a special deputy receiver is subject to the performance standards imposed by Section 2(a). The revised law omits the provision subjecting the special deputy receiver to those performance standards as unnecessary because those provisions apply to the special deputy receiver by their terms. The omitted law reads:

> (a) . . . A person designated by the commissioner to act as special deputy receiver under contract is subject to the performance standards imposed by this subsection. . . .

[Sections 442.057-442.100 reserved for expansion]

SUBCHAPTER C. CONDUCT OF DELINQUENCY PROCEEDINGS: GENERAL PROVISIONS

Revised Law

Sec. 442.101. VENUE. Exclusive venue of delinquency proceedings is in Travis County. (V.T.I.C. Art. 21.28, Sec. 2(i).)

Source Law

> (i) Venue. Exclusive venue of delinquency proceedings shall be in Travis County, Texas.

Revised Law

Sec. 442.102. RIGHTS AND LIABILITIES ESTABLISHED AS OF DATE DELINQUENCY PROCEEDING BEGINS. Except as otherwise directed by the court or expressly provided by this chapter, the rights and liabilities of an insurer that is the subject of a delinquency proceeding and of all other persons interested in the insurer's estate, including the insurer's creditors, policyholders, members, officers, directors, shareholders, and agents, are fixed as of the date of the commencement of the delinquency proceeding, subject to

the provisions of Subchapter E relating to the rights of claimants holding unliquidated or undetermined claims or demands. (V.T.I.C. Art. 21.28, Sec. 2(c).)

Source Law

> (c) Rights Fixed. The rights and liabilities of any such insurer and of its creditors, policyholders, members, officers, directors, stockholders, agents, and all other persons interested in its estate, shall, unless otherwise directed by the court, be fixed as of the date of the commencement of the delinquency proceedings, subject, however, to the provisions of Section 3 with respect to the rights of claimants holding unliquidated or undetermined claims or demands, and as otherwise expressly provided in this Article.

Revised Law

Sec. 442.103. TITLE TO ASSETS; PRIORITY OF RECEIVER'S RIGHTS. (a) The assets of an insurer that is the subject of a delinquency proceeding are in the custody of the court as of the date of the commencement of the proceeding.

(b) The receiver is vested by operation of law with the title to all of the insurer's property, contracts, and rights of action, wherever located, as of the date a court order is entered directing possession to be taken. The title of the receiver relates back to the date of the commencement of the delinquency proceeding unless the court provides otherwise.

(c) A contractual lien or statutory landlord's lien under Chapter 54, Property Code, that arises after the date of the commencement of the delinquency proceeding is secondary and inferior to the rights of the receiver.

(d) The filing or recording of an order described by Subsection (b) in any record office of the state provides the same notice as would be provided by a deed, bill of sale, or other evidence of title filed or recorded by the insurer. (V.T.I.C. Art. 21.28, Sec. 2(b).)

Source Law

> (b) Title in Receiver. The property and assets of such insurer shall be in the custody of the court as of the date of the commencement of such delinquency proceedings. The said receiver and his successors in office shall be vested by operation of law with the

title to all of the property, contracts, and rights of action of such insurer, wherever located, as of the date of entry of the order directing possession to be taken. Such title of the receiver shall relate back to the date of the commencement of the delinquency proceedings unless the court shall otherwise provide. A contractual lien or statutory landlord's lien under Chapter 54, Property Code, that arises after the date of the commencement of the delinquency proceedings is secondary and inferior to the rights of the receiver and his successors in office. The filing or recording of such an order in any record office of the State shall impart the same notice as would be imparted by a deed, bill of sale, or other evidence of title duly filed or recorded by such insurer.

Revisor's Note

(1) Section 2(b), V.T.I.C. Article 21.28, refers to the "property and assets" of an insurer. Throughout this chapter, the reference to "property" is omitted from the revised law in this context because under Section 1(c), V.T.I.C. Article 21.28, revised in this chapter as Section 442.001(a)(1), "assets" is defined to include all property of an insurer.

(2) Section 2(b), V.T.I.C. Article 21.28, refers to the "receiver and his successors in office." The references to the receiver's "successors in office" are omitted from the revised law because the receiver's "successors in office" are included within the meaning of "receiver."

(3) Section 2(b), V.T.I.C. Article 21.28, refers to a deed, bill of sale, or other evidence of title "duly" filed or recorded by an insurer. The revised law omits "duly" as unnecessary because the term does not add to the clear meaning of the law. A deed, bill of sale, or other evidence of title is not filed or recorded if it is not duly filed or recorded.

Revised Law

Sec. 442.104. DUTY OF RECEIVER TO TAKE POSSESSION OF ASSETS; INVENTORY. (a) The receiver shall promptly take possession of the assets of an insurer that is the subject of a delinquency proceeding and, as the court directs, manage those

assets in the person's own name as receiver or in the name of the insurer.

(b) The receiver is responsible for all assets coming into the receiver's possession.

(c) The receiver shall promptly prepare, in duplicate, an inventory of the insurer's assets. The receiver shall file one copy of the inventory with the department and one copy in the office of the clerk of the court. The copies of the inventory are open for inspection. (V.T.I.C. Art. 21.28, Secs. 2(a) (part), (d) (part), (f).)

Source Law

> (a) . . . The receiver shall forthwith take possession of the assets of such insurer and deal with the same in the person's own name as receiver or in the name of the insurer as the court may direct. . . .
>
> (d) Bonds. The receiver shall be responsible for all assets coming into his possession. . . .
>
> (f) Inventory. An inventory in duplicate of the insurer's assets shall be prepared forthwith by the receiver, one of which shall be filed in the office of the Board and one in the office of the clerk of the court having jurisdiction, which inventories shall be open to inspection.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.28, provides that a receiver has the powers specified by this code. The revised law omits that provision as unnecessary. The provisions of this code that specify those powers are sufficient authority for those powers. The omitted law reads:

> (a) . . . The receiver has the powers specified in this code. . . .

(2) Section 2(f), V.T.I.C. Article 21.28, refers to "the court having jurisdiction." The revised law substitutes a reference to "the court" because under Section 1(f), V.T.I.C. Article 21.28, revised in this chapter as Section 442.001(b), for purposes of this chapter "court" means the court in which a delinquency proceeding is pending, unless the

context clearly indicates otherwise, and it is clear from the context that the court to which the reference is made is the court in which the delinquency proceeding is pending.

Revised Law

Sec. 442.105. AUTHORITY TO REQUIRE BOND TO PROTECT ASSETS. The court may require:

(1) the receiver to provide one or more bonds; and

(2) if considered desirable by the court for the protection of the assets, a special deputy receiver or other assistant or employee appointed under this chapter to provide one or more bonds. (V.T.I.C. Art. 21.28, Sec. 2(d) (part).)

Source Law

> (d) . . . The court may require a bond, or bonds, from the said receiver, and, if deemed desirable for the protection of the assets, may require a bond, or bonds, of any special deputy receiver, or other assistant or employee appointed by or under the authority of this Article.

Revised Law

Sec. 442.106. DELIVERY OF PROPERTY AND RECORDS TO RECEIVER. (a) The officers, directors, shareholders, members, trustees, managing general agents, agents, administrators, claims adjusters, managers, attorneys-in-fact, and associate, deputy, or substitute attorneys-in-fact of a delinquent insurer shall immediately deliver to the receiver, without cost to the receiver, all property, books, records, accounts, documents, and other writings of the delinquent insurer or that relate to the business of the delinquent insurer.

(b) If by contract or otherwise any property, book, record, account, document, or other writing is owned by a person described by Subsection (a), the owner shall copy the item and deliver the copy to the receiver. The owner shall retain the original until notification that the item is no longer required in the administration of the insurer's estate or until another time as the court, after notice and hearing, directs. A copy is considered to

be a record of the delinquent insurer under Subchapter I. (V.T.I.C. Art. 21.28, Sec. 4(e).)

Source Law

> (e) Records with Third Parties. All officers, directors, stockholders, members, trustees, managing general agents, agents, administrators, claims adjusters, managers, attorneys-in-fact, or associate, deputy, or substitute attorneys-in-fact of the delinquent insurer shall immediately deliver to the possession of the receiver all properties, books, records, accounts, documents, and other writings of the delinquent insurer or that relate to the business of the delinquent insurer without cost to the receiver; however, if by contract or otherwise any of the properties, books, records, accounts, documents, and other writings belong to or are the property of those persons, they shall be copied, the copy delivered to the receiver, and the original retained by the owner until notification that it is no longer required in the administration of the insurer's estate or at any other time as the court, after notice and hearing, shall direct. The copies are deemed to be records of the delinquent insurer under Section 11 of this Article.

Revised Law

Sec. 442.107. DUTY OF RECEIVER TO CONDUCT INSURER'S BUSINESS. (a) On taking possession of the assets of a delinquent insurer, the receiver shall, subject to the direction of the court, immediately begin conducting the insurer's business or taking any steps necessary to conserve the assets and protect the rights of policyholders and claimants for the purpose of liquidating, rehabilitating, reinsuring, reorganizing, or conserving the affairs of the insurer.

(b) Notwithstanding the requirements of Subsection (a) or the terms of any insurance contract issued by a delinquent insurer, the receiver is not required to defend any action against an insured of a delinquent insurer. (V.T.I.C. Art. 21.28, Sec. 2(e).)

Source Law

> (e) Conducting of Business. Upon taking possession of the assets of a delinquent insurer the receiver shall, subject to the direction of the court, immediately proceed to conduct the business of the insurer, or to take such steps as may be necessary to conserve the assets and protect the rights of policyholders and claimants for the purpose of liquidating, rehabilitating, reinsuring, reorganizing or conserving the affairs of the insurer. Notwithstanding the foregoing requirements or the terms of any insurance contract issued by a delinquent

insurer, the receiver is not required to defend any action against an insured of a delinquent insurer.

Revised Law

Sec. 442.108. DISPOSAL OF PROPERTY; SETTLING OF CLAIMS. (a) Except as provided by Subsection (b), the receiver may, subject to the approval of the court:

(1) sell or otherwise dispose of all or part of the property of an insurer against whom a delinquency proceeding has been brought; and

(2) sell or compound all doubtful or uncollectible debts, or claims owed by or to the insurer, including claims based on an assessment levied against a member of a mutual insurer, a reciprocal or interinsurance exchange, or a Lloyd's plan.

(b) Without obtaining the approval of the court, the receiver may compromise or compound a debt or claim described by Subsection (a)(2) or sell an item of the insurer's property on terms the receiver considers to be in the best interest of the insurer if the amount of the debt or claim or the value of the item of property does not exceed $10,000, excluding interest.

(c) The receiver may, subject to the approval of the court, sell, agree to sell, or offer to sell any assets of the insurer to creditors of the insurer who seek to participate in the purchase of the assets, to be paid for wholly or partly out of dividends payable to those creditors. On application of the receiver, the court may designate representatives to act for those creditors in purchasing, holding, or otherwise managing those assets, and the receiver may, subject to the approval of the court, advance the expenses of those representatives against the security of the claims of those creditors.

(d) The receiver may, subject to the approval of the court and the commissioner, as required by this code, sell or otherwise dispose of the charter or certificate of authority of the insurer separately from the outstanding liabilities of the insurer. (V.T.I.C. Art. 21.28, Sec. 2(g).)

Source Law

(g) Disposal of Property; Settling Claims. The receiver may, subject to the approval of the court, (1) sell or otherwise dispose of the real and personal property, or any part thereof, of an insurer against whom a proceeding has been brought under this Article, and (2) sell or compound all doubtful or uncollectible debts, or claims owed by or owing to such insurer, including claims based upon an assessment levied against a member of a mutual insurer, reciprocal exchange, or an underwriter at Lloyds. Whenever the amount of any such debt or claim owed by or owing to such insurer or the value of any item of property of the insurer does not exceed Ten Thousand Dollars ($10,000), exclusive of interest, the receiver may compromise or compound such debt or claim or sell such property upon such terms as the receiver may deem for the best interests of said insurer without obtaining the approval of the court. The receiver may, subject to the approval of the court, sell or agree to sell, or offer to sell, any assets of such an insurer to such of its creditors who may desire to participate in the purchase thereof, to be paid for, in all or in part, out of dividends payable to such creditors, and, upon the application of the receiver, the court may designate representatives to act for such creditors in the purchase, holding and/or management of such assets, and the receiver may, subject to the approval of the court, advance the expenses of such representatives against the security of the claims of such creditors. The receiver may, subject to the approval of the court and the commissioner, as required by this code, sell or otherwise dispose of the charter or license of the insurer separate and apart from its outstanding liabilities.

Revisor's Note

(1) Section 2(g), V.T.I.C. Article 21.28, refers to a "proceeding . . . [brought] under this Article." Throughout this chapter the revised law substitutes a reference to a "delinquency proceeding" for the quoted language and similar phrases because a delinquency proceeding is the only kind of proceeding authorized by this chapter and that is the term used to describe such a proceeding in Section 1(b), V.T.I.C. Article 21.28, revised as Section 442.001(a)(2).

(2) Section 2(g), V.T.I.C. Article 21.28, refers to a "reciprocal exchange" and an "underwriter at Lloyds," meaning entities operating under Chapter 942 or 941, respectively, of this code. The terms most frequently used to refer to those entities are

"reciprocal or interinsurance exchange" and "Lloyd's plan." For consistent use of terminology in this code, the revised law substitutes "reciprocal or interinsurance exchange" and "Lloyd's plan" for "reciprocal exchange" and "underwriter at Lloyds," respectively.

(3) Section 2(g), V.T.I.C. Article 21.28, refers to the sale or other disposal of the "license" of an insurer. The revised law substitutes "certificate of authority" for "license" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

(4) Section 2(g), V.T.I.C. Article 21.28, refers to "separate and apart." The reference to "apart" is omitted from the revised law because "apart" is included within the meaning of "separate."

Revised Law

Sec. 442.109. BORROWING ON PLEDGE OF ASSETS. (a) To facilitate the rehabilitation, liquidation, conservation, or dissolution of an insurer under this chapter, the receiver may, subject to the approval of the court:

(1) borrow money;

(2) execute, acknowledge, and deliver a note or other evidence of indebtedness for the loan;

(3) secure the repayment of the loan by the mortgage, pledge, assignment, or transfer in trust of any or all of the insurer's property; and

(4) take any other action necessary and proper to obtain and provide for the repayment of the loan.

(b) The receiver is not under any obligation in the person's personal capacity or official capacity as receiver to repay any loan made under this section. (V.T.I.C. Art. 21.28, Sec. 15.)

Source Law

Sec. 15. For the purpose of facilitating the rehabilitation, liquidation, conservation or dissolution of an insurer pursuant to this Article the receiver may, subject to the approval of the court, borrow money and execute, acknowledge and deliver notes or other evidences of indebtedness therefor and secure the repayment of the same by the mortgage, pledge, assignment, transfer in trust, or hypothecation of any or all of the property whether real, personal or mixed of such insurer, and the receiver, subject to the approval of the court, shall have power to take any and all other action necessary and proper to consummate any such loans and to provide for the repayment thereof. The receiver shall be under no obligation personally or in his official capacity as receiver to repay any loan made pursuant to this section.

Revisor's Note

(1) Section 15, V.T.I.C. Article 21.28, refers to the "pledge" or "hypothecation" of property. The revised law omits "hypothecation" because "hypothecation" is included within the meaning of "pledge."

(2) Section 15, V.T.I.C. Article 21.28, refers to "property whether real, personal or mixed." The revised law omits the reference to "real, personal, or mixed" because under Section 311.005(4), Government Code (Code Construction Act), applicable to the revised law, "property" includes both real and personal property, and "mixed" property is property consisting of both real and personal property.

Revised Law

Sec. 442.110. DEPOSITORIES; ACCOUNTING. (a) Except as otherwise provided by this section, the receiver shall promptly deposit all money collected into the Texas Treasury Safekeeping Trust Company in accordance with procedures established by the comptroller.

(b) If determined advantageous by the receiver in the receiver's sound financial judgment, the receiver may deposit the money in one or more banks or savings and loan associations in this state insured by a federal agency that provides for deposit

insurance. If the amount deposited exceeds the maximum amount insured by the appropriate federal agency, the receiver shall, without the need for court approval, enter into any contracts and require any security the receiver considers proper to safeguard the deposit.

(c) The receiver shall account for all money collected or realized from the assets of each insurer for which the receiver has been appointed separately from all other money. (V.T.I.C. Art. 21.28, Sec. 2(h).)

Source Law

> (h) Depositories. Except as provided by this subsection, all money collected by the receiver shall be forthwith deposited into the Texas Treasury Safekeeping Trust Company in accordance with procedures established by the comptroller. The receiver may deposit the money in any bank, banks, or savings and loan association or associations in this State insured by a federal agency that provides for deposit insurance if the receiver, in the exercise of sound financial judgment, determines that it would be advantageous to do so. The funds collected or realized from the assets of each insurer for which the receiver has been appointed shall be accounted for by the receiver separately from all other funds. Whenever any account in a bank or savings and loan association exceeds the maximum amount insured by the appropriate federal agency, the receiver is hereby authorized and directed to make such contracts and require such security as it may deem proper for the safeguarding of such deposit without approval of the court.

Revised Law

Sec. 442.111. REPORTS ON STATUS OF PROCEEDING. The receiver shall:

(1) file with the department on the department's request reports showing the operation, receipts, expenditures, and general condition of any insurer of which the receiver is in charge at that time;

(2) on request, file a copy of a report described by Subdivision (1) with the court in which the receivership proceeding is pending; and

(3) file a final report regarding each insurer that has been liquidated or handled that:

(A) shows and fully explains all receipts and

expenditures; and

(B) accurately states the disposition of all of the insurer's assets. (V.T.I.C. Art. 21.28, Sec. 12(c).)

Source Law

> (c) Filing Reports. The receiver shall file reports with the Board upon its request showing the operation, receipts, expenditures, and general condition of any organization of which the receiver may have charge at that time, and, upon request, shall file a copy of said report with the court in which said receivership proceeding is pending. The receiver shall also file a final report of each organization which has been liquidated or handled showing all receipts and expenditures, and giving a full explanation of the same and a true statement of the disposition of all of the assets of each organization.

Revisor's Note

Section 12(c), V.T.I.C. Article 21.28, requires the receiver to file reports with the Texas Department of Insurance showing certain information regarding an "organization" of which the receiver is in charge or that has been liquidated or handled. The revised law substitutes "insurer" for "organization" for consistency with Section 2(a), V.T.I.C. Article 21.28, revised in pertinent part in this chapter as Section 442.051, which requires a receiver to take charge of the assets of an "insurer."

Revised Law

Sec. 442.112. BUSINESS PLAN REPORTS; OTHER PERIODIC REPORTS. (a) A special deputy receiver shall submit a monthly written report to the court and the commissioner that states the special deputy receiver's business plan for the receivership, including:

(1) the expenses incurred in administering the receivership during the preceding month and an estimate of those expenses for the succeeding month;

(2) a cost-benefit analysis of the expenditure of money other than money spent to pay claims;

(3) a budget of monthly expenses that explains any

variation from the original projection; and

(4) a list of any lawyers or law firms that offered to represent or represented the special deputy receiver in relation to the special deputy receiver's duties under this chapter, and any hours billed or fees paid to a lawyer or law firm that represented the special deputy receiver.

(b) The special deputy receiver shall submit the business plan report to the attorney general quarterly, and the attorney general may make recommendations to the commissioner based on the report.

(c) In addition to the business plan report, the special deputy receiver shall submit to the commissioner a monthly report relating to the special deputy receiver's activities in administering the receivership.

(d) On written application by the special deputy receiver and with the approval of the commissioner, the court may suspend the requirement for monthly reports, or require less frequent reports, on a showing that the costs of the monthly reports exceed the benefit derived from those reports. (V.T.I.C. Art. 21.28, Sec. 2(a) (part).)

Source Law

> (a) . . . The special deputy receiver shall submit monthly written reports to the court and commissioner that state the special deputy receiver's business plan for the receivership, including expenses incurred in administering the receivership during the preceding month and an estimate of those expenses for the succeeding month. The report must include a cost-benefit analysis on the expenditure of funds other than funds spent for the payment of claims. The business plan report must include a budget of monthly expenses that explains any variation from the original projection. The business plan report must include a list of any lawyers or law firms that offered to or did represent the special deputy receiver in relation to its duties under this article, and any hours billed or fees paid to a lawyer or law firm that represented the special deputy receiver. The special deputy receiver shall submit the business plan report to the attorney general on a quarterly basis, and the attorney general may make recommendations to the commissioner based on the report. In addition to the business plan report, the special deputy receiver shall submit a monthly report to the commissioner relating to the special deputy receiver's activities in administering the receivership. Upon written application by the special

deputy receiver and with approval of the commissioner, the court may suspend the requirement for monthly reports or require reports less frequently based upon a showing that the costs of such reports exceed the benefit derived from their filing.

Revised Law

Sec. 442.113. REPORT TO INSURANCE FRAUD UNIT. A special deputy receiver shall report to the insurance fraud unit any information discovered in the administration of a receivership relating to possible fraudulent, deceptive, or unlawful conduct by an insurer. (V.T.I.C. Art. 21.28, Sec. 12(i).)

Source Law

(i) Reports of Fraudulent Activities. The special deputy receiver shall report to the insurance fraud unit any information relating to possible fraudulent, deceptive, or unlawful conduct by an insurer discovered in administration of the receivership.

Revised Law

Sec. 442.114. PAYMENT OF LIQUIDATION EXPENSES; OBJECTION. (a) The commissioner or special deputy receiver shall pay the compensation of the special deputy receiver and all other expenses of a liquidation out of the money or other assets of the insurer.

(b) Each month, the receiver shall present to the court an itemized accounting, sworn to by the receiver, of the expenses. The court shall approve the accounting unless a party at interest files an objection on or before the 10th day after the date the accounting is presented. The objection must specify each item to which the party objects and the ground for that objection.

(c) The court shall set a hearing on an objection filed under Subsection (b) and shall notify the parties of the hearing. The objecting party has the burden of proof to show that an item to which the party objected is improper, unnecessary, or excessive. (V.T.I.C. Art. 21.28, Sec. 12(b) (part).)

Source Law

(b) [The commissioner may . . . set the compensation of . . . special deputy receivers] . . . . The payment of such compensation and all expenses of liquidation shall be made by the commissioner or special deputy receiver out of funds or assets of the insurer. An itemized report of such expenses, sworn to by the commissioner or a special

deputy receiver, shall be presented on a monthly basis to the court, which account shall be approved by the court unless objection is filed thereto within ten (10) days after the presentation of the account. The objection, if any, must be made by a party at interest and shall specify the item or items objected to and the ground of such objection. The court shall set the objection down for hearing, notifying the parties of the setting. The burden of proof shall be upon the party objecting to show that the items objected to are improper, unnecessary or excessive.

Revised Law

Sec. 442.115. INJUNCTIONS AND OTHER ORDERS. (a) On application by the receiver, the receivership court, with or without notice, may issue:

(1) an injunction restraining the insurer named in the order, the insurer's officers, directors, shareholders, members, trustees, agents, employees, policyholders, attorneys, managers, attorneys-in-fact, including associate, deputy, and substitute attorneys-in-fact, and all other persons from:

(A) engaging in the insurer's business; or

(B) wasting or disposing of the insurer's property; or

(2) an order requiring the delivery of the insurer's assets to the receiver.

(b) At any time during a delinquency proceeding, the receivership court may issue an injunction or order considered necessary to prevent:

(1) interference with the receiver or the proceeding;

(2) waste of the insurer's assets;

(3) the initiation or prosecution of an action;

(4) the obtaining of a preference, judgment, attachment, garnishment, or other lien; or

(5) the making of a levy against the insurer or against all or part of the insurer's assets. (V.T.I.C. Art. 21.28, Secs. 4(a), (b).)

Source Law

Sec. 4. (a) Injunctions. Upon an application by the receiver, the receivership court may, with or without notice, issue an injunction restraining the insurer named in the order, its officers, directors,

stockholders, members, trustees, agents, servants, employees, policyholders, attorneys, managers, attorneys-in-fact, associate, deputy, substitute attorneys-in-fact, and all other persons from the transaction of its business or the waste or disposition of its property, or requiring the delivery of its property and/or assets to the receiver subject to the further order of the court.

(b) Other Orders. Such court may at any time during a proceeding under this Article issue such other injunctions or orders as may be deemed necessary to prevent interference with the receiver or the proceeding, or waste of the assets of the insurer, or the commencement or prosecution of any actions, or the obtaining of preferences, judgments, attachments, garnishments, or other liens, or the making of any levy against the insurer or against its assets or any part thereof.

Revisor's Note

(1) Section 4(a), V.T.I.C. Article 21.28, refers to an insurer's "agents, servants, [and] employees." The revised law omits the reference to "servants" because "servants" is included within the meaning of "agents" or "employees."

(2) Section 4(a), V.T.I.C. Article 21.28, provides that a receivership court may issue certain orders "subject to the further order of the court." The revised law omits the quoted language as unnecessary because an order issued by a court is subject to a subsequent order of the court without an express statement to that effect.

Revised Law

Sec. 442.116. EFFECT OF INJUNCTION OR ORDER: DENIAL OF CLAIMS AND OTHER DEMANDS. The receiver for an insurer may deny a claim, judgment, lien, preference, or demand made or obtained against the insurer or the receiver after the date of receivership in derogation of the terms of an injunction or order under Section 442.115 until:

(1) proof of the justness of the claim, judgment, lien, preference, or demand is made before the receivership court; and

(2) the court approves the claim, judgment, lien, preference, or demand. (V.T.I.C. Art. 21.28, Sec. 4(c).)

Source Law

(c) No Preferences. Any claim, judgment, lien or preference against the insurer or its receiver obtained, after the date of receivership, in derogation of the terms of any such injunction or order of the receivership court may be denied by the receiver until proof of the justness of such claim, judgment, lien, preference or demand is made before and approved by the receivership court.

Revised Law

Sec. 442.117. OTHER PENDING ACTIONS; IMMUNITY. (a) A judgment or order of a court of this state or of another jurisdiction in an action pending by or against a delinquent insurer that is rendered after the commencement of the delinquency proceeding is not binding on the receiver unless the receiver was made a party to the action.

(b) A receiver and the receiver's agents and employees are not liable for, and a cause of action does not arise against the receiver or the receiver's agents or employees for, an act or failure to act by the person that relates to the adjustment, negotiation, or settlement of a claim. (V.T.I.C. Art. 21.28, Sec. 4(f).)

Source Law

(f) Pending Lawsuits. No judgment or order rendered by any court of this State or of any other jurisdiction in any action pending by or against the delinquent insurer after the commencement of delinquency proceedings shall be binding upon the receiver unless the receiver shall have been made a party to such suit.

A receiver and his agents and employees are not liable for and a cause of action may not be brought against any of them for an action taken or not taken by them relating to the adjustment, negotiation, or settlement of claims.

Revised Law

Sec. 442.118. EXTENSION OF TIME FOR PLEADING; INAPPLICABILITY OF CERTAIN LAWS. (a) The receiver is not required to plead to any action in which the receiver is a proper plaintiff or defendant in any court in this state until the first anniversary of the date the receiver is appointed.

(b) Sections 64.033, 64.052, 64.053, and 64.056, Civil Practice and Remedies Code, do not apply to an insolvent insurer

being administered under this chapter. (V.T.I.C. Art. 21.28, Sec. 4(g).)

Source Law

> (g) One Year Extension. The receiver shall not be required to plead to any suit in which he may be a proper party plaintiff or defendant, in any of the courts in this State until one (1) year after the date of his appointment as receiver, and the provisions of Sections 64.033, 64.052, 64.053, and 64.076, Civil Practice and Remedies Code, as amended, shall not apply to insolvent insurance companies being administered under this Article.

Revisor's Note

(1) Section 4(g), V.T.I.C. Article 21.28, provides in part that Section 64.076, Civil Practice and Remedies Code, does not apply to an insolvent insurer being administered under V.T.I.C. Article 21.28. Section 64.076 pertains to actions against receivers of railroad companies. The cross-reference to that section appears to be incorrect. The correct cross-reference appears to be to Section 64.056, Civil Practice and Remedies Code, which pertains to the liability of persons receiving receivership property. Section 64.056 is also cited in Sections 36.210(c) and 186.210(c), Finance Code, which are similar to Section 4(g), V.T.I.C. Article 21.28. The revised law is drafted accordingly.

(2) Section 4(g), V.T.I.C. Article 21.28, refers to certain sections of the Civil Practice and Remedies Code "as amended." The revised law omits "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 an amendment of the statute.

Revised Law

Sec. 442.119. EXCLUSIVE JURISDICTION OF OTHER ACTIONS. The court of competent jurisdiction of the county in which the

delinquency proceeding is pending has exclusive venue to hear and determine all actions or proceedings instituted by or against the insurer or receiver after the commencement of the delinquency proceeding. (V.T.I.C. Art. 21.28, Sec. 4(h).)

Source Law

> (h) New Lawsuits. The court of competent jurisdiction of the county in which the delinquency proceedings are pending under this Article shall have exclusive venue to hear and determine all actions or proceedings instituted after the commencement of delinquency proceedings by or against the insurer or receiver.

Revisor's Note
(End of Subchapter)

In 1989, Section 4, V.T.I.C. Article 21.28, was amended by Section 6.07, Chapter 1082, Acts of the 71st Legislature, Regular Session, to add Subsection (i) pertaining to criminal history information. That subsection was repealed by Section 46(18), Chapter 790, Acts of the 73rd Legislature, Regular Session, 1993. Accordingly, the revised law omits the portion of that subsection that is being printed. The omitted provision reads:

> (i) . . . All criminal history information records obtained by the receiver are privileged information and are for the exclusive use of the receiver. Except on court order or with the consent of the person being investigated, the records may not be released to any other person or agency. The receiver may destroy the criminal history information records after the records are used for the purposes authorized by this subsection. A person commits an offense if the person releases or discloses any information received under this subsection without the authorization provided by this subsection. An offense under this subsection is a Class A misdemeanor.

[Sections 442.120-442.150 reserved for expansion]

SUBCHAPTER D. GENERAL SUBPOENA POWERS; WITNESSES AND PRODUCTION OF RECORDS

Revised Law

Sec. 442.151. SUBPOENA AUTHORITY. The receiver may request

the court to issue ex parte a subpoena to compel the attendance and testimony of a witness before the receiver and the production of any book, account, paper, correspondence, or other record relating to a matter that pertains to the receivership estate. For that purpose:

(1) the court has statewide subpoena power and may compel attendance of witnesses and production of records before the receiver at the receiver's offices in Austin; and

(2) the receiver or the receiver's designated representative may administer oaths, examine witnesses, and receive evidence. (V.T.I.C. Art. 21.28, Sec. 4(d) (part).)

Source Law

> (d) . . . the receiver may request the court ex parte to issue a subpoena to compel the attendance and testimony of witnesses before the receiver and the production of any books, accounts, records, papers, and correspondence or other records relating to any matter that pertains to a receivership estate, and for this purpose the receiver or his designated representative may administer oaths and affirmations, examine witnesses, and receive evidence. In this connection the court has statewide subpoena power and may compel attendance and production of records before the receiver at his offices in Austin, Texas. . . .

Revisor's Note

(1) Section 4(d), V.T.I.C. Article 21.28, provides that certain authority of the receiver relating to the issuance of subpoenas is in addition to the authority granted by law to the receiver relating to the taking of depositions of witnesses in civil actions. 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 revised law omits the provision as unnecessary because the general principle applies to the revision. The omitted law reads:

> (d) Subpoenas. In addition to the authority granted by law to the receiver relating to the taking of depositions of witnesses in civil actions, . . . .

(2) Section 4(d), V.T.I.C. Article 21.28,

refers to "oaths and affirmations." The revised law omits the reference to "affirmations" because Section 311.005(1), Government Code (Code Construction Act), applicable to the revised law, states that an oath includes an affirmation.

Revised Law

Sec. 442.152. SERVICE OF SUBPOENA. A subpoena issued under this subchapter may be served, at the receiver's discretion, by the receiver, the receiver's authorized agent, a sheriff, or a constable. The sheriff's or constable's fee for serving the subpoena is the same as the fee paid the sheriff or constable for similar services. (V.T.I.C. Art. 21.28, Sec. 4(d) (part).)

Source Law

> (d) . . . The sheriff's or constable's fee for serving the subpoena shall be the same as those paid the sheriff or constable for similar services. Any subpoena issued under this subsection may be served, at the receiver's discretion, by the receiver, his authorized agent, a sheriff, or a constable.
> . . .

Revised Law

Sec. 442.153. ENFORCEMENT OF SUBPOENA. (a) On application of the receiver in the case of disobedience of a subpoena or the contumacy of a witness appearing before the receiver or the receiver's designated representative, the court may issue an order requiring the person subpoenaed to obey the subpoena, give evidence, or produce any book, account, paper, correspondence, or other record relating to the matter in question.

(b) The court may punish as contempt the failure to obey an order under this section. (V.T.I.C. Art. 21.28, Sec. 4(d) (part).)

Source Law

> (d) . . . In a case of disobedience of a subpoena, or of the contumacy of a witness appearing before the receiver or his designated representative, the receiver may invoke the aid of the court, and the court may issue an order requiring the person subpoenaed to obey the subpoena or give evidence or produce books, accounts, records, papers, and correspondence or other records respecting the matter in question. Any failure to obey such an order of the court may be punished as contempt by the court.
> . . .

Revisor's Note

Section 4(d), V.T.I.C. Article 21.28, states that a receiver may "invoke the aid of" a court. The revised law substitutes "[o]n application of the receiver" for the quoted phrase because, in context, the phrases are synonymous and "on application of the receiver" is more commonly used.

Revised Law

Sec. 442.154. COMPENSATION FOR ATTENDANCE. (a) A witness who is not a party and who is required to appear before the receiver is entitled to receive:

(1) reimbursement for mileage for traveling to or from the place where the witness's presence is required, if the place is more than 25 miles from the witness's place of residence, in the same amount for each mile as the mileage travel allowance for a state employee; and

(2) a fee for each day or part of a day the witness is required to be present as a witness that is equal to the greater of:

(A) $10; or

(B) the per diem travel allowance of a state employee.

(b) Each disbursement made to pay a fee under Subsection (a) shall be included and paid in the manner provided for the payment of other expenses under Sections 442.054, 442.111, and 442.114 and Subchapter J. (V.T.I.C. Art. 21.28, Sec. 4(d) (part).)

Source Law

(d) . . . Each witness who is not a party and who is required to attend before the receiver is entitled to receive:

(1) reimbursement for travel in the same amount per mile as the mileage travel allowance for state employees for going to and returning from the place where his presence is required, if the place is more than 25 miles from the witness's place of residence; and

(2) a fee of not less than Ten Dollars ($10) a day for each day or part of a day the witness is necessarily present as a witness, but in lieu of such Ten Dollar ($10) fee, a witness will receive a fee equal to the per diem travel allowance of a state employee if the amount exceeds Ten Dollars ($10). All

disbursements made in the payment of these fees shall be included and paid in the same manner as provided for the payment of other expenses in Section 12 of this Article.

. . .

Revised Law

Sec. 442.155. USE AS EVIDENCE. (a) On certification by the receiver or commissioner under official seal, any book, account, paper, correspondence, document, or other record produced or testimony taken under this chapter and held by the receiver is admissible in evidence in a case without:

(1) prior proof of correctness; or

(2) other proof except the certificate of the receiver or commissioner that the book, account, paper, correspondence, document, or other record or the testimony was received from the person producing the material or testifying.

(b) The certified book, account, paper, correspondence, document, or other record, or a certified copy of the book, account, paper, correspondence, document, or other record, is prima facie evidence of the facts disclosed by that item.

(c) This section does not limit any other provision of this chapter or any law that provides for the admission or evidentiary value of evidence. (V.T.I.C. Art. 21.28, Sec. 4(d) (part).)

Source Law

(d) . . . On certification by the receiver or the State Board of Insurance under official seal, any books, accounts, records, papers, correspondence, and other records and documents produced or testimony taken pursuant to this Article and held by the receiver are admissible in evidence in all cases without prior proof of their correctness and without other proof except the certificate of the receiver or the State Board of Insurance that the books, accounts, records, papers, correspondence, documents, and testimony were received from the person producing the material or testifying. The certified books, accounts, records, papers, correspondence, and other records and documents or certified copies of them are prima facie evidence of the facts they disclose. This section may not be construed to limit any other provision of this Article or any law that provides for the admission of evidence or for its evidentiary value.

Revisor's Note

Section 4(d), V.T.I.C. Article 21.28, provides that "[t]his section" may not be construed to limit any

other provision of Article 21.28 or any law that provides for the admission of evidence or for its evidentiary value. The pertinent part of Section 4, V.T.I.C. Article 21.28, to which "[t]his section" refers appears to be the paragraph of Section 4(d) that includes that provision, rather than the entire section. That paragraph is revised as this section, and the revised law is drafted accordingly.

Revised Law

Sec. 442.156. PROTECTIVE ORDERS. A person served with a subpoena under this subchapter may file a motion with the court for a protective order as provided by Rule 192.6, Texas Rules of Civil Procedure. (V.T.I.C. Art. 21.28, Sec. 4(d) (part).)

Source Law

(d) . . . Any person served with a subpoena under this subsection may file a motion with the court for a protective order as provided by Rule 166b of the Texas Rules of Civil Procedure. . . .

Revisor's Note

Section 4(d), V.T.I.C. Article 21.28, authorizes a person served with a subpoena under that section to file a motion for a protective order under Rule 166b, Texas Rules of Civil Procedure. That rule was repealed in 1998 and replaced in pertinent part by Rule 192.6, Texas Rules of Civil Procedure. The revised law is drafted accordingly.

[Sections 442.157-442.200 reserved for expansion]

SUBCHAPTER E. CLAIMS AGAINST RECEIVERSHIP ESTATE

Revised Law

Sec. 442.201. PROOF OF CLAIM REQUIRED; DEADLINE. (a) If a liquidation, rehabilitation, or conservation order has been entered in a delinquency proceeding, each person who may have a claim against the insurer as provided by Section 442.551, including a claimant with a secured claim or a claim based on trust or escrow funds, must present a proof of claim to the receiver:

(1) at a place specified by the receiver; and

(2) not later than the date specified by the court, which may not be before the 90th day after the date the order specifying the date is entered.

(b) The receiver shall notify all persons who may have a claim against the insurer, as disclosed by the insurer's books and records, regarding the requirement to present a proof of claim to the receiver. The notice must:

(1) specify the last day for presenting a proof of claim; and

(2) be given in a manner determined by the court.

(c) The receiver must receive the required proof of claim before paying a claim.

(d) If a proof of claim is not presented on or before the date specified by the court as required by Subsection (a), the claim may not share in any distribution of the insurer's assets by the receiver, except that, subject to court approval, the receiver may accept a claim presented not later than the 90th day after the date notice is mailed to the person under Subsection (b). (V.T.I.C. Art. 21.28, Secs. 3(a), (b).)

Source Law

Sec. 3. (a) Time for Filing. Where a liquidation, rehabilitation, or conservation order has been entered in a proceeding against an insurer under this Article, all persons who may have claims against such insurer as set out in Subsection (a) of Section 8 of this Article, including claimants with secured claims and claims based on trust or escrow funds, shall present proof of the same to the receiver at a place specified by him within a period of time to be specified by the court, in no event, however, less than ninety (90) days after the date of the entry of the order specifying such time. The receiver shall notify all persons who may have claims against such insurer as disclosed by its books and records, to present proof of the same to him within the time as fixed. The last day for the filing of proofs of claim shall be specified in the notice. Such notice shall be given in a manner determined by the court. Receipt of the required proof of claim by the receiver is a condition precedent to the payment of any claim, and except as provided by Subsection (b) of this section, claims that are not filed within the time specified by the court shall not participate in any distribution of the assets by the receiver.

(b) Late Filing. Subject to court approval, the

receiver may accept claims filed after the date specified by the court if the claims are filed with the receiver not later than the ninetieth (90th) day after the date notice of the claimant's right to file a proof of claim is mailed to the claimant.

Revised Law

Sec. 442.202. FORM AND CONTENT OF PROOF OF CLAIM. (a) A proof of claim must be in writing and signed by the claimant and must include:

(1) a statement of the claim;

(2) a description of the consideration for the claim;

(3) a statement of whether securities are held as consideration for the claim and, if so, a description of the securities;

(4) a statement of any right of priority of payment for the claim or other specific right asserted by the claimant;

(5) a statement of whether a payment has been made on the claim and, if so, a description of the payment made and the source of the payment;

(6) a statement that the amount claimed is justly owed by the insurer to the claimant; and

(7) any other matter that is required by the court in which the receivership is pending.

(b) A proof of claim must be in a form prescribed by the receiver, except that the receiver may accept a proof of claim on a form:

(1) used for proof of claim by the insurer before the receivership; or

(2) prepared or accepted by a receiver or a guaranty fund in another state, if the receiver in this state is an ancillary receiver.

(c) A proof of claim must be made under oath, unless the receiver waives the oath.

(d) A written instrument on which a claim is based must be presented with a proof of claim unless lost or destroyed. After the instrument is presented and until final disposition of the claim,

the receiver may permit the claimant to substitute a copy of the instrument. If the instrument is lost or destroyed, a statement of that fact and of the circumstances of the loss or destruction must be made under oath and presented with the claim.

(e) The receiver may accept from each authorized guaranty association a single proof of claim combining all claims and related administrative expenses assigned to that association. A proof of claim presented by a guaranty association must contain any other information the receiver requires. (V.T.I.C. Art. 21.28, Sec. 3(c).)

Source Law

(c) Proof Necessary. (1) A proof of claim shall consist of a written statement signed by the claimant that includes the following:

(A) the claim;

(B) the consideration for the claim; and whether any, and if so, what securities are held for the consideration for that claim;

(C) any right of priority of payment for the claim or other specific rights asserted by the claimant;

(D) whether any payments have been made on the claim, and if so, what payments have been made on the claim and from what sources;

(E) a statement that the sum claimed is justly owed by the insurer to the claimant; and

(F) any other matters that are required by the court in which the receivership is pending.

(2) A proof of claim shall be in a form designated by the receiver, except that the receiver may accept a proof of claim on a form:

(A) used for proof of claim by the insurer before the receivership; or

(B) prepared or accepted by a receiver or a guaranty fund in another state, if the receiver in this state is an ancillary receiver.

(3) A proof of claim shall be filed under oath, unless the oath is waived by the receiver.

(4) If a claim is founded upon an instrument in writing, such instrument, unless lost or destroyed, shall be filed with the proof of claim. After the instrument is filed, the receiver may in his discretion permit the claimant to substitute a true copy of the instrument, until the final disposition of the claim. If the instrument is lost or destroyed, a statement of that fact and of the circumstances of the loss or destruction shall be filed under oath with the claim.

(5) The receiver may accept a single proof of claim from each properly authorized insurance guaranty association combining all claims and related administrative expenses assigned to that association. A proof of claim submitted by a guaranty association must set forth any other information the receiver may require.

Revisor's Note

(1) Section 3(c)(4), V.T.I.C. Article 21.28, refers to a "true" copy of an instrument. The revised law omits the quoted language as unnecessary because "true" is included in the meaning of "copy." For example, the absence of "true" before "copy" does not imply that one can make a fraudulent copy of a document required by a statute.

(2) Section 3(c)(5), V.T.I.C. Article 21.28, refers to a "properly authorized insurance guaranty association." The revised law omits "properly" as unnecessary because the term does not add to the clear meaning of the law. A guaranty association is not authorized if it is not properly authorized. Throughout this chapter, the revised law omits "insurance" in this context for consistency in use of terminology in this code.

Revised Law

Sec. 442.203. UNLIQUIDATED OR UNDETERMINED CLAIM OR DEMAND. (a) A claim based on an unliquidated or undetermined demand must be presented within the time limit provided by this chapter for presenting a claim. The claim may not share in any distribution to claimants until the claim is definitely liquidated, determined, and allowed. After the claim is liquidated, determined, and allowed, the claim shares ratably with the claims of the same class in all subsequent distributions.

(b) For the purposes of this chapter, a claim or demand is considered unliquidated or undetermined if:

(1) a right of action on the claim or demand accrued as of the date:

(A) the delinquency proceeding was commenced; or

(B) the insurance policy was canceled, if applicable; and

(2) the liability on the claim or demand has not been

determined or the amount of the claim or demand has not been liquidated.

(c) If the receiver is otherwise able to close the receivership proceeding, the proposed closing is a sufficient ground to reject any remaining unliquidated or undetermined claim or demand. The receiver shall notify the claimant of the receiver's intention to close the proceeding and shall allow liquidation or determination of those claims during the 60 days after the date of the notice. If a remaining claim is not liquidated or determined on or before the 60th day after the date of the notice, the receiver may reject the claim. (V.T.I.C. Art. 21.28, Sec. 3(d).)

Source Law

> (d) Unliquidated or Undetermined Claims or Demands. Claims based on unliquidated or undetermined demands must be filed within the time limit provided in this Article for the filing of claims, but claims based on those demands shall not share in any distribution to claimants until those claims are definitely liquidated, determined, and allowed. Thereafter, the claims shall share ratably with the claims of the same class in all subsequent distributions. An unliquidated or undetermined claim or demand under this Article is any claim or demand on which a right of action has accrued at the date of the commencement of the delinquency proceedings, or the insurance policy cancellation date if applicable, and on which the liability has not been determined or the amount of the claim or demand liquidated. If the receiver in all other respects is in a position to close the receivership proceedings, the proposed closing is sufficient grounds for the rejection of any remaining unliquidated or undetermined claim or demand. The receiver shall notify those claimants of his intention to close the proceedings and shall allow a 60-day period for liquidation and determination of those claims. If the remaining claims are not liquidated or determined within the 60-day period, the receiver may reject the claims and the provisions of Subsection (h) of this section apply.

Revisor's Note

Section 3(d), V.T.I.C. Article 21.28, authorizes the receiver to reject certain claims and demands and states that the provisions of Section 3(h), Article 21.28, apply. That section is revised in this chapter as Sections 442.206-442.208. The revised law omits the reference to the applicability of Section 3(h) because that section applies by its terms to the

approval or rejection of claims filed against an insurer, and an express reference to the section's applicability is unnecessary.

Revised Law

Sec. 442.204. THIRD-PARTY CLAIMS AND DEMANDS. (a) If a court has entered a liquidation, rehabilitation, or conservation order in a delinquency proceeding, a person who has a cause of action against an insured of the insurer under a liability insurance policy issued by the insurer is entitled to file a claim with the receiver, regardless of whether the claim is unliquidated or undetermined.

(b) A claim described by Subsection (a) may be approved if:

(1) it may be reasonably inferred from the proof presented on the claim that the person would be able to obtain a judgment on the cause of action against the insured;

(2) the person provides suitable proof that, other than those already presented, no additional valid claims against the insurer arising out of the person's cause of action may be made; and

(3) the total liability of the insurer to all claimants arising out of the same act of the insured is not greater than the total liability of the insurer would be if the insurer were not in liquidation, rehabilitation, or conservation.

(c) A judgment entered against an insured or insurer before the date of the commencement of the delinquency proceeding may not be given a priority higher than Class 3 under Section 442.551 unless the judgment creditor proves to the receiver's satisfaction the allegations supporting the judgment.

(d) A judgment against an insured taken after the date of the commencement of a delinquency proceeding with respect to the insurer may not be considered in the proceeding as evidence of liability or of the amount of damages. A judgment against an insured taken by default or by collusion before the commencement of the delinquency proceeding may not be considered in the proceeding

as conclusive evidence of the liability of the insured on the cause of action or of the amount of damages to which the person is entitled. (V.T.I.C. Art. 21.28, Sec. 3(e).)

Source Law

> (e) Third Party Claims. Where a liquidation, rehabilitation or conservation order has been entered in a proceeding against an insurer under this Article, any person who has a cause of action against an insured of such insurer under a liability insurance policy issued by such insurer, shall have the right to file a claim with the receiver, regardless of the fact that such claim may be unliquidated or undetermined, and such claim may be approved (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 persons 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 out of the same act of its insured shall be no greater than its total liability would be were it not in liquidation, rehabilitation or conservation. A judgment entered against an insured or insurer before the date on which the delinquency proceedings commenced may not be accorded higher than a Class 3 priority under Subsection (a) of Section 8 of this Article unless the judgment creditor proves to the receiver's satisfaction the allegations supporting the judgment. No judgment against an insured taken after the date of the commencement of the delinquency proceedings shall be considered in the proceedings as evidence of liability, or of the amount of damages, and no judgment against an insured taken by default or by collusion prior to the commencement of the delinquency proceedings shall be considered as conclusive evidence in the proceeding, either of the liability of such insured to such person upon such cause of action, or of the amount of damages to which such person is therein entitled.

Revised Law

Sec. 442.205. OFFSETS. (a) Except as provided by Subsection (b), the receiver shall set off mutual debts and mutual credits arising out of one or more contracts between the insurer and another person in connection with a claim or delinquency proceeding, and the receiver may allow or pay only the balance.

(b) The receiver may not allow an offset in favor of a person if:

(1) the obligation of the insurer to the person would not, on the date of the commencement of the delinquency proceeding or as otherwise provided by Section 442.102, entitle the person to

share as a claimant in the assets of the insurer;

(2) the obligation of the insurer to the person was purchased by or transferred to the person after the commencement of the delinquency proceeding or for the purpose of increasing offset rights;

(3) the obligation of the person is to pay:

(A) an assessment levied against the members of a mutual insurer, a reciprocal or interinsurance exchange, or a Lloyd's plan; or

(B) a balance on a subscription to the capital stock of a stock insurance corporation;

(4) the obligation of the person is as a trustee or fiduciary; or

(5) the obligation between the person and the insurer arises from a reinsurance transaction in which the person or the insurer assumed risks and obligations from the other party and then ceded to that party substantially the same risks and obligations.

(c) The receiver shall provide a person with an accounting statement identifying each debt that is due and payable. A person shall promptly pay to the receiver any amount due and payable to the insurer against which the person asserts an offset of mutual credits that may become due and payable from the insurer in the future. Notwithstanding Subchapter L or any other provision of this chapter, the receiver shall promptly and fully refund, to the extent of the person's prior payment, any mutual credits that become due and payable to the person by the insurer. (V.T.I.C. Art. 21.28, Secs. 3(f), (g).)

Source Law

(f) Offsets. In all cases of mutual debts or mutual credits, whether arising out of one or more contracts between the insurer and another person in connection with any claim or proceeding under this Article, such credits and debts shall be set off and the balance only shall be allowed or paid, except as provided in subsection (g).

(g) No Offsets. No offsets shall be allowed in favor of any person where (1) the obligation of the insurer to such person would not at the date of the commencement of the delinquency proceedings or as

otherwise provided in Section 2(c), entitle him to share as a claimant in the assets of such insurer, or (2) the obligation of the insurer to such person was purchased by or transferred to such person subsequent to the commencement of the delinquency proceedings or for the purpose of increasing offset rights, or (3) the obligation of such person is to pay an assessment levied against the members of a mutual insurer, or reciprocal exchange, or underwriters at Lloyds, or to pay a balance upon a subscription to the capital stock of a stock insurance corporation, or (4) the obligation of such person is as a trustee or fiduciary, or (5) the obligations between the person and the insurer arise from reinsurance transactions in which either the person or the insurer has assumed risks and obligations from the other party and then has ceded back to that party substantially the same risks and obligations. The receiver shall provide persons with accounting statements identifying all debts that are due and payable. If a person owes the insurer amounts that are due and payable, against which the person asserts offset of mutual credits that may become due and payable from the insurer in the future, the person shall promptly pay to the receiver the amounts due and payable. Notwithstanding Section 8, or any other provision of this Article, the receiver shall promptly and fully refund, to the extent of the person's prior payments, any mutual credits that become due and payable to the person by the insurer.

Revisor's Note

Section 3(g), V.T.I.C. Article 21.28, refers to a "reciprocal exchange" and "underwriters at Lloyds." The revised law substitutes "reciprocal or interinsurance exchange" and "Lloyd's plan" for "reciprocal exchange" and "underwriters at Lloyds," respectively, for the reason stated in Revisor's Note (2) to Section 442.108.

Revised Law

Sec. 442.206. APPROVAL OR REJECTION OF CLAIM. (a) The receiver may approve or reject a claim filed against the insurer.

(b) On a rejection of a claim in whole or in part, the receiver shall notify the claimant in writing of the rejection. (V.T.I.C. Art. 21.28, Sec. 3(h) (part).)

Source Law

(h) Action on Claims. The receiver shall have the discretion to approve or reject any claim filed against the insurer. . . . Upon the rejection of each claim either in whole or in part, the receiver shall notify the claimant of such rejection by written notice. . . .

Revised Law

Sec. 442.207. APPEAL OF RECEIVER'S REJECTION OF CLAIM. (a) The receiver's rejection of a claim may be appealed in the court. The appeal must be brought within three months after the date of service of notice of the rejection.

(b) If the receiver's action is appealed within the time prescribed by Subsection (a), review is de novo as if originally filed in the court and is subject to the rules of procedure and appeal applicable to civil cases. The appeal is separate from the delinquency proceeding, and an attempt to appeal the receiver's action by intervening in the delinquency proceeding does not comply with this subsection.

(c) If the receiver's action is not appealed within the time prescribed by Subsection (a), the action is final and not subject to judicial review. (V.T.I.C. Art. 21.28, Sec. 3(h) (part).)

Source Law

> (h) . . . Action upon a claim so rejected must be brought in the court in which the delinquency proceeding is pending within three (3) months after service of notice; otherwise, the action of the receiver shall be final and not subject to review. Such action shall be de novo as if originally filed in said court and subject to the rules of procedure and appeal applicable to civil cases. This action shall be a separate action from the delinquency proceeding, and a claimant's attempt to appeal the action of the receiver by way of intervening in the delinquency proceeding does not comply with this subsection.

Revisor's Note

Section 3(h), V.T.I.C. Article 21.28, refers to the court "in which the delinquency proceeding is pending." The revised law omits the quoted language as unnecessary because under Section 1(f), V.T.I.C. Article 21.28, revised in this chapter as Section 442.001(b), for purposes of this chapter, "court" means the court in which a delinquency proceeding is pending, unless the context clearly indicates otherwise.

Revised Law

Sec. 442.208. OBJECTION TO CLAIM BY INTERESTED PARTY. (a) An interested party may object to a claim not rejected by the receiver by filing an objection with the receiver.

(b) The receiver shall promptly present the objection to the court for a determination after notice and hearing. (V.T.I.C. Art. 21.28, Sec. 3(h) (part).)

Source Law

> (h) . . . Objections to any claim not rejected may be made by any party interested, by filing the objections with the receiver, who shall forthwith present them to the court for determination after notice and hearing. . . .

Revised Law

Sec. 442.209. REFERRAL OF CLAIM TO GUARANTY ASSOCIATION. Notwithstanding any other provision of this chapter, the receiver shall refer a claim covered by a guaranty fund created under Chapter 462, 463, or 2602 to the appropriate guaranty association for processing. (V.T.I.C. Art. 21.28, Sec. 3(i).)

Source Law

> (i) Notwithstanding any other provision of this article, if a claim is covered by a guaranty fund created under Article 9.48, 21.28-C, or 21.28-D of this code, the receiver shall refer the claim to the appropriate guaranty association for processing.

Revised Law

Sec. 442.210. WORKERS' COMPENSATION CLAIMS. (a) The receiver shall notify the Texas Workers' Compensation Commission immediately on a finding of insolvency or impairment with regard to an insurance company that has in force any workers' compensation coverage in this state.

(b) On receipt of the notice under Subsection (a), the Texas Workers' Compensation Commission shall submit to the receiver a list of active cases pending before the commission in which:

(1) the insurance company has accepted liability;

(2) it appears that a bona fide dispute does not exist;

(3) payments were begun before the finding of insolvency or impairment; and

(4) payment of future or past workers' compensation benefits is due.

(c) Notwithstanding the other provisions of this subchapter, the receiver may begin or continue the payment of claims on cases included in the list submitted under Subsection (b).

(d) Files and other information delivered by the Texas Workers' Compensation Commission to the receiver may be delivered to the Texas Property and Casualty Insurance Guaranty Association.

(e) The Texas Workers' Compensation Commission shall report to the department any act of a workers' compensation insurance company that may indicate that the company is financially impaired, delinquent, or insolvent. (V.T.I.C. Art. 21.28, Secs. 3A(a), (b), (c), (d) (part), (e).)

Source Law

> Sec. 3A. (a) The liquidator shall notify the Texas Workers' Compensation Commission immediately upon a finding of insolvency or impairment upon any insurance company which has in force any workers' compensation coverage in Texas.
>
> (b) The Texas Workers' Compensation Commission shall, upon said notice, submit to the liquidator a list of active cases pending before the Texas Workers' Compensation Commission in which there has been an acceptance of liability by the carrier, where it appears that no bona fide dispute exists and where payments were commenced prior to the finding of insolvency or impairment and where future or past indemnity or medical payments are due.
>
> (c) Notwithstanding the provisions of Section 3 of this Article, the liquidator is authorized to commence or continue the payment of claims based upon the list submitted in Subsection (b) above.
>
> (d) . . . Files and information delivered by the Texas Workers' Compensation Commission to the liquidator may be delivered to the Texas Workers' Compensation Pool or . . . .
>
> (e) The Texas Workers' Compensation Commission shall report to the State Board of Insurance any occasion when a workers' compensation insurer has committed acts that may indicate insurer financial impairment, delinquency or insolvency.

Revisor's Note

(1) Section 3A(b), V.T.I.C. Article 21.28, refers to a "carrier" and to "future or past indemnity or medical payments." Section 3A(e), Article 21.28, refers to an "insurer." The revised law substitutes

"insurance company" for "carrier" and "insurer" and substitutes "payment of future or past workers' compensation benefits" for "future or past indemnity or medical payments" for consistency with the terminology used in the Labor Code with respect to workers' compensation insurance and benefits.

(2) Section 3A(d), V.T.I.C. Article 21.28, requires the receiver to "contract with the Texas Workers' Compensation Pool or any other qualified organization for claims adjusting" services and authorizes the receiver to deliver files and other information received from the Texas Workers' Compensation Commission to that pool or organization. The reference to the "Texas Workers' Compensation Pool" is a reference to the Texas workers' compensation assigned risk pool, which was created under former V.T.I.C. Article 5.76. That article was repealed by Chapter 1, Acts of the 71st Legislature, 2nd Called Session, 1989, which amended this code by adding V.T.I.C. Article 5.76-2 and took effect January 1, 1991. Article 5.76-2 revised, amended, and continued the Texas workers' compensation assigned risk pool as the Texas workers' compensation insurance facility. Article 5.76-2 was repealed by Chapter 594, Acts of the 75th Legislature, Regular Session, 1997. Section 1.03 of that act directed that the facility be converted to a Texas stock property and casualty insurance company or, in specified circumstances, the operation of the facility be transferred to the Texas Property and Casualty Insurance Guaranty Association. However, following enactment of Chapter 594 in 1997, the facility was transferred to a private stock insurance company.

The revised law omits the requirement that the

receiver contract with the "Texas Workers' Compensation Pool" or any other qualified organization for claims adjusting services because that provision has been impliedly repealed. Section 3A, V.T.I.C. Article 21.28, was added by Chapter 904, Acts of the 69th Legislature, Regular Session, 1985. At that time, the receiver was the entity charged with processing and paying workers' compensation claims. V.T.I.C. Article 21.28-C, which regulates the Texas Property and Casualty Insurance Guaranty Association and is revised in this code as Chapter 462, required the receiver to process covered claims under that article, which included claims under workers' compensation insurance policies, in the same manner as other claims as provided by V.T.I.C. Article 21.28. To permit the receiver to pay all covered claims, the Texas Property and Casualty Insurance Guaranty Association was required to pay the receiver the amount determined by the receiver to be necessary to supplement the assets of the impaired insurer.

In 1991, Section 3, V.T.I.C. Article 21.28, was amended by Chapter 12, Acts of the 72nd Legislature, 2nd Called Session, to add Subsection (i). That subsection, revised in this chapter as Section 442.209, provides that, notwithstanding any other provision of the article, if a claim is covered by a guaranty fund created under V.T.I.C. Article 9.48, 21.28-C, or 21.28-D, the receiver is required to refer the claim to the appropriate guaranty association for processing. Chapter 12 also amended V.T.I.C. Article 21.28-C in its entirety. Section 8(d), V.T.I.C. Article 21.28-C, revised in relevant part in this code as Section 462.301, now requires the Texas Property and Casualty Insurance Guaranty Association to

investigate and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation. That article does not require the association to enter into a contract with the receiver, nor does it authorize the receiver to contract with another organization to process workers' compensation insurance claims. Furthermore, in 1993, V.T.I.C. Article 21.28-C was amended by Chapter 685, Acts of the 73rd Legislature, Regular Session, to add Section 25(a), revised in this code as Section 462.010(a), which provides that if a conflict exists between that article and any other statutory provision relating to the association, that article controls.

Since workers' compensation insurance claims are now required to be referred to the Texas Property and Casualty Insurance Guaranty Association for processing and since the association is required to adjust those claims, the revised law omits as impliedly repealed the requirement that the receiver contract with the "Texas Workers' Compensation Pool" or any other qualified organization for claims adjusting.

Section 3A(d), V.T.I.C. Article 21.28, also authorizes the receiver to deliver files and other information received from the Texas Workers' Compensation Commission to the "Texas Workers' Compensation Pool" or any organization with which the receiver has contracted for claims adjusting services. For the reasons provided above, the revised law substitutes a reference to the association for the reference to the pool and omits the reference regarding the delivery of files and other information to an organization providing claims adjusting services. The omitted law reads:

(d) In order to avoid undue delay in the payment of covered workers' compensation claims, the liquidator shall contract with the Texas Workers' Compensation Pool or any other qualified organization for claims adjusting. [Files and information delivered by the Texas Workers' Compensation Commission to the liquidator may be delivered to the Texas Workers' Compensation Pool or] any organization with which the liquidator has contracted for claims adjusting services.

[Sections 442.211-442.250 reserved for expansion]

SUBCHAPTER F. VOIDABLE TRANSFERS OR LIENS

Revised Law

Sec. 442.251. CERTAIN TRANSFERS OR LIENS VOIDABLE. A transfer of or lien on the assets of an insurer is voidable if the transfer or lien was:

(1) made or created:

(A) within four months before the date of the commencement of the delinquency proceeding; and

(B) with the intent of giving to a creditor or enabling the creditor to obtain a greater percentage of the creditor's debt than is to be given to or obtained by another creditor of the same class; and

(2) accepted by the creditor having reasonable cause to believe that a preference described by Subdivision (1)(B) would occur. (V.T.I.C. Art. 21.28, Sec. 5(a).)

Source Law

Sec. 5. (a) Transfers or Liens Voidable. Any transfer or lien upon the property or assets of an insurer which is made or created within four (4) months prior to the commencement of delinquency proceedings under this Article, with the intent of giving to any creditor or enabling him to obtain a greater percentage of his debt than of any other creditor of the same class, and which is accepted by such creditor, having reasonable cause to believe that such preference will occur, shall be voidable.

Revised Law

Sec. 442.252. PERSONAL LIABILITY FOR VOIDABLE TRANSFER OR LIEN. (a) The following persons are personally liable for the property of the insurer or the benefit of that property received as a result of a transfer or lien described by Section 442.251:

(1) each director, officer, agent, employee, shareholder, member, attorney-in-fact, including an associate, substitute, or deputy attorney-in-fact, underwriter, subscriber, or other person acting on behalf of the insurer who is concerned in the transfer or lien; and

(2) each person who, as a result of the transfer or lien, receives the property of the insurer or the benefit of that property.

(b) A person who is personally liable under Subsection (a) shall account to the receiver for the benefit of the creditors of the insurer. (V.T.I.C. Art. 21.28, Sec. 5(b).)

Source Law

> (b) Personal Liability. Every director, officer, agent, employee, stockholder, member, attorney-in-fact, associate, substitute or deputy attorney-in-fact, underwriter, subscriber, and any other person acting on behalf of such insurer, who shall be concerned in any such prohibited act or deed, and every person receiving thereby property of such insurer, or the benefit thereof, shall be personally liable therefor, and shall be bound to account to the receiver for the benefit of the creditors of the insurer.

Revisor's Note

Section 5(b), V.T.I.C. Article 21.28, refers to "such prohibited act or deed," meaning an act or deed prohibited by Section 5(a) of that article, revised in this chapter as Section 442.251. Section 5(a) does not contain a prohibition per se. That provision states that certain transfers and liens are voidable. Accordingly, the revised law refers to a transfer or lien "described" by Section 442.251.

Revised Law

Sec. 442.253. AVOIDANCE OF TRANSFER OR LIEN; RECOVERY OF PROPERTY. The receiver may:

(1) avoid a transfer of or lien on the assets of an insurer that a creditor, shareholder, or member of the insurer might have avoided; and

(2) recover the transferred property or the value of

that property from the person to whom the property was transferred or from a person who received the property, unless the transferee or recipient was a bona fide holder for value before the date of the commencement of the proceeding. (V.T.I.C. Art. 21.28, Sec. 5(c).)

Source Law

> (c) Avoiding and Recovery. The receiver in any proceeding under this Article, may avoid any transfer of, or lien upon the property or assets of an insurer which any creditor, stockholder or member of such insurer might have avoided, and may recover the property so transferred or its value from the person to whom it was transferred, unless he was a bona fide holder for value prior to the date of the commencement of proceedings under this Article. Such property or its value may be recovered from anyone who has received it, except a bona fide holder for value as above specified.

[Sections 442.254-442.300 reserved for expansion]

SUBCHAPTER G. ASSESSMENTS

Revised Law

Sec. 442.301. APPLICATION FOR ASSESSMENT. (a) Not later than the fourth anniversary of the date of an order of rehabilitation or liquidation of a domestic insurer, the receiver may apply to the court to levy an assessment against the members of a mutual insurance company, the members of a reciprocal or interinsurance exchange, or the insureds of a Lloyd's plan who have been issued an insurance policy that expressly provides that the policy is subject to assessment.

(b) The application must state:

(1) the reasonable value of the insurer's assets;

(2) the insurer's probable liabilities; and

(3) the probable assessment, if any, necessary to pay all possible claims and expenses in full, including expenses of administration and collection. (V.T.I.C. Art. 21.28, Sec. 7(a).)

Source Law

> Sec. 7. (a) Application. Within four (4) years from the date of an order of rehabilitation, or liquidation, of a domestic insurer, the receiver may make an application to the court to levy an assessment against the members of a mutual insurer, members of a reciprocal exchange, or the insureds of a Lloyds who have been issued an insurance policy that provides that the policy is subject to assessment. Such

application shall set forth the reasonable value of the assets of such insurer, its probable liabilities, and the probable necessary assessment, if any, to pay all possible claims and expenses in full, including expenses of administration and collection.

Revisor's Note

(1) Section 7(a), V.T.I.C. Article 21.28, refers to a "mutual insurer," "reciprocal exchange," and "Lloyds." The revised law substitutes "mutual insurance company," "reciprocal or interinsurance exchange," and "Lloyd's plan" for "mutual insurer," "reciprocal exchange," and "Lloyds" for the reason stated in Revisor's Note (2) to Section 442.108.

(2) Section 7(a), V.T.I.C. Article 21.28, authorizes the receiver to apply to the court to levy an assessment against certain members or insureds who have been issued an insurance policy that provides that the policy is subject to assessment. The revised law refers to an insurance policy that "expressly" provides that the policy is subject to assessment to conform to Section 7(b), Article 21.28, revised in this chapter as Section 442.302, which provides that the court may not levy an assessment against a member or insured with regard to an insurance policy that does not expressly provide that the policy is subject to assessment.

Revised Law

Sec. 442.302. LEVY. (a) After giving notice in the manner designated by the court to each member or insured described by Section 442.301, the court shall consider the application made under that section and may levy one or more assessments, subject to Subsection (c).

(b) The assessment or assessments must cover the excess of the insurer's probable liabilities over the reasonable value of the insurer's assets, together with the estimated cost of collection and percentage of uncollectibility of the assessments.

(c) The court may not levy an assessment against a member or insured with regard to an insurance policy that does not expressly provide that the policy is subject to assessment. (V.T.I.C. Art. 21.28, Sec. 7(b).)

Source Law

> (b) Levy. After notice to each member or insured in the manner designated by the court, the court shall proceed to consider such report and may levy one or more assessments. Such assessment or assessments shall cover the excess of the probable liabilities over the reasonable value of the assets, together with the estimated cost of collection and percentage of uncollectibility thereof. An assessment shall not be levied against any such member or insured with respect to a policy that does not contain an express provision that the policy is an assessable policy.

Revisor's Note

> Section 7(b), V.T.I.C. Article 21.28, requires the court to consider "such report," meaning a report on a requested assessment. The revised law substitutes "the application made under [Section 442.301]" for "such report" because Section 7(a), V.T.I.C. Article 21.28, revised in this chapter as Section 442.301, authorizes the receiver to submit an application for an assessment to the court.

Revised Law

Sec. 442.303. COLLECTION. After the court enters an order of assessment under Section 442.302 and after the time for appeal expires, the receiver shall collect the assessments. The receiver may bring an action in a court of competent jurisdiction in the county in which the delinquency proceeding is pending to collect an assessment. (V.T.I.C. Art. 21.28, Sec. 7(c).)

Source Law

> (c) Collection. After the entry of such an order of assessment and the expiration of the time for appeal, the receiver shall proceed to collect such assessments, and for the purpose of such collection may bring suit for the same in any court of competent jurisdiction in the county in which such delinquency proceeding is pending.

Revised Law

Sec. 442.304. SUBCHAPTER NOT EXCLUSIVE. The provisions of this subchapter are in addition to any other remedies for the levy and collection of assessments. (V.T.I.C. Art. 21.28, Sec. 7(d).)

Source Law

(d) Provisions Cumulative. The provisions of this Section are cumulative of any other remedies for the levy and collection of assessments.

[Sections 442.305-442.350 reserved for expansion]

SUBCHAPTER H. REINSURANCE

Revised Law

Sec. 442.351. REINSURER'S LIABILITY. (a) If the receiver has a claim under an insurance policy covered by reinsurance, the liability of the reinsurer to the receiver under the reinsured contract may not be reduced because of the delinquency proceeding against the delinquent insurer, regardless of any contrary provision in the reinsurance contract, unless:

(1) the reinsurance contract or other written agreement was entered into before the delinquency proceeding, is otherwise permitted by law, and specifically provides another payee of the reinsurance if the ceding insurer becomes insolvent; or

(2) the assuming insurer, with the consent of the direct insured, has assumed in accordance with an assumption reinsurance agreement the policy obligations of the ceding insurer:

(A) as direct obligations of the assuming insurer to the payees under the policy; and

(B) in substitution for the obligations of the ceding insurer to the payees.

(b) Except as provided by Subsection (a), any reinsurance is payable to the receiver under a reinsured contract by the assuming insurer on the basis of:

(1) an approved claim under Section 442.206; and

(2) a claim paid by a guaranty association under Chapter 462, 463, or 2602 or by the guaranty association of another

state. (V.T.I.C. Art. 21.28, Sec. 10(a).)

Source Law

Sec. 10. (a) Reinsurer's Liability. If the receiver has claims under policies covered by reinsurance, there shall be no diminution of the liability of the reinsurer to the receiver under the contracts reinsured because of the delinquency proceeding against the delinquent company, regardless of any provisions in the reinsurance contract to the contrary, except: (i) where the contract or other written agreement entered into prior to the delinquency proceeding and otherwise permitted by law specifically provides another payee of such reinsurance in the event of the insolvency of the ceding insurer; or (ii) where the assuming insurer, with the consent of the direct insured, has assumed such policy obligations of the ceding insurer pursuant to an assumption reinsurance agreement as direct obligations of the assuming insurer to the payees under policies and in substitution for the obligations of the ceding insurer to such payees. With the sole exception of (i) and (ii) above, any reinsurance shall be payable to the receiver under a contract reinsured by the assuming insurer on the basis of approved claims under Section 3(h) of this Article and claims paid under Articles 9.48, 21.28-C, and 21.28-D of this code or the guaranty associations of other states.

Revisor's Note

Section 10(a), V.T.I.C. Article 21.28, provides that, with the "sole" exception of certain referenced provisions, any reinsurance is payable to the receiver under a contract reinsured by the assuming insurer on the basis of certain claims. The revised law omits "sole" as unnecessary because the word does not add to the clear meaning of the law. A reference to provisions that state an exception to a general rule is sufficient to limit the exception to only those provisions.

Revised Law

Sec. 442.352. NOTICE OF CLAIM TO REINSURER; INTERPOSITION OF DEFENSE. (a) Within a reasonable time after a claim against the receiver under an insurance policy covered by reinsurance is filed in the delinquency proceeding, the receiver shall give written notice of the pendency of the claim to each affected reinsurer.

(b) While the claim is pending, an affected reinsurer may,

at the reinsurer's expense, investigate the claim and interpose in the proceeding in which the claim is to be adjusted any defense the reinsurer considers available to the delinquent insurer or the receiver.

(c) Subject to court approval, the expense incurred by an assuming insurer under Subsection (b) is chargeable against the delinquent insurer as part of the expense of liquidation to the extent of a proportionate share of any benefit that may accrue to the delinquent insurer solely as a result of the defense undertaken by the assuming insurer. If two or more assuming insurers are involved in the same claim and a majority in interest elect to interpose a defense to the claim, the expense shall be apportioned in accordance with the terms of the reinsurance agreement as if the expense had been incurred by the ceding insurer. (V.T.I.C. Art. 21.28, Sec. 10(b).)

Source Law

(b) Notice to Reinsurer. The liquidator or receiver shall give written notice to the affected reinsurers of the pendency of a claim against the receiver under a policy covered by reinsurance within a reasonable time after such claim is filed in the delinquency proceeding. During the pendency of such claim any affected reinsurer may investigate such claim and interpose, at its own expense, in the proceeding where the claim is to be adjusted any defense or defenses which it may deem available to the delinquent company, the liquidator or the receiver. Subject to court approval, the expense thus incurred shall be chargeable against the delinquent company as part of the expense of liquidation to the extent of a proportionate share of the benefit which may accrue to the delinquent company solely as a result of the defense undertaken by the assuming insurer. Where two or more assuming insurers are involved in the same claim and a majority in interest elect to interpose a defense to such claim, the expense shall be apportioned in accordance with the terms of the reinsurance agreement as though such expense had been incurred by the ceding insurer.

Revisor's Note
(End of Subchapter)

Section 10(c), V.T.I.C. Article 21.28, provides that V.T.I.C. Article 6.16 remains in full force and effect and governs as to insurance companies affected by that article. As enacted by Chapter 491, Acts of

the 52nd Legislature, Regular Session, 1951, Article 6.16 contained provisions governing diminution of the liability of an assuming insurer because of the insolvency of the ceding insurer, notice by the receiver of the insolvent ceding insurer regarding the pendency of a claim against the insolvent ceding insurer, investigation and defense of the claim by the assuming insurer, and recovery of the expenses incurred by the assuming insurer. Chapter 267, Acts of the 54th Legislature, Regular Session, 1955, amended Article 21.28 by adding Section 10. As added, that section contained provisions that were similar to, but not the same as, the provisions of Article 6.16 described above. Chapter 88, Acts of the 68th Legislature, Regular Session, 1983, amended Article 6.16 by striking the provisions of the article described above. Article 6.16 was revised in this code in 2001 as Section 862.101, which took effect June 1, 2003. However, since that section no longer contains any provisions that conflict with Section 10, the statement of the continued applicability of that section is omitted. The omitted law reads:

> (c) Provided, however, that Article 6.16 of the Insurance Code of 1951, Acts Regular Session of the Fifty-second Legislature, 1951, Chapter 491, page 868, shall remain in full force and effect and shall govern as to those insurance companies affected thereby.

[Sections 442.353-442.400 reserved for expansion]

SUBCHAPTER I. RECORDS AND OTHER INFORMATION

Revised Law

Sec. 442.401. USE OF RECORDS AND OTHER INFORMATION AS EVIDENCE. (a) A book, paper, document, or record of a delinquent insurer received by the receiver and held in the course of the delinquency proceeding or a certified copy of the book, paper, document, or record signed and under the official seal of the

commissioner or receiver is admissible in evidence in a case without proof of correctness or other proof except the certificate of the commissioner or receiver that the book, paper, document, or record was received from the custody of the delinquent insurer or found among the insurer's effects.

(b) The certified original or a certified copy of a book, paper, document, or record described by this section or Section 442.402 is prima facie evidence of the facts disclosed by the book, paper, document, or record. (V.T.I.C. Art. 21.28, Secs. 11(a), (c).)

Source Law

> Sec. 11. (a) Records Admitted. All books, records, documents and papers of any delinquent insurer received by the receiver and held in the course of the delinquency proceedings, or certified copies thereof, under the hand and official seal of the Board and/or receiver, shall be received in evidence in all cases without proof of the correctness of the same and without other proof, except the certificate of the Board and/or receiver that the same was received from the custody of the delinquent insurer or found among its effects.
>
> (c) Prima-facie Evidence. Such original books, records, documents and papers, or certified copies thereof, or any part thereof, when received in evidence shall be prima-facie evidence of the facts disclosed thereby.

Revised Law

Sec. 442.402. CERTIFICATES BY RECEIVER. (a) The receiver may:

(1) certify to the correctness of a book, paper, document, or record of the receiver's office, including a book, paper, document, or record described by Section 442.401; and

(2) certify under seal of the commissioner to a fact contained in a book, paper, document, or record of the department.

(b) A book, paper, document, or record certified as described by Subsection (a) is admissible in evidence in any case in which the original would be evidence. (V.T.I.C. Art. 21.28, Sec. 11(b).)

Source Law

(b) Certificates. The receiver shall have the

authority to certify to the correctness of any paper, document or record of the receiver's office, including those described in (a) of this section, and to make certificates under seal of the Board and certified by the receiver certifying to any fact contained in the papers, documents or records of the Texas Department of Insurance; and the same shall be received in evidence in all cases in which the originals would be evidence.

Revisor's Note

(1) Section 11(b), V.T.I.C. Article 21.28, refers to a "paper, document or record" and to "papers, documents or records." The revised law adds references to a "book" for consistency with Sections 11(a) and (c), Article 21.28, revised in this chapter as Section 442.401, which refer to "books, records, documents and papers."

(2) Section 11(b), V.T.I.C. Article 21.28, refers to the "Texas Department of Insurance." Section 31.001 of this code defines "department" for purposes of this code and the other insurance laws of this state to mean the Texas Department of Insurance. The revised law is drafted accordingly.

Revised Law

Sec. 442.403. MAINTENANCE OF RECORDS. (a) The receiver may devise a method for the effective, efficient, and economical maintenance of the records of the delinquent insurer and of the receiver's office. The method may include maintaining those records on any medium approved by the records management division of the Texas State Library.

(b) A copy of an original record or another record that is maintained within the scope of this subchapter on a medium approved by the records management division of the Texas State Library and that is produced by the receiver or the receiver's authorized representative under this chapter:

(1) has the same effect as the original record; and

(2) may be used in the same manner as the original record in a judicial or administrative proceeding in this state.

(c) The receiver may reserve the estate assets for deposit in an account to be used for the specific purpose of maintenance, storage, and disposal of records in closed receivership estates. (V.T.I.C. Art. 21.28, Sec. 11(d).)

Source Law

> (d) Maintenance of Records. The receiver may devise a method for the effective, efficient, and economical maintenance of the records of the delinquent insurer and of the liquidator's office including maintaining those records on any medium approved by the Records Management Division of the Texas State Library. A copy of an original record or any other record that is maintained on any medium approved by the Records Management Division of the Texas State Library within the scope of this section that is produced by the receiver or his authorized representative under this Article shall have the same force and effect as the original record and may be used the same as the original record in any judicial or administrative proceeding in this state. In order to maintain the records of delinquent insurers after the closing of the receivership proceedings, the receiver may reserve assets of an estate to be deposited in an account to be used for the specific purpose of maintenance, storage, and disposal of records in closed receivership estates.

Revisor's Note

Section 11(d), V.T.I.C. Article 21.28, provides that a copy of a record maintained in a certain manner has the same "force and effect" as the original record. The reference to "force" is omitted from the revised law because "force" is included within the meaning of "effect."

Revised Law

Sec. 442.404. DISPOSAL OF RECORDS. On approval by the court, the receiver may dispose of any records of the delinquent insurer that are obsolete and unnecessary to the continued administration of the receivership proceeding. (V.T.I.C. Art. 21.28, Sec. 11(e).)

Source Law

> (e) Disposition of Records. On approval by the court, the receiver may dispose of any records of the delinquent insurer that are obsolete and unnecessary to the continued administration of the receivership proceedings.

Revised Law

Sec. 442.405. INAPPLICABILITY OF PUBLIC INFORMATION LAW. Chapter 552, Government Code, does not apply to any record of a receivership estate, or to any record of an insurer before the insurer's receivership, held by the receiver under this chapter. (V.T.I.C. Art. 21.28, Sec. 11(f).)

Source Law

(f) Open Records. Chapter 552, Government Code, shall not apply to any records of a receivership estate, or to the records of an insurance company prior to its receivership, held by the receiver or by a special deputy receiver under this Article.

Revisor's Note

Section 11(f), V.T.I.C. Article 21.28, refers to records held by the "receiver or by a special deputy receiver." The revised law omits the reference to the special deputy receiver as unnecessary because, in accordance with the portion of Section 2(a), V.T.I.C. Article 21.28, revised in this chapter as Section 442.051, the special deputy receiver acts as receiver. Similar changes are made in this context throughout this chapter.

[Sections 442.406-442.450 reserved for expansion]

SUBCHAPTER J. AUDITS

Revised Law

Sec. 442.451. AUDITS OR INVESTIGATIONS OF RECEIVER, SPECIAL DEPUTY RECEIVER, OR GUARANTY ASSOCIATION. (a) The commissioner shall adopt rules, after submitting the rules to the state auditor for review and comment, prescribing the audits required for the receiver, each special deputy receiver, and each guaranty association established under Chapter 462, 463, or 2602. The rules must include provisions relating to the scope, frequency, reporting requirements, and cost of audits.

(b) As determined necessary by the commissioner or the state auditor to supplement audits conducted under rules adopted under Subsection (a), the state auditor may conduct audits or

investigations, as defined by Sections 321.0131-321.0136, Government Code, of the receiver, each special deputy receiver, and each guaranty association described by Subsection (a). The audited or investigated entity shall reimburse the state auditor for costs associated with the audit or investigation. (V.T.I.C. Art. 21.28, Secs. 12(j), (k).)

Source Law

(j) The Board shall adopt rules prescribing the audit coverage required for the receiver, each special deputy receiver appointed under this section, and each guaranty association established under Article 9.48, 21.28-C, or 21.28-D of this code. Such rules shall include, but not be limited to, provisions relating to the scope, frequency, reporting requirements, and cost of audits, and shall be submitted to the state auditor for review and comment prior to adoption.

(k) The state auditor is authorized to conduct audits, as defined by Sections 321.0131 through 321.0136, Government Code, of the receiver, each special deputy receiver appointed under this section, and each guaranty association established under Article 9.48, 21.28-C, or 21.28-D of this code, as the commissioner or the state auditor determines to be necessary to supplement audits conducted under Subsection (j) of this section. Costs associated with any such audit shall be reimbursed to the state auditor by the audited entity.

Revisor's Note

(1) Section 12(j), V.T.I.C. Article 21.28, refers to "include, but not be limited to." The revised law omits "but not be limited to" as unnecessary because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, 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.

(2) Section 12(k), V.T.I.C. Article 21.28, refers to "audits, as defined by Sections 321.0131 through 321.0136, Government Code." Section 321.0136, Government Code, defines "investigation." Accordingly, the revised law refers to "audits or

investigations" as defined by those sections.

Revised Law

Sec. 442.452. PLAN AND REPORT REGARDING AUDIT OF RECEIVER. (a) The state auditor may conduct an audit of the receiver in accordance with the audit plan under Chapter 321, Government Code. The state auditor shall conduct the audit in the manner provided by that chapter.

(b) The state auditor's report of an audit under this section may include:

(1) an analysis of:

(A) the overall performance of the receiver;

(B) the receiver's financial operations and condition;

(C) the receipts and expenditures made in connection with each audited receivership;

(D) the adequacy of the receiver's bond in relation to assets, receipts, and expenditures; and

(E) the feasibility of using attorneys employed by the receiver in all litigation;

(2) the amount of money made available to the receiver by a guaranty association in connection with each audited receivership and a detail of the purpose and manner of expenditure of the money;

(3) the ratio of the total amount of paid claims to the total costs incurred in connection with each audited receivership; and

(4) the ratio of the receiver's administrative expenses to the total costs incurred in connection with each audited receivership.

(c) The state auditor shall file:

(1) copies of the auditor's report in the manner required by Section 321.014, Government Code; and

(2) an additional copy of the report with the department. (V.T.I.C. Art. 21.28, Secs. 12(d), (e), (f).)

Source Law

(d) Audit. The state auditor may conduct an audit of the liquidator in accordance with the audit plan reviewed and approved by the legislative audit committee. The audits authorized by this subsection shall be conducted in the manner provided by Chapter 321, Government Code.

(e) Contents of Auditor's Report. The state auditor's report of the audit authorized by Subsection (d) of this section may include:

(1) an analysis of the overall performance of the liquidator;

(2) an analysis of the liquidator's financial operations and condition;

(3) an analysis of receipts and expenditures made in connection with each audited receivership and an analysis of the adequacy of the receiver's bond in relation to assets, receipts, and expenditures;

(4) the amount of funds made available to the liquidator by a guaranty association in connection with each audited receivership and a detail of the purpose and manner of expenditure of such funds;

(5) the ratio of the total amount of claims paid to the total costs incurred in connection with each audited receivership;

(6) the ratio of the liquidator's administrative expenses to the total costs incurred in connection with each audited receivership; or

(7) an analysis of the feasibility of using attorneys who are employees of the liquidator in all litigation.

(f) Filing of Auditor's Reports. Copies of the auditor's report shall be filed in the manner required by Section 321.014, Government Code. An additional copy of the report shall be filed with the board and the commissioner.

Revisor's Note

Section 12(d), V.T.I.C. Article 21.28, authorizes the state auditor to conduct an audit of the receiver in accordance with the audit plan "reviewed and approved by the legislative audit committee" and also requires the state auditor to conduct the audit in the manner provided by Chapter 321, Government Code. The revised law substitutes a reference to Chapter 321, Government Code, for the quoted language because the audit is required to be conducted under that chapter and Section 321.013(c), Government Code, requires that the audit plan be reviewed and approved by the legislative audit committee.

Revised Law

Sec. 442.453. COURT-ORDERED AUDIT. (a) A court in which a receivership action is pending may order an audit of the books and records of the receiver relating to the receivership. The receiver shall make the books and records available to the auditor as required by the court order.

(b) A report of an audit conducted under this section shall be filed with the department and the appropriate guaranty association.

(c) The receiver shall pay the expenses of an audit conducted under this section. (V.T.I.C. Art. 21.28, Sec. 12(g).)

Source Law

> (g) Court-Ordered Audit. A court in which a receivership action is pending may order an audit of the books and records of the liquidator as they relate to the receivership. A report of an audit ordered under this subsection shall be filed with the board, the commissioner, and the appropriate guaranty association. The liquidator shall make the books and records relating to the receivership available to the auditor as required in the court order. The liquidator shall pay the expenses of an audit ordered under this subsection.

[Sections 442.454-442.500 reserved for expansion]

SUBCHAPTER K. DISTRIBUTION OF ASSETS: EARLY ACCESS

Revised Law

Sec. 442.501. APPLICATION FOR APPROVAL OF PROPOSAL TO DISTRIBUTE ASSETS. (a) Not later than the 120th day after the date of the commencement of an insolvency proceeding against an impaired insurer, the receiver may apply to the court for approval of a proposal to distribute assets out of marshalled assets as they become available to a guaranty association or foreign guaranty association with a Class 1 or Class 2 claim under this chapter.

(b) If the receiver fails to apply for approval within the period prescribed by Subsection (a), a guaranty association may apply to the court and request that the receiver submit a proposal to distribute assets.

(c) If the receiver determines that there are insufficient assets to distribute, the receiver may file a statement of the

reasons for that determination instead of filing an application under this section. A statement under this subsection is considered to be an application by the receiver for purposes of this section. (V.T.I.C. Art. 21.28, Sec. 7A(a).)

Source Law

> Sec. 7A. (a) Within 120 days of the commencement of the insolvency proceeding against an impaired insurer, the liquidator or a special deputy receiver appointed under this Article may make application to the court for approval of a proposal to disburse assets out of marshaled assets, from time to time as such assets become available, to a guaranty association or foreign guaranty association having Class 1 or Class 2 claims against the estate of the impaired insurer because of such insolvency. If the receiver or special deputy receiver fails to make such application within 120 days, the guaranty association may submit an application to the court requesting that the receiver or special deputy receiver submit a proposal to disburse assets. If the liquidator or special deputy receiver determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by a filing by the liquidator or special deputy receiver stating the reasons for this determination.

Revisor's Note

(1) Section 7A(a), V.T.I.C. Article 21.28, authorizes the receiver to "disburse" assets. Other sections of Article 21.28 refer to the "disbursement" of assets and use other similar phrases. The revised law substitutes "distribute" for "disburse" in this context for consistency in use of terminology. Similar changes are made throughout this chapter.

(2) Section 7A(a), V.T.I.C. Article 21.28, refers to Class 1 or Class 2 claims "against the estate of the impaired insurer because of such insolvency." The revised law omits the quoted language as unnecessary because Class 1 and Class 2 claims under this chapter are categories of claims established under Section 442.551 and are brought against the estate of an impaired insurer. Claims are brought against an insurer under this chapter because of the insurer's insolvency. Therefore, a Class 1 or Class 2

claim could not be brought against anything other than the impaired insurer's estate because of the insolvency.

Revised Law

Sec. 442.502. CONTENTS OF PROPOSAL TO DISTRIBUTE ASSETS. (a) A proposal to distribute assets under Section 442.501 must include provisions for:

(1) reserving amounts sufficient to allow the payment of Class 1 claims;

(2) to the extent the assets of the insolvent insurer allow any payment of Class 2 claims, reserving amounts sufficient to provide equal pro rata distributions to the Class 2 claimants other than the guaranty associations;

(3) distributing the assets marshalled as of the date of the proposal and distributing other assets as they become available;

(4) equitably allocating distributions among guaranty associations and foreign guaranty associations entitled to distributions, including providing for:

(A) distributions to the associations in amounts estimated to be at least equal to the claim payments made or to be made by the associations for which the associations could assert a claim against the receiver; and

(B) distributions for the pro rata amount of the associations' Class 2 claims if the assets, as they become available for distribution, do not equal or exceed the amount of the claim payments made or to be made by the associations; and

(5) with regard to an insolvent insurer writing life or health insurance or annuities, distributing the assets to:

(A) a guaranty association or foreign guaranty association covering life or health insurance or annuities; or

(B) any other entity or organization reinsuring, assuming, or guaranteeing insurance policies or contracts under the laws creating an association described by Paragraph (A).

(b) The proposal to distribute assets must also include provisions that require:

(1) the receiver to obtain from each guaranty association described by Subsection (a)(4) an agreement to return to the receiver on request and on approval by the court any previously distributed assets, together with income on the assets, required to pay Class 1 claimants and any federal claimants asserting priority claims; and

(2) each guaranty association or foreign guaranty association to make a full report to the receiver, as requested by the receiver but not more frequently than quarterly, accounting for:

(A) the assets distributed to the association;

(B) all distributions made from those assets;

(C) any interest earned by the association on those assets; and

(D) any other matter as the court directs.

(c) A guaranty association or foreign guaranty association is not required to provide a bond under Subsection (b)(1). (V.T.I.C. Art. 21.28, Secs. 7A(b), (c), (d).)

Source Law

(b) Such proposal shall, at a minimum, include provisions for:

(1) reserving amounts sufficient to allow the payment of Class 1 claims, and to the extent the assets of the insolvent insurer will allow any payment to be made on Class 2 claims, reserving amounts sufficient to provide equal pro-rata distributions to the Class 2 claimants other than the guaranty associations;

(2) disbursement of the assets marshaled to date and the subsequent distribution of assets as they become available;

(3) equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled thereto;

(4) the securing of the liquidator or special deputy receiver from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the liquidator upon request and approval by the court such assets, together with income on assets previously disbursed, as may be required to pay Class 1 claimants and any federal claimants asserting priority claims. No bond shall be required of any such association; and

(5) a full report to be made by each

association to the liquidator or special deputy receiver, as requested by the liquidator or special deputy receiver, but no more frequently than quarterly, accounting for the assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets and any other matter as the court may direct.

(c) The proposal submitted by the liquidator or special deputy receiver shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the liquidator, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments made or to be made by the association, then disbursements shall be made for the pro-rata amount of the association's Class 2 claim.

(d) The proposal submitted by the liquidator or special deputy receiver shall, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursement of assets to any guaranty association or foreign guaranty association covering life or health insurance or annuities or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the acts creating such associations.

Revised Law

Sec. 442.503. NOTICE OF APPLICATION. (a) The receiver shall give notice of an application for approval of a proposal to distribute assets to a guaranty association or foreign guaranty association in, and to the commissioner of insurance of, each of the states. Notice under this subsection must be deposited in the United States certified mail, first class postage prepaid, at least 30 days before the date the application is submitted to the court.

(b) The receiver shall also give notice of the application to reasonably identifiable Class 1 and Class 2 claimants. Notice under this subsection must be given in a manner the court considers appropriate, including notice by publication.

(c) The court may act on the application if:

(1) notice has been given as provided by this section; and

(2) the receiver's proposal to distribute assets complies with this subchapter. (V.T.I.C. Art. 21.28, Sec. 7A(e).)

Source Law

(e) Notice of the application shall be given to the association in and to the commissioners of insurance of each of the states. Notice shall be considered to have been given when deposited in the

United States certified mail, first class postage prepaid, at least 30 days prior to the submission of the application to the court. Action of the application may be taken by the court if notice has been given and if the liquidator's or special deputy receiver's proposal complies with the requirements of this section. Notice of the application shall be given to those Class 1 and Class 2 claimants that are reasonably ascertainable in a manner deemed appropriate by the court, including notice by publication.

[Sections 442.504-442.550 reserved for expansion]

SUBCHAPTER L. DISTRIBUTION OF ASSETS

Revised Law

Sec. 442.551. PRIORITY OF CLAIMS FOR DISTRIBUTION OF ASSETS. (a) The priorities provided by this section are established to:

(1) provide for the orderly liquidation of a receivership estate; and

(2) further the protection of policyholders and persons making claims under insurance policies.

(b) The priority of distribution of assets from the insurer's estate must be in accordance with:

(1) the distribution plan approved by the court under Subchapter K; and

(2) the order of each class as provided by this section.

(c) Each claim in each class must be paid in full, or an adequate amount of money must be retained for that payment, before a payment is made for a claim in the next class.

(d) Subclasses may not be established within a class.

(e) The classes of claims are as follows:

(1) Class 1:

(A) all of the receiver's, conservator's, and supervisor's costs and expenses of administration, including repayment of any money spent by the receiver under Section 442.607;

(B) all of a guaranty association's or foreign guaranty association's costs and expenses of administration related to a receivership estate and all of the expenses of that

association in handling claims; and

(C) claims of secured creditors to the extent of the value of the security as provided by Section 442.554;

(2) Class 2:

(A) all claims by policyholders, beneficiaries, and insureds, and liability claims against insureds covered under insurance policies and contracts issued by the insurer; and

(B) all claims by a guaranty association or a foreign guaranty association that are payments of proper policyholder claims;

(3) Class 3: claims of the federal government that are not included in Class 2;

(4) Class 4: all other claims of general creditors not falling within a higher priority under this subchapter, including claims for taxes and debts due a state or local government that are unsecured; and

(5) Class 5: claims of surplus or contribution note holders, debenture holders, or holders of similar obligations and proprietary claims of shareholders, members, or other owners according to the terms of the instruments.

(f) For the purpose of Subsection (e)(1)(B), attorney's fees incurred by a guaranty association or foreign guaranty association in the defense of an insured under an insurance policy issued by an impaired insurer are an expense incurred in handling a claim. (V.T.I.C. Art. 21.28, Secs. 8(a)(1), (2).)

Source Law

Sec. 8. (a) Priority of Distribution of Assets. (1) In order to provide for the orderly liquidation of a receivership estate and to further the protection of policyholders and those making claims under insurance policies, the following priorities are established. The priority of distribution of assets from the insurer's estate shall be in accordance with the disbursement plan approved by the court under Section 7A of this Article, and in accordance with the order of each class as provided by this subsection. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class.

(2) Classes of claims:

(A) Class 1:

(i) All of the receiver's, conservator's, and supervisor's costs and expenses of administration, including repayment of funds advanced to the receiver from the abandoned property fund of the department.

(ii) All of an insurance guaranty association's or foreign insurance guaranty association's costs and expenses of administration related to a receivership estate and all of the expenses of an insurance guaranty association or foreign insurance guaranty association in handling claims. For the purpose of this subparagraph, attorney's fees incurred by an insurance guaranty association or foreign insurance guaranty association in the defense of an insured under a policy issued by an impaired insurer constitute an expense incurred in handling claims.

(iii) Secured creditors to the extent of the value of the security as provided by Section 8(c) of this Article.

(B) Class 2:

(i) All claims by policyholders, beneficiaries, insureds, and liability claims against insureds covered under insurance policies and insurance contracts issued by the insurer.

(ii) All claims by an insurance guaranty association or a foreign insurance guaranty association that are payments of proper policyholder claims.

(C) Class 3: Claims of the federal government not included in Class 2, above.

(D) Class 4: All other claims of general creditors not falling within any other priority under this section including claims for taxes and debts due any state or local government which are not secured claims.

(E) Class 5: Claims of surplus or contribution note holders, holders of debentures or holders of similar obligations and proprietary claims of shareholders, members, or other owners according to the terms of the instruments.

Revisor's Note

(1) Section 8(a)(2)(A)(i), V.T.I.C. Article 21.28, defines Class 1 claims to include the receiver's, conservator's, and supervisor's costs and expenses of administration, including "repayment of funds advanced to the receiver from the abandoned property fund of the department." Sections 8(g) and (i), Article 21.28, revised in this chapter as Sections 442.601, 442.603, and 442.604, provide a procedure for declaring that certain unclaimed money is abandoned and is the property of the Texas Department of Insurance. Section 8(i), Article 21.28,

revised in pertinent part in this chapter as Section 442.604, requires the department to deposit the abandoned money in accordance with Section 2(h), Article 21.28, revised in this chapter as Section 442.110, and Section 8(j), Article 21.28, revised in this chapter as Section 442.607, authorizes the receiver to spend the abandoned money. In addition, Section 8A, V.T.I.C. Article 21.28, revised in this chapter as Sections 442.605-442.607, provides a similar procedure for declaring that proceeds derived from certain unclaimed assets are abandoned and are the property of the department. Section 8A also requires the department to deposit the proceeds in accordance with Section 2(h), Article 21.28, revised in this chapter as Section 442.110, and states that "[s]uch funds may be used as provided in Section 8(j) of this Article." Because Section 8(j), Article 21.28, revised in this chapter in Section 442.607, provides the authority for the receiver to spend abandoned money, and because the described provisions of Article 21.28 do not refer to an "abandoned property fund of the department," the revised law substitutes a cross-reference to Section 442.607 for the reference to the "abandoned property fund of the department."

(2) Section 8(a)(3), V.T.I.C. Article 21.28, states that the provisions of Section 8(a), Article 21.28, are severable from each other. The revised law omits that provision because it duplicates Section 311.032, Government Code (Code Construction Act), applicable to the revised law. That provision 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:

(3) If any provision of this

subsection or the application of any provision of this subsection to any person or circumstance is held invalid, that invalidity does not affect the other provisions or applications of this subsection.

Revised Law

Sec. 442.552. PAYMENT OF WAGES OF EMPLOYEES OF INSURER SUBJECT TO TEMPORARY RESTRAINING ORDER. (a) The receiver shall pay as a Class 1 claim under Section 442.551 wages owed to employees of an insurer against which a temporary restraining order has been issued under this chapter for services rendered during the period covered by the order.

(b) The receiver shall pay for services under Subsection (a) at the rate and in the same manner as if paid by the insurer. (V.T.I.C. Art. 21.28, Sec. 6 (part).)

Source Law

Sec. 6. The receiver shall pay wages actually owed to employees of an insurer against whom a temporary restraining order has been issued under this Article for services rendered during the period covered by the temporary restraining order as a Class 1 claim as provided by Section 8(a) of this Article. Payment for those services must be made at the rate and in the same manner as if paid by the insurer. . . .

Revised Law

Sec. 442.553. PAYMENT OF WAGES OF EMPLOYEES OF INSURER SUBJECT TO TEMPORARY INJUNCTION. (a) The receiver may pay wages owed to employees of an insurer against which a temporary injunction has been issued under this chapter for services rendered after the issuance of the injunction.

(b) Payment for services under Subsection (a) is an expense of administration. (V.T.I.C. Art. 21.28, Sec. 6 (part).)

Source Law

Sec. 6. . . . The receiver may pay wages actually owed to employees of an insurer against whom a temporary injunction has been issued under this Article for services rendered after the issuance of the temporary injunction. Payment for those services is made at the discretion of the receiver and as an expense of administration.

Revised Law

Sec. 442.554. SECURED CREDITOR. (a) The owner of a secured

claim against an insurer for which a receiver has been appointed in any state may surrender the owner's security and file a claim as a general creditor, or the claim may be discharged by resort to the security.

(b) If a claim described by Subsection (a) is discharged by resort to the security, any deficiency shall be treated as a claim against the general assets of the insurer on the same basis as a claim of an unsecured creditor. If the amount of the deficiency was adjudicated in an ancillary delinquency proceeding as provided by Subchapter P or by a court of competent jurisdiction in a proceeding in which the domiciliary receiver was provided with notice and an opportunity for hearing, the amount is conclusive. If the amount was not adjudicated as provided by this subsection, the amount shall be determined in the delinquency proceeding in the domiciliary state.

(c) The value of any security held by a secured creditor shall be determined under supervision of the court by:

(1) conversion of the security into money according to the terms of the agreement under which the security was delivered to the creditor; or

(2) agreement, arbitration, compromise, or litigation between the creditor and the receiver. (V.T.I.C. Art. 21.28, Sec. 8(c).)

Source Law

> (c) Secured Creditor. (1) The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this chapter, or if it has been adjudicated by a court of competent jurisdiction in a proceeding in which the domiciliary receiver has had notice and an opportunity to be heard, such amount shall be conclusive; otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state.
>
> (2) The value of any security held by a secured creditor shall be determined under supervision of the court by:

(A) converting the security into money according to the terms of the agreement pursuant to which the security was delivered to the creditor; or

(B) by agreement, arbitration, compromise, or litigation between the creditor and the receiver.

Revisor's Note

Section 8(c)(1), V.T.I.C. Article 21.28, refers to the adjudication of a deficiency in an ancillary proceeding as provided "in this chapter," meaning V.T.I.C. Chapter 21. Section 13, V.T.I.C. Article 21.28, revised in this chapter as Subchapter P, is included in Chapter 21 and governs ancillary delinquency proceedings. The revised law is drafted accordingly.

Revised Law

Sec. 442.555. DIVIDEND PAYMENTS. (a) On the direction and approval of the court and in accordance with the priorities provided by this subchapter, the receiver may make periodic dividend payments, including payments of policyholder claims, to facilitate the rehabilitation, liquidation, conservation, or dissolution of an insurer.

(b) The receiver at all times shall reserve sufficient assets to pay the expenses of administration. (V.T.I.C. Art. 21.28, Sec. 8(b).)

Source Law

(b) Dividend Payments. On the direction and approval of the court and pursuant to the priorities provided by this section, the receiver may make periodic dividend payments, including payments of policyholder claims, for the purpose of facilitating the rehabilitation, liquidation, conservation, or dissolution of an insurer. The receiver at all times shall reserve sufficient assets for the payment of the expenses of administration.

Revised Law

Sec. 442.556. CLAIMANTS OF OTHER STATES OR FOREIGN COUNTRIES. (a) If a claimant of another state or of a foreign country is entitled to or receives a dividend on the claim out of a statutory deposit or the proceeds of a bond or other asset located in that state or foreign country, the claimant is not entitled to

share in the distribution of any additional dividend from the receiver until all other claimants of the same class receive an equal dividend on their claims, regardless of their residence or the location of the acts or contracts on which the claims are based.

(b) After the other claimants of the same class receive an equal dividend on their claims, the claimant of the other state or of the foreign country is entitled to share in the distribution of additional dividends by the receiver, along with and in the same manner as all other creditors of the same class, regardless of their residence. (V.T.I.C. Art. 21.28, Sec. 8(e).)

Source Law

> (e) Foreign Claimants. If any claimant of another state or foreign country shall be entitled to or shall receive a dividend upon his claim out of a statutory deposit or the proceeds of any bond or other asset located in such other state or foreign country, then such claimants shall not be entitled to any further dividend from the receiver until and unless all other claimants of the same class, irrespective of residence or place of the acts or contracts upon which their claims are based, shall have received an equal dividend upon their claims; and after such equalization, such claimants shall be entitled to share in the distribution of further dividends by the receiver, along with and like all other creditors of the same class, wheresoever residing.

Revised Law

Sec. 442.557. SETOFF OF DIVIDEND AMOUNT. On the declaration of a dividend, the receiver shall apply the amount of the dividend against any debt owed to the insurer by the person entitled to the dividend. (V.T.I.C. Art. 21.28, Sec. 8(f).)

Source Law

> (f) Setoff by Receiver. Upon the declaration of a dividend, the receiver shall apply the amount of such dividend against any indebtedness owed to the insurer by the person entitled to such dividend.

Revised Law

Sec. 442.558. CLAIMS UNDER SEPARATE ACCOUNTS ESTABLISHED BY DOMESTIC LIFE INSURANCE COMPANIES. (a) Each claim under a separate account established under Chapter 1152 shall be satisfied out of the portion of the assets in the separate account that is equal to the reserves maintained in the account for the applicable

contracts.

(b) To the extent reserves maintained in a separate account exceed the amounts needed to satisfy claims under the applicable contracts, the excess shall be treated as general assets of the domestic life insurance company. (V.T.I.C. Art. 21.28, Sec. 8(k) (part).)

Source Law

> (k) Every claim under a separate account established under Article 3.75 of this code, providing that the income, gains, and losses, realized and unrealized, from assets allocated to the separate account shall be credited to or charged against the account, without regard to other income, gains, or losses of the life insurance company, shall be satisfied out of the assets in the separate account equal to the reserves maintained in such account for the contracts. . . . To the extent, if any, reserves maintained in the separate account are in excess of the amounts needed to satisfy claims under the separate account contracts, the excess shall be treated as general assets of the life insurance company.

Revisor's Note

(1) Section 8(k), V.T.I.C. Article 21.28, refers to a separate account established under V.T.I.C. Article 3.75, "providing that the income, gains, and losses, realized and unrealized, from assets allocated to the separate account shall be credited to or charged against the account, without regard to other income, gains, or losses of the life insurance company." Article 3.75 is revised in this code as Chapter 1152. The revised law omits the quoted language as unnecessary because it duplicates Section 1152.057 of this code, which requires a life insurance company to credit to or charge against a separate account the income, gain, or loss, realized or unrealized, from an asset allocated to the account without regard to other income, gains, or losses of the company.

(2) Section 8(k), V.T.I.C. Article 21.28, provides that to the extent reserves maintained in a

separate account established under V.T.I.C. Article 3.75 exceed the amounts needed to satisfy claims under the applicable contracts, the excess is treated as general assets of the "life insurance company." The revised law substitutes "domestic life insurance company" for "life insurance company" because Article 3.75, which is revised in this code as Chapter 1152, applies only to domestic life insurance companies.

(3) Section 8(k), V.T.I.C. Article 21.28, provides that to the extent provided under contracts established under V.T.I.C. Article 3.75, the portion of the assets of a separate account equal to the reserves and other contract liabilities for the separate account is not chargeable with liabilities arising out of any other business of the life insurance company that owns the account. The revised law omits that provision as unnecessary because it duplicates Section 1152.059 of this code, which provides that to the extent provided under the applicable contracts, the portion of a separate account's assets equal to the reserves and other contract liabilities regarding that account is not chargeable with a liability arising out of any other business of the life insurance company. The omitted law reads:

> (k) . . . To the extent provided under contracts established under Article 3.75 of this code, that portion of the assets of any separate account equal to the reserves and other contract liabilities for the separate account is not chargeable with liabilities arising out of any other business of the company. . . .

Revised Law

Sec. 442.559. INTEREST. Interest does not accrue on a claim after the date of the commencement of a delinquency proceeding. (V.T.I.C. Art. 21.28, Sec. 8(d).)

Source Law

(d) Interest. Interest shall not accrue on any claim subsequent to the date of the commencement of delinquency proceedings.

[Sections 442.560-442.600 reserved for expansion]

SUBCHAPTER M. UNCLAIMED ASSETS

Revised Law

Sec. 442.601. DELIVERY OF UNCLAIMED MONEY TO DEPARTMENT. (a) Except as provided by Subsection (b), any unclaimed dividend on an approved claim, unclaimed returned assessment, or other unclaimed money that is subject to distribution to a claimant, policyholder, or other person and that remains in the possession of the receiver after payment of the final dividend shall be delivered to the department at the time the receivership is closed.

(b) If a final dividend is paid less than 90 days before the date the receivership is closed, the receiver may continue, for a period not to exceed 90 days from the date the receivership is closed, any bank account of the receivership from which any unclaimed dividend might be paid, before the receiver delivers the unclaimed dividend to the department.

(c) The department shall deposit the money in trust in an account to be maintained with the comptroller. (V.T.I.C. Art. 21.28, Sec. 8(g).)

Source Law

(g) Unclaimed Funds. Unclaimed dividends on approved claims, unclaimed returned assessments, and all other unclaimed funds subject to distribution to claimants, policyholders or other persons, remaining in the receiver's hands after payment of the final dividend shall be delivered to the Board at the time the receivership is closed, or in the event a final dividend is paid less than ninety (90) days prior to the closing of the receivership, the receiver may continue the bank account or accounts of such receivership from which such funds might be paid, for a period of time not to exceed ninety (90) days from the date of the closing of said receivership, before the same are so delivered to the Board. Such funds shall be deposited by the Board in trust in a special account to be maintained with the comptroller.

Revisor's Note

Section 8(g), V.T.I.C. Article 21.28, refers to a

"special" account. The revised law omits the designation of the account as being "special" because that designation is unnecessary. The designation of an account as a special account has no legal effect.

Revised Law

Sec. 442.602. RECOVERY OF UNCLAIMED MONEY BY OWNER. (a) On receipt of satisfactory written and verified proof of ownership not later than the second anniversary of the date money is deposited with the comptroller under Section 442.601, the department shall certify that fact to the comptroller.

(b) On certification under Subsection (a), the comptroller shall issue a warrant drawn on the state treasury for the money in favor of each person entitled to the money. (V.T.I.C. Art. 21.28, Sec. 8(h).)

Source Law

(h) Recovery by Owner. On receipt of satisfactory written and verified proof of ownership within two (2) years from the date such funds are so deposited with the comptroller, the Board shall certify such facts to the Comptroller, who shall issue proper warrant therefor in favor of the parties respectively entitled thereto, drawn on the State Treasury.

Revisor's Note

Section 8(h), V.T.I.C. Article 21.28, refers to a "proper" warrant. Throughout this chapter, the revised law omits "proper" in this context as unnecessary because the term does not add to the clear meaning of the law. A document is not a warrant if it is not a proper warrant.

Revised Law

Sec. 442.603. APPLICATION FOR DECLARATION OF ABANDONMENT OF MONEY; NOTICE. (a) After money deposited with the comptroller under Section 442.601 has remained unclaimed for two years, the receiver may initiate an action to declare the money abandoned and that the money is the property of the department by filing in the court of competent jurisdiction in the county in which the

delinquency proceeding is or was pending a notice that the receiver intends to declare the money abandoned and claim the money as the property of the department. The action may be for all or part of the money accumulated in any particular receivership.

(b) The notice must state:

(1) the name of each person entitled to the money;

(2) the person's last known address; and

(3) the nature or source and amount of the money.

(c) On the filing of the notice by the receiver, the court shall set a date for the hearing on the application that is at least 20 days after the date the notice was filed and shall make a notation of the date of the hearing on the notice.

(d) A copy of the notice with the judge's notation of the date of the hearing must be posted on the courthouse door for at least 20 days before the date a hearing is held on the application. At least 10 days before the date set for the hearing, notice of the filing of the application must be published in a newspaper of general circulation in the county in which the application is pending. The notice must be addressed to the owners of unclaimed money in the particular receivership involved in the application and must state generally that a hearing will be held on the specified date to declare the money abandoned and that the money is the property of the department. (V.T.I.C. Art. 21.28, Sec. 8(i) (part).)

Source Law

(i) Declaration of Abandonment. After such funds have remained unclaimed for two (2) years, the Liquidator may initiate action to have them declared to be abandoned, and the property of the State Board of Insurance. Such action shall be commenced by the filing by the Liquidator, in the court of competent jurisdiction in the county in which the delinquency proceeding is, or was pending, of a notice of his intention to declare such funds to be abandoned, and that he is claiming the same as the property of the State Board of Insurance. Such action may be for all or any part of such funds accumulated in any one particular receivership. Such notice shall state the name or names of the person or persons entitled thereto, his or their last known address, and the nature or source and amount of the fund or funds. Upon the filing of such notice by the Liquidator, the court

shall set a date for the hearing of the application, and shall make notation thereon of the date of such hearing, which date shall be at least twenty (20) days subsequent to the date of the filing of said notice. A copy of said notice, with the judge's notation thereon shall be posted on the courthouse door of said court for at least twenty (20) days before a hearing is had thereon. Notice of the filing of the application shall be published at least once, and at least ten (10) days prior to the date set for such hearing, in a newspaper of general circulation in the county where the application is pending. Such notice shall be addressed to the true owners of unclaimed funds in the particular receivership involved in the application and shall state generally that a hearing shall be had on the date specified for the purpose of declaring such funds to be abandoned and the property of the State Board of Insurance. . . .

Revisor's Note

(1) Section 8(i), V.T.I.C. Article 21.28, requires that notice of the filing of an application be published "at least once." The revised law omits the quoted language as unnecessary because a requirement that notice be published necessarily implies that the notice be published at least once.

(2) Section 8(i), V.T.I.C. Article 21.28, refers to the "true" owners of unclaimed money. The revised law omits "true" as unnecessary because the word does not add to the clear meaning of the law. A person who is an owner of unclaimed money is necessarily a "true" owner of the money.

Revised Law

Sec. 442.604. HEARING ON APPLICATION FOR DECLARATION OF ABANDONMENT OF MONEY; JUDGMENT. (a) At a hearing on an application filed under Section 442.603, proof to the satisfaction of the court of the following is prima facie evidence that each person entitled to money deposited with the comptroller under Section 442.601 intends to abandon the money and that the department is the owner of the money:

(1) the money, or a check for the money, was sent by the receiver to the last known address of each person entitled to the money;

(2) the money, or a check for the money, was returned

unclaimed or the check for the money was not cashed;

(3) the money was delivered to the department as required by Section 442.601;

(4) the money has remained unclaimed for two years; and

(5) notice of the filing of the application was published as required by Section 442.603.

(b) On a finding by the court under Subsection (a), the court may render judgment accordingly. On receipt of the judgment, the department shall certify that fact to the comptroller.

(c) On certification under Subsection (b), the comptroller shall issue a warrant for the money in favor of the department. The department shall promptly deposit the money in accordance with Section 442.110, except that the money derived from one insurer is not required to be kept separate from money derived from another insurer. (V.T.I.C. Art. 21.28, Sec. 8(i) (part).)

Source Law

> (i) . . . Upon the hearing on such application of the Liquidator, proof to the satisfaction of the court:
>
> (1) That such funds, or the checks therefor, had previously been sent by the Receiver to the last known address of the person or persons entitled thereto;
>
> (2) That such funds, or the checks therefor, had been returned unclaimed or that the check or checks therefor had not been cashed;
>
> (3) That the funds had been delivered to the Board as required by Subsection (g) above;
>
> (4) That such money remained unclaimed with the Board for two (2) years; and
>
> (5) That notice of the filing of the application has been published as herein provided, shall be prima facie evidence of the intention of the person or persons entitled thereto to abandon the same, and that the Board is the rightful owner thereof. Upon such finding by the court, the court shall be authorized to render judgment accordingly. Upon receipt of such judgment, the Board shall certify such fact to the Comptroller of Public Accounts, who shall issue proper warrant therefor to the State Board of Insurance. The Board shall forthwith deposit such funds in accordance with the provisions of Section 2(h) of this Article, except that such funds derived through any one insurer need not be kept separate from such funds derived through any other insurer.

Revisor's Note

(1) Section 8(i)(5), V.T.I.C. Article 21.28,

refers to the "rightful" owner of unclaimed money. The revised law omits "rightful" as unnecessary because the word does not add to the clear meaning of the law. A person who is an owner of unclaimed money is necessarily a "rightful" owner of the money.

(2) Section 8(i)(5), V.T.I.C. Article 21.28, refers to the "Comptroller of Public Accounts." The revised law substitutes the term "comptroller" because Section 403.001, Government Code, defines "comptroller" in any state statute to mean the comptroller of public accounts.

Revised Law

Sec. 442.605. USE OF CERTAIN UNLIQUIDATED ASSETS; DEPOSIT OF PROCEEDS IN TRUST. (a) Any assets other than cash that remain in the possession of the receiver after payment of the final dividend in a receivership estate may be conveyed, transferred, or assigned to the commissioner to be handled as a trust.

(b) The commissioner may convey, transfer, and assign any assets, including causes of action, judgments, and claims, and settle or release causes of action, judgments, claims, and liens on terms and for amounts the commissioner considers to be in the best interest of the trust, regardless of whether the assets have previously or may subsequently come into the commissioner's possession.

(c) From proceeds derived from any assets described by Subsection (b), the commissioner or the special deputy receiver shall defray the costs incident to the sale, settlement, release, or other transaction by which the proceeds are obtained and deliver the remainder to the department. The department shall deposit the money in trust in an account to be maintained with the comptroller and to be handled, disposed of, and used as provided by Sections 442.606 and 442.607. (V.T.I.C. Art. 21.28, Sec. 8A (part).)

Source Law

Sec. 8A. Any and all assets other than cash

remaining in the receiver's hands after payment of the final dividend may be conveyed, transferred or assigned to the commissioner to be handled as a trust. The commissioner shall have authority to convey, transfer, and assign any assets, including causes of action, judgments, and claims, and to settle or release causes of action, judgments, claims, and liens on such terms and for such amounts as he deems for the best interest of such trust, whether such assets have heretofore or may hereafter come into his hands. From proceeds derived from any such assets the commissioner or the special deputy receiver shall defray the costs incident to the sale, settlement, release or other transaction whereby such proceeds are obtained, and deliver the remainder to the Board to be deposited by it in trust in a special account to be maintained with the comptroller to be handled, disposed of and used as follows:

. . .

Revisor's Note

Section 8A, V.T.I.C. Article 21.28, refers to a "special" account. The revised law omits the designation of the account as being "special" for the reason stated in the revisor's note to Section 442.601.

Revised Law

Sec. 442.606. APPLICATION FOR DECLARATION OF ABANDONMENT OF PROCEEDS IN TRUST; NOTICE AND HEARING. (a) On application by the commissioner and after notice and hearing, a court of competent jurisdiction of Travis County may make an order directing disposition of money deposited in a trust account under Section 442.605(c).

(b) The notice must be addressed to all persons having an interest, as claimants or otherwise, in the assets of the particular receivership involved in the application and must state:

(1) the amount of the money and the receivership from which the money was derived; and

(2) generally that a hearing will be held on the specified date to determine the disposition of the money, including a declaration that the money is abandoned and is the property of the department.

(c) The notice required by Subsection (a) must be:

(1) posted on the courthouse door for at least 20 days before the date the hearing is held; and

(2) published at least 10 days before the date set for the hearing in a newspaper of general circulation in Travis County.

(d) If the court finds that money derived from a receivership is sufficient to justify the reopening of the receivership and the payment of a dividend, the court may enter an order to that effect. If the money is insufficient for that purpose, the court may declare the money abandoned.

(e) A certified copy of a judgment declaring the money abandoned is sufficient authority for the comptroller to issue a warrant for the money in favor of the department. On issuance of the warrant, the department shall promptly deposit the money in accordance with Section 442.110, except that money derived from one insurer is not required to be kept separate from money derived from another insurer. (V.T.I.C. Art. 21.28, Sec. 8A (part).)

Source Law

> Sec. 8A. . . . An order directing disposition of such funds may be made by a court of competent jurisdiction of Travis County, Texas, upon application of the commissioner, after notice and hearing. Notice shall be posted on the courthouse door of said court for at least twenty (20) days before a hearing is had on the commissioner's application, and notice shall be published at least once, and at least ten (10) days prior to the date set for such hearing, in a newspaper of general circulation in Travis County. Such notice shall state the amount of the funds and the receivership from which they were derived. It shall be addressed to all persons having an interest, as claimant or otherwise, in the assets of the particular receivership involved in the application, and shall state generally that a hearing shall be had on the date specified for the purpose of determining the disposition to be made of such funds, including a declaration that such funds are abandoned and the property of the State Board of Insurance.
>
> If the court finds that funds derived from any receivership are sufficient to justify re-opening of the receivership and payment of a dividend, then such may be ordered, but otherwise, if such funds are insufficient for that purpose, the court may declare such funds abandoned and a certified copy of such judgment will be authority for the comptroller to issue a Warrant therefor to the State Board of Insurance. The Board shall forthwith deposit such funds in accordance with the provisions of Section 2(h) of this Article, except that funds derived from one insurer need not be kept separate from funds derived through any other insurer.
>
> . . .

Revisor's Note

Section 8A, V.T.I.C. Article 21.28, requires that notice of an application be published "at least once." The revised law omits the quoted language for the reason stated in Revisor's Note (1) to Section 442.603.

Revised Law

Sec. 442.607. USE OF ABANDONED MONEY. (a) The receiver, with the consent of the department, may spend money deposited by the department under Sections 442.604 and 442.606 to:

(1) pay expenses of the office of the receiver that are not properly chargeable to any one receivership or conservatorship estate; and

(2) continue the administration of a receivership or conservatorship by the receiver as receiver or conservator, if the department considers the continuation to be in the best interest of the receivership or conservatorship estate.

(b) Any money applied under Subsection (a)(2) to a receivership estate must be repaid from the assets of that estate before the payment of any additional dividends in that receivership, including policyholder claims and other claims.

(c) Any money applied under Subsection (a)(2) to a conservatorship estate must be repaid from the assets of that estate before the release of that conservatorship for continued operation. (V.T.I.C. Art. 21.28, Secs. 8(j), 8A (part).)

Source Law

[Sec. 8]

(j) Use of Abandoned Funds. Such funds so deposited by the Board in accordance with Subsection (i) above may be expended by the Liquidator, with the consent of the Board, for the purpose of paying expenses of the office of the Liquidator and/or Receiver that are not properly chargeable to any one receivership or conservatorship estate, and for the purpose of financing continued operation of any receivership or conservatorship then being administered by the Liquidator as Receiver or Conservator, when in the discretion of the Board it appears to be in the best interest of such receivership or conservatorship estate that it not be closed, and that additional administration be had thereon. Any funds so applied from this source to another receivership or conservatorship estate are to be

repaid from the assets of the receivership or conservatorship estate to which they were applied before additional dividends, including policyholder and other claims, are paid in any such receivership, or before the conservatorship is released for continued operation.

Sec. 8A. . . . [funds derived from any receivership] . . . .

Such funds may be used as provided in Section 8(j) of this Article.

[Sections 442.608-442.650 reserved for expansion]

SUBCHAPTER N. TRANSFER OR DISPOSAL OF EXCESS ASSETS

Revised Law

Sec. 442.651. TRANSFER OF REMAINING ASSETS OF STOCK INSURANCE COMPANY TO AGENT. (a) After the receiver has provided for unclaimed dividends and all of the liabilities of a stock insurance company, the receiver shall call a meeting of the shareholders of the insurer by:

(1) publishing notice of the meeting in one or more newspapers in the county in which the principal office of the insurer was located; and

(2) giving written notice of the meeting to each shareholder of record at the shareholder's last known address.

(b) At the meeting, the shareholders shall appoint one or more agents to take over the liquidation of the insurer for the benefit of the shareholders. Voting privileges are governed by the insurer's bylaws. A majority of the shares must be represented at the agent's appointment. The agent or agents shall execute and file with the court one or more bonds as approved by the court, conditioned on the faithful performance of all the duties of the trust.

(c) Under order of the court, the receiver shall transfer and deliver to the agent or agents for continued liquidation under the court's supervision all assets of the insurer remaining in the possession of the receiver. After the transfer and delivery, the receiver and the department, and each employee of the receiver or the department, are discharged from any further liability to the insurer and the creditors and shareholders of the insurer.

(d) This section does not permit the insurer to continue engaging in the business of insurance. The charter of the insurer and each certificate of authority or other permit issued under or in connection with the charter are ipso facto revoked by the order of the court directing the receiver to transfer and deliver the remaining assets of the insurer to the agent or agents. (V.T.I.C. Art. 21.28, Sec. 9(a).)

Source Law

> Sec. 9. (a) Excess Assets--Stock Companies. When the receiver shall have made provision for unclaimed dividends and all of the liabilities of a stock insurance company, he shall call a meeting of the stockholders of the insurer by giving notice thereof in one (1) or more newspapers in the county where the principal office of the insurer was located, and by written notice to the stockholders of record at their last known address. At such meeting, the stockholders shall appoint an agent or agents to take over the affairs to continue the liquidation for benefit of the stockholders. Voting privileges shall be governed by the insurer's bylaws. A majority of the stock shall be represented at the agent's appointment. Such agent or agents shall execute and file with the court such bond or bonds as shall be approved by it, conditioned on the faithful performance of all the duties of the trust. Under order of the court the receiver shall then transfer and deliver to such agent or agents for continued liquidation under the court's supervision all assets of insurer remaining in his hands, whereupon the receiver and the Board, and each member and employee thereof, shall be discharged from any further liability to such insurer and its creditors and stockholders; provided, however, that nothing herein contained shall be so construed as to permit the insurer to continue in business as such, but the charter of such insurer and all permits and licenses issued thereunder or in connection therewith shall be ipso facto revoked and annulled by such order of the court directing the receiver to transfer and deliver the remaining assets of such insurer to such agent or agents.

Revisor's Note

(1) Section 9(a), V.T.I.C. Article 21.28, refers to the "Board," meaning the State Board of Insurance, and each "member and employee" of the board. The revised law substitutes "department" for "Board" for the reason stated in Revisor's Note (5) to Section 442.001. Because the State Board of Insurance has been abolished as explained in that revisor's note, the revised law omits the reference to each "member" of

the board.

(2) Section 9(a), V.T.I.C. Article 21.28, provides that under certain circumstances the charter of an insurer and the permits and "licenses" issued to the insurer are "revoked and annulled." The revised law substitutes "certificate of authority" for "licenses" for the reason stated in Revisor's Note (3) to Section 442.108. Also, the revised law omits "annulled" as unnecessary because, in context, "annulled" is included within the meaning of "revoked."

Revised Law

Sec. 442.652. DISPOSAL OF REMAINING ASSETS OF INSURER OTHER THAN STOCK INSURANCE COMPANY. After the receiver has provided for unclaimed dividends and all of the liabilities of an insurer other than a stock insurance company, the receiver shall dispose of any remaining assets as directed by the receivership court. (V.T.I.C. Art. 21.28, Sec. 9(b).)

Source Law

(b) Excess Assets--Other Companies. After the receiver shall have made provision for unclaimed dividends and all of the liabilities of any insurer other than a stock insurance company, he shall dispose of any remaining assets as directed by the receivership court.

Revised Law

Sec. 442.653. TRANSFER OF REMAINING ASSETS OF INSURER TO GUARANTY ASSOCIATION. (a) Notwithstanding any other provision of this chapter, in closing a receivership estate, a special deputy receiver, on approval of the court, may transfer any remaining asset, cause of action asserted on behalf of the impaired insurer, judgment, claim, or lien to the appropriate guaranty association.

(b) A transfer under Subsection (a):

(1) is not a preference or voidable transfer; and

(2) is considered a distribution under Sections 442.551(a)-(d).

(c) If the amount realized by the guaranty association is materially greater than the amount loaned by the guaranty association to the receivership estate, the court may order the reopening of the receivership to distribute the excess money.

(d) This subchapter does not transfer any liability of an impaired insurer to the guaranty association that would not constitute a claim payable under Chapter 462, 463, or 2602. (V.T.I.C. Art. 21.28, Sec. 9(c).)

Source Law

> (c) Excess Assets--Guaranty Associations. Notwithstanding any other provisions of this article in closing an estate, a special deputy receiver, on approval of the court, may transfer any remaining assets, causes of action asserted on behalf of the impaired insurer, judgment, claims, or liens to the appropriate guaranty association and this transfer shall not be a preference or voidable transfer but shall be considered a distribution under Section 8(a)(1) of this article. In the event the sum realized by the guaranty association is materially larger than the amount loaned to the estate by the guaranty association, the court may order reopening of the estate to disburse the excess funds. Nothing in this section shall be construed as a transfer of any liability of an impaired insurer to the guaranty association that would not constitute a claim payable under Articles 9.48, 21.28-C, or 21.28-D of this code.

[Sections 442.654-442.700 reserved for expansion]

SUBCHAPTER O. DURATION AND REOPENING OF RECEIVERSHIP

Revised Law

Sec. 442.701. LIMITATION ON DURATION OF RECEIVERSHIP. (a) Except as otherwise provided by this section, each receivership or other delinquency proceeding prescribed by this chapter shall be administered in accordance with Section 64.072, Civil Practice and Remedies Code.

(b) To the extent the proceeding applies to claims against a workers' compensation insurance policy or a title insurance policy, a receivership or other delinquency proceeding shall be administered continuously for any period necessary to effect the receivership's or proceeding's purposes, and any arbitrary limitation on that period provided by another law of this state with regard to the administration of receiverships or of corporate

affairs generally does not apply to the proceeding.

(c) Instead of the winding up and distribution of a receivership estate of an insurer without capital stock, the court shall order revival and reinstatement of the charter, certificates of authority or other permits, franchises, and management contracts or other control instruments of the insurer if the insurer's remaining cash on hand and on deposit, less any outstanding enforceable liabilities, exceeds the minimum amount of capital and surplus prescribed for that insurer under Section 822.054, 822.202, 822.210, or 841.054. (V.T.I.C. Art. 21.28, Sec. 9(d).)

Source Law

(d) Limitation. Except as otherwise provided by this subsection, each receivership or other delinquency proceeding prescribed by this Article shall be administered in accordance with Section 64.072, Civil Practice and Remedies Code. To the extent a receivership or delinquency proceeding initiated against an insurer applies to claims against a workers' compensation insurance policy or a title insurance policy, the receivership or delinquency proceeding shall be administered continuously for whatever length of time is necessary to effectuate its purposes, and no arbitrary period prescribed elsewhere by the laws of Texas limiting the time for the administration of receiverships or of corporate affairs generally shall be applicable thereto. Instead of the winding up and distribution of a receivership estate of an insurer without capital stock, the court shall order revival and reinstatement of the charter, permits, licenses, franchises, and management contracts or other control instruments of the insurer if the insurer's remaining cash on hand and on deposit, less any outstanding valid and enforceable liabilities, exceeds the minimum amount of capital and surplus prescribed for that insurer under Article 2.02 or Section 1 of Article 3.02 of this code.

Revisor's Note

(1) Section 9(d), V.T.I.C. Article 21.28, refers to a receivership or delinquency proceeding "initiated against an insurer." The revised law omits the quoted language as unnecessary because a receivership is a form of delinquency proceeding and under Section 1(b), V.T.I.C. Article 21.28, revised in this chapter as Section 442.001(a)(2), a delinquency proceeding is defined as a proceeding "commenced . . . against an insurer" for certain purposes.

(2) Section 9(d), V.T.I.C. Article 21.28, refers to the "licenses" of an insurer. The revised law substitutes "certificates of authority" for "licenses" for the reason stated in Revisor's Note (3) to Section 442.108.

(3) Section 9(d), V.T.I.C. Article 21.28, refers to "valid and enforceable" liabilities. The revised law omits the reference to "valid" because the term is included within the meaning of "enforceable."

(4) Section 9(d), V.T.I.C. Article 21.28, refers to V.T.I.C. Article 2.02 and Section 1, V.T.I.C. Article 3.02. Those provisions are revised in various places in this code, but the pertinent provisions are revised as Sections 822.054, 822.202, 822.210, and 841.054 of this code. The revised law is drafted accordingly.

Revised Law

Sec. 442.702. REOPENING OF RECEIVERSHIP. (a) If after the receivership has been closed by final order of the court the receiver discovers assets not known to the receiver during the receivership, the receiver shall report the receiver's findings to the court.

(b) The court may reopen the receivership for continued liquidation if the court finds that the value of the discovered assets justifies the reopening. (V.T.I.C. Art. 21.28, Sec. 9(e).)

Source Law

(e) Reopening. If after the receivership shall have been closed by final order of the court, the liquidator shall discover assets not known to him during receivership, he shall report his findings to the court. It shall be within the discretion of the court as to whether the value of the after-discovered assets shall justify the reopening of the receivership for continued liquidation.

[Sections 442.703-442.750 reserved for expansion]

SUBCHAPTER P. ANCILLARY DELINQUENCY PROCEEDINGS

Revised Law

Sec. 442.751. APPOINTMENT OF ANCILLARY RECEIVER. (a) On the petition of the department, a court of competent jurisdiction in this state shall appoint the commissioner as ancillary receiver in this state for an insurer domiciled in another jurisdiction if a receiver should be appointed for that insurer under the laws of this state.

(b) The department:

(1) may file the petition on the department's own initiative; and

(2) shall file the petition if at least 10 residents of this state who have claims against the insurer file one or more petitions in writing with the department requesting the appointment of an ancillary receiver. (V.T.I.C. Art. 21.28, Sec. 13 (part).)

Source Law

> Sec. 13. A court of competent jurisdiction in this State shall, on the petition of the State Board of Insurance, appoint the liquidator herein provided as ancillary receiver in this State of an insurer domiciliary in another state or jurisdiction when under the laws of this State a receiver should be appointed. The Board shall file such petition on its own initiative or if ten (10) or more persons resident in this State, having claims against such insurer, file a petition or petitions in writing with the Board, requesting the appointment of such ancillary receiver. . . .

Revisor's Note

(1) Section 13, V.T.I.C. Article 21.28, requires a court to appoint the "liquidator" as ancillary receiver of an insurer in certain situations. As stated in Revisor's Note (4) to Section 442.001, the position of liquidator has been eliminated and the term "liquidator" in the source law is defined to mean "receiver" and to include the commissioner of insurance or a person designated by the commissioner to serve as special deputy receiver. While the revised law generally substitutes "receiver"

for "liquidator," in the context of Section 13, it is clear that the commissioner must initially be appointed as ancillary receiver. The revised law is drafted accordingly.

(2) Section 13, V.T.I.C. Article 21.28, refers to "another state or jurisdiction." The revised law omits the reference to "state" because "state" is included within the meaning of "another . . . jurisdiction."

(3) Section 13, V.T.I.C. Article 21.28, provides that the Texas Department of Insurance "shall" file a petition with a court requesting the appointment of an ancillary receiver "on its own initiative" or if at least 10 resident claimants file a similar petition with the department. The revised law provides that the department "may" file a petition with the court "on the department's own initiative" and "shall" file a petition if at least 10 resident claimants file a petition with the department because the reference to the department's initiative implies that the department has discretion whether to file a petition with a court unless at least 10 resident claimants file a petition with the department.

Revised Law

Sec. 442.752. POWERS AND DUTIES OF ANCILLARY RECEIVER. (a) The ancillary receiver is entitled to sue for and possess the assets of the insurer in this state and has the same powers and duties with regard to those assets as a receiver of an insurer domiciled in this state.

(b) On commencement of the delinquency proceeding in this state, the ancillary receiver is immediately entitled to possession and control of any special or statutory deposits of the insurer that are located in this state. The ancillary receiver may use those deposits:

(1) to pay expenses of the administration of the receivership proceeding; and

(2) after paying the expenses under Subdivision (1), to pay approved claims against the deposits. (V.T.I.C. Art. 21.28, Sec. 13 (part).)

Source Law

> Sec. 13. . . . Such ancillary receiver shall have the right to sue for and reduce to possession the assets of such insurer in this State, and shall have the same powers and be subject to the same duties with respect to such assets, as are possessed by a receiver of a domiciliary insurer under the laws of this State. On commencement of the delinquency proceedings in this State, the ancillary receiver in this State immediately is entitled to possession and control of any special or statutory deposits of the delinquent insurer located within this State. The ancillary receiver may use those special or statutory deposits first towards the payment of expenses of the administration of the receivership proceedings then towards the payment of approved claims against the deposits. . . .

Revised Law

Sec. 442.753. COORDINATION WITH RECEIVER IN OTHER STATE. If a receiver of a delinquent insurer has been appointed both in this state and in another state, the receiver in this state may, under supervision of the receivership court in this state and regardless of whether the receiver in this state is an ancillary receiver, contract with the receiver in the other state to coordinate the administration of the receiverships in the interest of efficiency and economy in any manner consistent with this chapter. (V.T.I.C. Art. 21.28, Sec. 14.)

Source Law

> Sec. 14. In cases where a receiver of any delinquent insurer has been appointed both in Texas and in some other state, the Texas receiver, either domiciliary or ancillary, may, under supervision of the Texas receivership court, contract with the receiver in such other state for the administration of the affairs of their respective receiverships in any manner consistent with this Article which will enable the respective receivers to coordinate their activities in the interest of efficiency and economy.

Revised Law

Sec. 442.754. APPLICABILITY OF CHAPTER TO ANCILLARY DELINQUENCY PROCEEDINGS. The conduct of ancillary delinquency

proceedings under this subchapter is subject to the other provisions of this chapter. (V.T.I.C. Art. 21.28, Sec. 13 (part).)

Source Law

> Sec. 13. . . . The remaining provisions of this Article shall be applicable to the conduct of such ancillary proceedings.

[Sections 442.755-442.800 reserved for expansion]

SUBCHAPTER Q. AGENCY CONTRACTS WITH CERTAIN INSURERS

Revised Law

Sec. 442.801. REQUIRED CONTRACT PROVISION. An agency contract entered into on or after August 27, 1973, by an insurer writing fire and casualty insurance in this state must contain, or shall be construed to contain, the following provision:

> Notwithstanding any other provision of this contract, the obligation of the agent to remit written premiums to the insurer shall be changed on the commencement of a delinquency proceeding as defined by Chapter 442, Insurance Code, as amended. After the commencement of the delinquency proceeding, the obligation of the agent to remit premiums is limited to premiums earned before the cancellation date of insurance policies stated in the order of a court of competent jurisdiction under Chapter 442, Insurance Code, canceling the policies. The agent does not owe and may not be required to remit to the insurer or to the receiver any premiums that are unearned as of the cancellation date stated in the order.

(V.T.I.C. Art. 21.11-2, Sec. 1.)

Source Law

> Art. 21.11-2
> Sec. 1. Every agency contract entered into on and after the effective date of this Act by an insurance company writing fire and casualty insurance in Texas shall contain, or shall be construed to contain, the following provision:
> Notwithstanding any other provision of this contract, the obligation of the agent to remit written premiums to the company shall be changed upon the commencement of delinquency proceedings as defined in Article 21.28, Insurance Code of Texas of 1951, as

amended. Subsequent to the commencement of delinquency proceedings, the obligation of the agent to remit premiums shall be confined to premiums earned prior to the date of cancellation of policies stated in the order of a court of competent jurisdiction under Article 21.28 of this code canceling the policies. The agent shall not owe or remit to the company or to the Liquidator-Receiver any premiums that are unearned as of the date of the cancellation stated in the order canceling the policies.

Revisor's Note

Section 1, V.T.I.C. Article 21.11-2, refers to "the effective date of this Act," meaning the effective date of V.T.I.C. Article 21.11-2. That article took effect August 27, 1973. The revised law is drafted accordingly.

Revised Law

Sec. 442.802. DISPOSITION OF PREMIUMS. (a) On or after the cancellation date of insurance policies as stated in the court's order canceling the policies, the agent shall promptly account to the receiver for:

(1) all unearned premiums to be returned to the insured or the replacement coverage to be obtained for the insured; and

(2) the earned premiums to be paid to the receiver.

(b) The agent shall:

(1) promptly return to an insured who paid the premiums any unearned premiums in the possession of the agent on the cancellation date of the policy; or

(2) with the approval of the insured, use the unearned premiums to purchase new coverage for the insured with a different insurer.

(c) The agent shall promptly remit to the receiver any earned premiums in the possession of the agent. (V.T.I.C. Art. 21.11-2, Sec. 2.)

Source Law

Sec. 2. On or after the effective date of the cancellation of policies stated in the court's order canceling policies, the agent shall promptly account to the receiver for all premiums to be returned to the insured or the replacement coverage to be obtained and

the earned premiums to be paid to the receiver. Any of those unearned premiums in the hands of the agent on the effective date of the policy cancellations shall be returned promptly by the agent to the insured who paid them or, with the approval of the insured, shall be used to purchase new coverage for the insured with a different insurer. Any of the earned premiums in the hands of the agent shall be remitted promptly to the receiver.

Revised Law

Sec. 442.803. EFFECT OF SUBCHAPTER ON ACTION BY RECEIVER AGAINST AGENT. This subchapter does not prejudice a cause of action by the receiver against an agent to recover:

(1) unearned premiums that were not returned to policyholders; or

(2) earned premiums that were not promptly remitted to the receiver. (V.T.I.C. Art. 21.11-2, Sec. 3.)

Source Law

Sec. 3. This article does not prejudice any cause of action by the receiver against any agent for the recovery of unearned premiums that were not returned to policyholders and earned premiums that were not promptly remitted to the receiver.

Revised Law

Sec. 442.804. AGENT NOT RECEIVER'S AGENT. This subchapter does not render the agent an agent of the receiver for earned or unearned premiums. (V.T.I.C. Art. 21.11-2, Sec. 4.)

Source Law

Sec. 4. This article may not be construed to render the agent an agent of the receiver for earned or unearned premiums.

[Chapters 443-460 reserved for expansion]

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CHAPTER 461. GENERAL PROVISIONS

Revised Law

Sec. 461.001. APPLICABILITY OF CHAPTER. (a) Except as

provided by Subsection (b), this chapter applies to an insurance policy, contract, certificate, evidence of coverage, or application delivered or issued for delivery in this state that is not covered by an insurance guaranty fund or other solvency protection arrangement authorized by this code.

(b) This chapter does not apply to:

(1) a fidelity, surety, or guaranty bond; or

(2) marine insurance as defined by Section 1807.001. (V.T.I.C. Art. 21.28-E, Secs. (a) (part), (c).)

Source Law

> Art. 21.28-E. (a) Each insurance policy or contract or application or certificate or evidence of coverage, other than a fidelity, surety, or guaranty bond, delivered or issued for delivery in this state that is not covered by an insurance guaranty fund or other solvency protection arrangement authorized by this code . . . .
>
> (c) The provisions of this article shall not apply to marine insurance as defined by Article 5.53.

Revised Law

Sec. 461.002. DISCLOSURE OF GUARANTY FUND NONPARTICIPATION. (a) Each insurance policy, contract, certificate, evidence of coverage, or application subject to this chapter must include a statement that, if the insurer is unable to fulfill the insurer's contractual obligation under the policy, contract, certificate, or evidence of coverage, the insurer is not covered by an insurance guaranty fund or other solvency protection arrangement.

(b) The statement must be in 10-point type and affixed to the first page of the insurance policy, contract, certificate, evidence of coverage, or application. (V.T.I.C. Art. 21.28-E, Sec. (a) (part).)

Source Law

> Art. 21.28-E. (a) [Each insurance policy or contract or application or certificate or evidence of coverage . . . delivered or issued for delivery in this state that is not covered by an insurance guaranty fund or other solvency protection arrangement authorized by this code] must have affixed to the first page in 10-point type a statement to the effect that, in the event the insurer is unable to fulfill its

contractual obligation under this policy or contract or the certificate or evidence of coverage, the insurer is not covered by an insurance guaranty fund or other solvency protection arrangement.

Revised Law

Sec. 461.003. FORM OF STATEMENT; PROHIBITION. (a) The commissioner by rule shall promulgate the statement that an insurer must use to comply with this chapter.

(b) An insurer may not include in an insurance policy, contract, certificate, evidence of coverage, or application a statement that does not conform to the appropriate statement prescribed by the commissioner. (V.T.I.C. Art. 21.28-E, Sec. (b).)

Source Law

(b) The State Board of Insurance by rule shall promulgate the statements that must be used by insurers to comply with this article, and an insurer may not include in an insurance policy, contract, or application or a certificate or evidence of coverage a statement that does not conform to the appropriate statement promulgated by the board.

Revisor's Note

Section (b), V.T.I.C. Article 21.28-E, refers to the "State Board of Insurance" and the "board." 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. Accordingly, the revised law substitutes a reference to the commissioner for references to the State Board of Insurance.

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CHAPTER 462. TEXAS PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 462.001. SHORT TITLE. This chapter may be cited as the Texas Property and Casualty Insurance Guaranty Act. (V.T.I.C. Art. 21.28-C, Sec. 1.)

Source Law

Art. 21.28-C

Sec. 1. This article shall be known as the Texas Property and Casualty Insurance Guaranty Act.

Revised Law

Sec. 462.002. PURPOSES. The purposes of this chapter are to:

(1) provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment;

(2) avoid financial loss to claimants or policyholders because of an insurer's impairment;

(3) assist in the detection and prevention of insurer insolvencies; and

(4) provide an association to assess the cost of that protection among insurers. (V.T.I.C. Art. 21.28-C, Sec. 2.)

Source Law

Sec. 2. The purpose of this Act is to:

(1) provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment;

(2) avoid financial loss to claimants or policyholders because of the impairment of an insurer;

(3) assist in the detection and prevention of insurer insolvencies; and

(4) provide an association to assess the cost of that protection among insurers.

Revised Law

Sec. 462.003. CONSTRUCTION. This chapter shall be liberally construed to implement the purposes of this chapter described by Section 462.002, which shall be used to aid and guide interpretation of this chapter. (V.T.I.C. Art. 21.28-C, Sec. 4.)

Source Law

Sec. 4. This Act shall be liberally construed to effect the purposes under Section 2 of this Act, which will constitute an aid and guide to interpretation.

Revised Law

Sec. 462.004. GENERAL 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 insurer on December 31 of the year preceding the date the insurer becomes an impaired insurer.

(2) "Association" means the Texas Property and Casualty Insurance Guaranty Association.

(3) "Board" means the board of directors of the association.

(4) "Claimant" means an insured making a first-party claim or a person instituting a liability claim.

(5) "Impaired insurer" means a member insurer that is:

(A) placed in:

(i) temporary or permanent receivership or liquidation under a court order, including a court order of another state, based on a finding of insolvency; or

(ii) conservatorship after the commissioner determines that the insurer is insolvent; and

(B) designated by the commissioner as an impaired insurer.

(6) "Member insurer" means an insurer, including a stock insurance company, a mutual insurance company, a Lloyd's plan, a reciprocal or interinsurance exchange, and a county mutual insurance company, that:

(A) writes any kind of insurance to which this chapter applies under Sections 462.007 and 462.008, including reciprocal or interinsurance exchange contracts; and

(B) holds a certificate of authority to engage in the business of insurance in this state.

(7) "Person" means an individual, corporation, partnership, association, or voluntary organization. (V.T.I.C. Art. 21.28-C, Secs. 5(2), (3), (4), (5) (part), (9), (10), (12).)

Source Law

(2) "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 preceding the date the insurer becomes an impaired insurer.

(3) "Association" means the Texas Property and Casualty Insurance Guaranty Association.

(4) "Board" means the board of directors of the association.

(5) "Claimant" means any insured making a first-party claim or any person instituting a liability claim. . . .

(9) "Impaired insurer" means:

(A) a member insurer that is placed in temporary or permanent receivership or liquidation under an order of a court of competent jurisdiction, including the courts of any other state, based on a finding of insolvency and that has been designated an impaired insurer by the commissioner; or

(B) a member insurer placed in conservatorship after it has been determined by the commissioner to be insolvent and that has been designated an impaired insurer by the commissioner.

(10) "Member insurer" means any insurer who:

(A) writes any kind of insurance to which this Act applies under Section 3 of this Act, including the exchange of reciprocal or inter-insurance contracts; and

(B) is licensed to transact insurance in this state, including any stock, mutual, Lloyds insurer, reciprocal or inter-insurance exchange, or county mutual insurance company.

(12) "Person" means any individual, corporation, partnership, association, or voluntary organization.

Revisor's Note

(1) Section 5(1), V.T.I.C. Article 21.28-C, defines "account" to mean certain specific accounts created under this chapter. The revised law omits the definition as unnecessary because the revised law, when referring to one of the specific accounts included in the definition, incorporates references to indicate to which account the revised law refers. The omitted law reads:

Sec. 5. In this Act:

(1) "Account" means any one of the three accounts created under Section 6 of this Act.

(2) Section 5(2), V.T.I.C. Article 21.28-C, refers to December 31 of "the year next preceding." The revised law omits "next" as unnecessary. "The year preceding" means "the year next preceding."

(3) Section 5(6), V.T.I.C. Article 21.28-C, defines "commissioner." The revised law omits the definition as unnecessary because Section 31.001 of this code defines "commissioner" to mean the "commissioner of insurance" for purposes of this code. The omitted law reads:

(6) "Commissioner" means the commissioner of insurance.

(4) Section 5(9), V.T.I.C. Article 21.28-C, 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 the matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts in this state.

(5) Section 5(10), V.T.I.C. Article 21.28-C, refers to a "Lloyds insurer" and a "reciprocal or inter-insurance exchange." For consistency of terminology within this code, the revised law substitutes a reference to a "Lloyd's plan" for the reference to "Lloyds insurer," and substitutes a reference to "interinsurance" for the reference to "inter-insurance."

(6) Section 5(10), V.T.I.C. Article 21.28-C, refers to an insurer "licensed" to engage in business in this state. Throughout this chapter, the revised law substitutes "that holds a certificate of authority" or "authorized" for "licensed" because

"certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 462.005. 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 the person or a 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. 21.28-C, Sec. 5(7).)

Source Law

(7) "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. 462.006. NET DIRECT WRITTEN PREMIUMS. (a) Except as provided by Subsection (b) and subject to Subsection (c), in this chapter, "net direct written premiums" means direct premiums written in this state on insurance policies to which this chapter applies, less return premiums on those policies and dividends paid or credited to policyholders on that direct business.

(b) Subject to Subsection (c), for assessing the workers' compensation line of business, the term "net direct written premiums" includes the modified annual premium before the application of a deductible premium credit, less return premiums on those policies and dividends paid or credited to policyholders on that direct business.

(c) The term "net direct written premiums" does not include premiums on contracts between insurers or reinsurers. (V.T.I.C. Art. 21.28-C, Sec. 5(11).)

Source Law

> (11) "Net direct written premiums", when assessing other than the workers' compensation line of business, means direct premiums written in this state on insurance policies to which this Act applies, less return premiums on those policies and dividends paid or credited to policyholders on that direct business. The term does not include premiums on contracts between insurers or reinsurers. When assessing the workers' compensation line of business, the term "net direct written premiums" includes the modified annual premium prior to the application of any deductible premium credit, less return premiums on those policies and dividends paid or credited to policyholders on that direct business. The term does not include premiums on contracts between insurers or reinsurers.

Revised Law

Sec. 462.007. APPLICABILITY IN GENERAL; EXCEPTIONS. (a) Except as provided by Subsection (b), this chapter applies to each kind of direct insurance.

(b) Except as provided by Subchapter F, this chapter does not apply to:

(1) life, annuity, health, or disability insurance;

(2) mortgage guaranty, financial guaranty, or other kinds of insurance offering protection against investment risks;

(3) a fidelity or surety bond, or any other bonding obligation;

(4) credit insurance, vendors' single-interest insurance, collateral protection insurance, or similar insurance protecting a creditor's interest arising out of a creditor-debtor transaction;

(5) insurance of warranties or service contracts;

(6) title insurance;

(7) ocean marine insurance;

(8) a transaction or combination of transactions between a person, including an affiliate of the person, and an insurer, including an affiliate of the insurer, that involves the transfer of investment or credit risk unaccompanied by the transfer of insurance risk; or

(9) insurance provided by or guaranteed by government. (V.T.I.C. Art. 21.28-C, Sec. 3(a).)

Source Law

Sec. 3. (a) This Act applies to all kinds of direct insurance, and except as provided in Section 12 of this Act, is not applicable to the following:

(1) life, annuity, health, or disability insurance;

(2) mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks;

(3) fidelity or surety bonds, or any other bonding obligations;

(4) credit insurance, vendors' single-interest insurance, collateral protection insurance, or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

(5) insurance of warranties or service contracts;

(6) title insurance;

(7) ocean marine insurance;

(8) any transaction or combination of transactions between a person, including an affiliate of such a person, and an insurer, including an affiliate of such an insurer, that involves the transfer of investment or credit risk unaccompanied by the transfer of insurance risk; or

(9) any insurance provided by or guaranteed by government.

Revised Law

Sec. 462.008. APPLICABILITY TO TEXAS MUTUAL INSURANCE COMPANY. (a) This chapter applies to insurance written through the Texas Mutual Insurance Company only as provided by this section.

(b) This chapter applies to the Texas Mutual Insurance Company on a prospective basis on and after January 1, 2000. The Texas Mutual Insurance Company is only liable for assessments for a claim with a date of injury that occurs on or after January 1, 2000. The association, with respect to an insolvency of the Texas Mutual Insurance Company, is only liable for a claim with a date of injury

that occurs on or after January 1, 2000. (V.T.I.C. Art. 21.28-C, Sec. 3(b).)

Source Law

> (b) This Act applies to insurance written through the Texas Mutual Insurance Company only as provided by this subsection. The application of this article to the Texas Mutual Insurance Company is on a prospective basis on and after January 1, 2000. That company is only liable for assessments for a claim with a date of injury that occurs on or after January 1, 2000. The association, with respect to an insolvency of the company, is only liable for a claim with a date of injury that occurs on or after January 1, 2000.

Revised Law

Sec. 462.009. APPLICABILITY TO FORMER TEXAS WORKERS' COMPENSATION INSURANCE FACILITY AND SUCCESSOR. (a) Notwithstanding any other provision of this chapter, this chapter applies to each insurance policy issued under Article 5.76 or 5.76-2, as those articles existed before their repeal.

(b) Notwithstanding any other provision of this chapter, the stock insurance company that resulted from the transfer of the former Texas workers' compensation insurance facility is considered an impaired insurer for purposes of this chapter if any action described by Section 462.004(5) is taken with respect to the company.

(c) A claim under an insurance policy described by Subsection (a) is a covered claim for purposes of this chapter if the claim is a covered claim for purposes of Sections 462.201-462.203, 462.205-462.210, 462.213, 462.214, and 462.305 without regard to whether the stock insurance company described by Subsection (b):

(1) issued or assumed the policy; or

(2) was authorized to engage in business in this state at the time:

(A) the policy was written; or

(B) the company became an impaired insurer.

(d) If a conflict exists between this section and any other statute relating to the former Texas workers' compensation

insurance facility or the association, this section controls. (V.T.I.C. Art. 21.28-C, Sec. 26.)

Source Law

Sec. 26. (a) Notwithstanding any other provision of this article, this article applies to each policy of insurance issued under Article 5.76 of this code or Article 5.76-2 of this code, as that article existed before its repeal.

(b) Notwithstanding any other provision of this article, after the conversion of the Texas workers' compensation insurance facility to a stock insurance company, that converted facility shall be considered an impaired insurer for purposes of this article if any of the actions described by Section 5(9)(A) or (B) of this article occur to the converted facility.

(c) A claim under such an insurance policy is a covered claim for purposes of this article if the claim satisfies the definition under Section 5(8) of this article, whether or not the converted facility:

(1) issued or assumed the policy; or

(2) was licensed to do business in this state at the time:

(A) the policy was written; or

(B) the converted facility became an impaired insurer.

(d) If a conflict exists between this section and any other statute relating to the Texas workers' compensation insurance facility or the Texas Property and Casualty Insurance Guaranty Association, this section controls.

Revisor's Note

(1) Section 26(a), V.T.I.C. Article 21.28-C, refers to an insurance policy issued under "Article 5.76 of this code or Article 5.76-2 of this code, as that article existed before its repeal." Section 26 was added by Chapter 594, Acts of the 75th Legislature, Regular Session, 1997. V.T.I.C. Article 5.76-2 was repealed by the same act. At the time of enactment of Section 26, V.T.I.C. Article 5.76 had been repealed by Chapter 1, Acts of the 71st Legislature, 2nd Called Session, 1989. For clarity and consistency, the revised law refers to both articles as they existed before repeal.

(2) Section 26(b), V.T.I.C. Article 21.28-C, governs the applicability of the article after the conversion of the Texas workers' compensation insurance facility to a stock insurance company.

Section 1.03, Chapter 594, Acts of the 75th Legislature, Regular Session, 1997, directed that the facility be converted to a Texas stock property and casualty insurance company or, in specified circumstances, the operation of the facility be transferred to the Texas Property and Casualty Insurance Guaranty Association. However, following enactment of Chapter 594 in 1997, the facility was transferred to a private stock insurance company. The revised law is drafted accordingly.

Revised Law

Sec. 462.010. CONFLICT WITH OTHER LAWS. (a) Except as provided by Subsection (b), if this chapter conflicts with another statute relating to the association, this chapter controls.

(b) This section does not apply to a conflict between this chapter and:

(1) Subtitle A, Title 5, Labor Code, except as described by Subsection (c); or

(2) Subtitle E, Title 10.

(c) This chapter controls with respect to subrogation rights of an insurance carrier under Chapter 417, Labor Code, against an impaired insurer's insured or the association. (V.T.I.C. Art. 21.28-C, Sec. 25.)

Source Law

Sec. 25. (a) Except as provided in Subsection (b) of this section, if a conflict exists between this Act and any other statutory provision relating to the association, this Act shall control.

(b) This section does not apply to a conflict between this Act and:

(1) Subtitle A, Title 5, Labor Code, except that this Act controls with respect to subrogation rights of an insurance carrier under Chapter 417, Labor Code, against an insured of an impaired insurer or the association;

(2) Subchapter D, Chapter 5, of this code; or

(3) Article 5.76-2, 5.76-3, 5.76-4, or 5.76-5 of this code.

Revisor's Note

Section 25(b)(3), V.T.I.C. Article 21.28-C,

provides that Section 25 does not apply to a conflict between Article 21.28-C, revised as this chapter, and V.T.I.C. Article 5.76-2. The revised law omits the reference to Article 5.76-2 because that article was repealed by Chapter 594, Acts of the 75th Legislature, Regular Session, 1997. In addition, Section 1.13 of that act added Section 26, V.T.I.C. Article 21.28-C, revised in this chapter as Section 462.009, which governs applicability of this chapter to insurance policies issued under former Article 5.76-2.

Revised Law

Sec. 462.011. IMMUNITY IN GENERAL. (a) Liability does not exist and a cause of action does not arise against any of the following persons for any good faith act or omission in performing the person's powers and duties under this chapter:

(1) the commissioner or the commissioner's representative;

(2) the association or the association's agent or employee;

(3) a member insurer;

(4) the board;

(5) the receiver; or

(6) a special deputy receiver or the special deputy receiver's agent or employee.

(b) The attorney general shall defend any action to which this section applies that is brought against the commissioner or the commissioner's representative, the association or the association's agent or employee, a member insurer or the insurer's agent or employee, a board member, or a special deputy receiver or the special deputy receiver's agent or employee, 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 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 the association or the association's agent or employee, a member insurer or the member insurer's agent or employee, a board member, or a special deputy receiver or the special deputy receiver's agent or employee 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. (V.T.I.C. Art. 21.28-C, Sec. 16.)

Source Law

Sec. 16. (a) There is no liability on the part of, and no cause of action of any nature arises against, any member insurer, the association or its agents or employees, the board of directors, receiver, special deputy receiver or its agents or employees, or the commissioner or the commissioner's representatives for any good faith action or failure to act in the performance of powers and duties under this Act.

(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 to 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 16(a), V.T.I.C. Article 21.28-C, limits the liability of certain persons for an "action or failure to act." Section 27, V.T.I.C. Article

21.28-C, revised in this chapter as Section 462.013, limits the liability of certain persons for their "act or omission." The quoted phrases are synonymous, and for consistency the revised law uses "act or omission" in both instances.

(2) Section 16(b), V.T.I.C. Article 21.28-C, requires the attorney general to defend certain actions 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 to its agents or employees, or the commissioner or the commissioner's representatives." The section further states defense of "any person or entity" is not required with respect to an issue other than the applicability or effect of the immunity created by Section 16. The revised law omits the reference to "entity" because the term "person," as defined by Section 5(12), V.T.I.C. Article 21.28-C, revised in this chapter as Section 462.004(7), describes all of the types of entities to which the required defense would apply.

(3) Section 16(b), V.T.I.C. Article 21.28-C, 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. 462.012. IMMUNITY IN RELATION TO CERTAIN REPORTS AND RECOMMENDATIONS. Liability does not exist and a cause of action does not arise against any of the following persons for a statement made in good faith by the person in a report or recommendation made under Section 462.111 or 462.113:

(1) the commissioner or the commissioner's representative;

(2) the association or the association's agent or employee;

(3) a member insurer; or

(4) the board. (V.T.I.C. Art. 21.28-C, Sec. 13(c).)

Source Law

(c) There shall be no liability on the part of, and no cause of action of any nature shall arise against the association or its agents or employees, the board of directors, member insurers, or the commissioner or the commissioner's authorized representative for any statement made in good faith by them in any report or recommendation made under this section.

Revisor's Note

Section 13(c), V.T.I.C. Article 21.28-C, refers to "the commissioner's authorized representative." The revised law omits "authorized" as unnecessary in this context. A person is not a representative of the commissioner of insurance if the person is not authorized to act as a representative.

Revised Law

Sec. 462.013. IMMUNITY IN RELATION TO CERTAIN NEGOTIATIONS. (a) Liability does not exist and a cause of action does not arise against any of the following persons for an act or omission in the performance of an activity related to the negotiations relating to the privatization of the former Texas workers' compensation facility:

(1) the commissioner or the commissioner's representative;

(2) the association or the association's agent or employee;

(3) a member insurer; or

(4) a board member.

(b) This section applies to each activity undertaken by a person described by Subsection (a), regardless of the date of the act or omission. (V.T.I.C. Art. 21.28-C, Sec. 27.)

Source Law

Sec. 27. There is no liability on the part of, and a cause of action does not arise against, any member insurer of the association, the association, an agent or employee of the association, a member of the board of directors of the association, or the commissioner or the commissioner's representative for any act or omission in the performance of any activity related to the negotiations relating to the privatization of the Texas workers' compensation insurance facility. This section applies to each activity undertaken by such a person or entity, regardless of the date of the act or omission.

Revisor's Note

Section 27, V.T.I.C. Article 21.28-C, refers to the liability of "any member insurer of the association, the association, an agent or employee of the association, a member of the board of directors of the association, or the commissioner or the commissioner's representative." The section subsequently refers to "such a person or entity." The revised law omits the reference to "entity" because the term "person," as defined by Section 5(12), V.T.I.C. Article 21.28-C, revised in this chapter as Section 462.004(7), describes all of the listed entities.

Revised Law

Sec. 462.014. RULES. The commissioner shall adopt reasonable rules as necessary to implement and supplement this chapter and this chapter's purposes. (V.T.I.C. Art. 21.28-C, Sec. 23.)

Source Law

Sec. 23. 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

(1) Section 23, V.T.I.C. Article 21.28-C, 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 State Board of Insurance have been changed appropriately.

(2) Section 23, V.T.I.C. Article 21.28-C, refers to "rules and regulations." 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. That definition applies to the revised law.

Revised Law

Sec. 462.015. INFORMATION PROVIDED BY OR TO COMMISSIONER. (a) The commissioner shall notify the association of the existence of an impaired insurer not later than the third day after the date 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 a member insurer at the time the complaint is filed with a court.

(b) On the board's request, the commissioner shall provide the association with a statement of the net direct written premiums of each member insurer. (V.T.I.C. Art. 21.28-C, Secs. 10(a), (b).)

Source Law

Sec. 10. (a) The commissioner shall notify the association of the existence of an impaired insurer not later than three days after 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 a member company at the same time that the complaint is filed with a court of competent jurisdiction.

(b) On request of the board of directors, the commissioner shall provide the association with a statement of the net direct written premiums of each member insurer.

Revised Law

Sec. 462.016. PENALTY FOR FAILURE TO PAY ASSESSMENTS OR COMPLY WITH PLAN OF OPERATION. (a) The commissioner shall suspend

or revoke, after notice and hearing, the certificate of authority to engage in the business of insurance in this state of a member insurer that:

(1) fails to pay an assessment at the time the assessment is due; or

(2) otherwise fails to comply with the plan of operation.

(b) As an alternative to action under Subsection (a), the commissioner may assess a fine on a member insurer that fails to pay an assessment at the time the assessment is due. The fine may not exceed the lesser of:

(1) five percent of the unpaid assessment per month; or

(2) $100 per month. (V.T.I.C. Art. 21.28-C, Sec. 10(d).)

Source Law

(d) The commissioner shall suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or otherwise fails to comply with the plan of operation. As an alternative, the commissioner may assess a fine on any member insurer that fails to pay an assessment when due. The fine may not exceed the lesser of five percent of the unpaid assessment per month or $100 per month.

Revised Law

Sec. 462.017. APPEALS AND OTHER ACTIONS. (a) A final action or order of the commissioner under this chapter is subject to judicial review by a court.

(b) Venue in a suit against the commissioner or association relating to an action or ruling of the commissioner or association under this chapter is in Travis County. 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. 21.28-C, Secs. 10(f), (g).)

Source Law

(f) Any final action or order of the commissioner under this Act is subject to judicial

review by a court of competent jurisdiction.

(g) Venue in a suit against the association or commissioner relating to any action or ruling of the association or commissioner made under this Act is in Travis County. The association or commissioner is not required to give an appeal bond in an appeal of a cause of action arising under this Act.

[Sections 462.018-462.050 reserved for expansion]

SUBCHAPTER B. GOVERNANCE OF ASSOCIATION

Revised Law

Sec. 462.051. ASSOCIATION AS LEGAL ENTITY; MEMBERSHIP. (a) The Texas Property and Casualty Insurance Guaranty Association is a nonprofit unincorporated legal entity.

(b) The association is composed of all member insurers. A member insurer must remain a member of the association as a condition of engaging in the business of insurance in this state. (V.T.I.C. Art. 21.28-C, Sec. 6 (part).)

Source Law

Sec. 6. The Texas Property and Casualty Insurance Guaranty Association is a nonprofit, unincorporated legal entity composed of all member insurers, who must be members of the association as a condition of their authority to transact insurance in this state. . . .

Revised Law

Sec. 462.052. BOARD OF DIRECTORS. (a) The association's powers are exercised through a board of directors consisting of nine individuals.

(b) Member insurers shall select five insurance industry board members, subject to the approval of the commissioner. In approving selections to the board, the commissioner shall consider whether all member insurers are fairly represented.

(c) Four board members must be public representatives appointed by the commissioner. (V.T.I.C. Art. 21.28-C, Secs. 6 (part), 7(a) (part), (b).)

Source Law

Sec. 6. . . . The association . . . shall exercise its powers through the board of directors. . . .

Sec. 7. (a) The board of directors of the association is composed of nine persons . . . . Five members shall be selected by member insurers, subject to the approval of the commissioner. [To be eligible

to serve as an insurance industry board member . . . ] The remaining members shall be representatives of the general public appointed by the commissioner. . . .

(b) In approving selections to the board, the commissioner shall consider whether all member insurers are fairly represented.

Revised Law

Sec. 462.053. ELIGIBILITY TO SERVE AS PUBLIC REPRESENTATIVE. A board member who is a public representative may not be:

(1) an officer, director, or employee of an insurer, insurance agency, agent, broker, 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, in connection with the person's representation of clients in the field of insurance; or

(3) related to a person described by Subdivision (1) or (2) within the second degree of affinity or consanguinity. (V.T.I.C. Art. 21.28-C, Sec. 7(d).)

Source Law

(d) 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 Texas Department of Insurance;

(2) a person required to register with the Texas Ethics Commission under Chapter 305, Government Code, in connection with the person's representation of clients in the field of insurance; or

(3) related to a person described by Subdivision (1) or (2) of this subsection within the second degree of affinity or consanguinity.

Revisor's Note

(1) Section 7(d)(1), V.T.I.C. Article 21.28-C, refers to a "solicitor." The revised law omits that reference 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," to which

Section 7(d)(1) refers.

(2) Section 7(d)(1), V.T.I.C. Article 21.28-C, refers to the "Texas Department of Insurance." The revised law substitutes "department" for the quoted reference because, under Section 31.001 of this code, "department" is defined for purposes of this code to mean the Texas Department of Insurance.

Revised Law

Sec. 462.054. ELIGIBILITY TO SERVE AS INDUSTRY REPRESENTATIVE. To be eligible to serve as an insurance industry board member, an individual must be a full-time employee of a member insurer. (V.T.I.C. Art. 21.28-C, Sec. 7(a) (part).)

Source Law

> (a) . . . To be eligible to serve as an insurance industry board member, a person must be a full-time employee of a member insurer. . . .

Revised Law

Sec. 462.055. TERM; VACANCY. (a) A board member serves a term established by the plan of operation.

(b) The remaining board members, by majority vote, shall fill a vacancy on the board for the unexpired term, subject to the commissioner's approval. (V.T.I.C. Art. 21.28-C, Sec. 7(a) (part).)

Source Law

> (a) [The board of directors] . . . who serve terms as established in the plan of operation. . . . Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner.

Revised Law

Sec. 462.056. REIMBURSEMENT OF BOARD MEMBERS. A board member may be reimbursed from the assets of the association for expenses the board member incurs as a board member. (V.T.I.C. Art. 21.28-C, Sec. 7(c).)

Source Law

> (c) Members of the board of directors may be reimbursed from the assets of the association for

expenses incurred by them as members of the board of directors.

Revised Law

Sec. 462.057. 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. 21.28-C, Sec. 7(e).)

Source Law

(e) Each member of the board of directors 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).

Revisor's Note

Section 7(e), V.T.I.C. Article 21.28-C, 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). 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. 462.058. CONFLICT OF INTEREST. (a) A director of the association or a member insurer or other entity represented by the director may not receive money or another valuable thing directly, indirectly, or through any substantial interest in any other corporation, firm, or business unit for negotiating, procuring, participating in, recommending, or aiding in a reinsurance agreement, merger, or other transaction, including the purchase, sale, or exchange of assets, insurance policies, or property made by the association or the supervisor, conservator, or receiver on behalf of an impaired insurer.

(b) The director, member insurer, or entity may not be

pecuniarily or contractually interested, as principal, coprincipal, agent, or beneficiary, directly, indirectly, or through any substantial interest in any other corporation, firm, or business unit, in the reinsurance agreement, merger, purchase, sale, exchange, or other transaction. (V.T.I.C. Art. 21.28-C, Sec. 7(f).)

Source Law

> (f) A director of the association or any member company or other entity represented by the director may not receive any money or valuable thing directly, indirectly, or through any substantial interest in any other corporation, firm, or business unit for negotiating, procuring, participating, recommending, or aiding in a transaction, reinsurance agreement, merger, purchase, sale, or exchange of assets, policies of insurance, or property made by the association or the supervisor, conservator, or receiver on behalf of an impaired insurer. The director, company, or entity may not be pecuniarily or contractually interested, as principal, co-principal, agent, or beneficiary, directly, indirectly, or through any substantial interest in any other corporation, firm, or business unit, in the transaction, reinsurance agreement, merger, purchase, sale, or exchange.

Revised Law

Sec. 462.059. MEETING BY CONFERENCE CALL. (a) 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.

(b) The meeting is subject to the notice requirements that apply to other meetings.

(c) 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. (V.T.I.C. Art. 21.28-C, Sec. 8(k).)

Source Law

> (k)(1) 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.

(2) The meeting is subject to the notice requirements applicable to other meetings.

(3) The notice of the meeting must specify as the location of the meeting the location where meetings of the board are usually held.

(4) 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.

Revisor's Note

Section 8(k)(1), V.T.I.C. Article 21.28-C, 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.

[Sections 462.060-462.100 reserved for expansion]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF ASSOCIATION

Revised Law

Sec. 462.101. GENERAL POWERS AND DUTIES. (a) The association may:

(1) employ or retain persons as necessary to handle claims and perform other duties of the association;

(2) borrow money necessary to implement this chapter in accordance with the plan of operation;

(3) sue or be sued;

(4) negotiate and enter into a contract as necessary to implement this chapter; and

(5) perform other acts as necessary or proper to implement this chapter.

(b) A contract authorized by Subsection (a)(4) includes a lump-sum or structured compromise and settlement agreement with a claimant who has a claim for medical or indemnity benefits for a period of three years or more, other than a settlement or lump-sum payment in violation of Subtitle A, Title 5, Labor Code. (V.T.I.C. Art. 21.28-C, Sec. 8(h) (part).)

Source Law

(h) The association may:

(1) employ or retain persons as necessary to handle claims and perform other duties of the association;

(2) borrow funds necessary to implement this Act in accordance with the plan of operation;

(3) sue or be sued;

(4) negotiate and become a party to contracts as necessary to implement this Act, including lump-sum or structured compromise and settlement agreements with claimants who have claims for medical or indemnity benefits for a period of three years or more other than a settlement or lump-sum payment in violation of the Texas Workers' Compensation Act (Article 8308-1.01 et seq., Vernon's Texas Civil Statutes);

(5) perform other acts as necessary or proper to implement this Act; or

. . .

Revisor's Note

(1) Section 8(h)(2), V.T.I.C. Article 21.28-C, refers to "funds." Throughout this chapter, the revised law substitutes "money" for "funds" because, in context, "funds" and "money" are synonymous and "money" is more commonly used.

(2) Section 8(h)(4), V.T.I.C. Article 21.28-C, refers to the Texas Workers' Compensation Act (Article 8308-1.01 et seq., Vernon's Texas Civil Statutes). That act was codified in 1993 as Subtitle A, Title 5, Labor Code. The revised law is drafted accordingly.

Revised Law

Sec. 462.102. ASSOCIATION NOT IN PLACE OF IMPAIRED INSURER. In performing the association's statutory 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 insurer; or

(3) to otherwise stand in the place of the impaired insurer for any purpose, including for the purpose of determining whether the association is subject to personal jurisdiction of the courts of another state. (V.T.I.C. Art. 21.28-C, Sec. 8(b) (part).)

Source Law

(b) . . . In performing its statutory obligations under this Act, 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, and shall not be considered to otherwise stand in the shoes of the impaired insurer for any purpose, including the issue of whether the association is amenable to the personal jurisdiction of the courts of any other state.

Revised Law

Sec. 462.103. PLAN OF OPERATION. (a) The association shall perform the association's functions under a plan of operation necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The plan of operation must:

(1) be submitted to and approved in writing by the commissioner;

(2) establish:

(A) procedures under which the powers and duties of the association are performed;

(B) procedures for handling assets of the association;

(C) the amount and method of reimbursing board members;

(D) acceptable forms of proof of covered claims;

(E) regular places and times for board meetings;

(F) procedures for records to be kept of each financial transaction of the association, the association's agents, and the board; and

(G) procedures under which selections for the board are submitted to the commissioner;

(3) provide:

(A) for the establishment of a claims filing procedure that includes:

(i) notice by the association to claimants;

(ii) procedures for filing claims seeking recovery from the association; and

(iii) a procedure for appealing the denial

of claims by the association; and

(B) that a member insurer aggrieved by a final action or decision of the association may appeal to the commissioner not later than the 30th day after the date of the action or decision; and

(4) 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 shall 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 member insurer shall comply with the plan of operation. (V.T.I.C. Art. 21.28-C, Secs. 6 (part), 9(a), (b), (c), (d), (f).)

Source Law

Sec. 6. . . . The association shall perform its functions under a plan of operation approved under Section 9 of this Act and . . . .

Sec. 9. (a) The association shall submit to the commissioner a plan of operation and any amendments necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments take effect on approval in writing by the commissioner.

(b) If the association fails to submit suitable amendments to the plan, the commissioner, after notice and hearing, shall adopt reasonable rules as necessary or advisable to implement this Act. Those rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(c) All member insurers shall comply with the plan of operation.

(d) The plan of operation must:

(1) establish the procedures under which the powers and duties of the association are performed;

(2) establish procedures for handling assets of the association;

(3) establish the amount and method of reimbursing members of the board of directors;

(4) provide for the establishment of a claims filing procedure that includes, but is not limited to, notice by the association to claimants, procedures for filing claims seeking recovery from the association, and a procedure for appealing the denial of claims by the association; and

(5) establish acceptable forms of proof of covered claims.

(f) The plan of operation must:

(1) establish regular places and times for meetings of the board of directors;

(2) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(3) provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner not later than the 30th day after the date of the action or decision;

(4) establish the procedures under which selections for the board of directors are submitted to the commissioner; and

(5) contain additional provisions as necessary or proper for the execution of the powers and duties of the association.

Revisor's Note

Section 9(d)(4), V.T.I.C. Article 21.28-C, refers to a claims filing procedure that includes "but is not limited to" certain procedures. The revised law omits the quoted language as unnecessary because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, and Section 312.011(19), Government Code, applicable to civil statutes, 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. 462.104. NOTICE TO INSUREDS. (a) The commissioner may require that the association notify an impaired insurer's insureds and any other interested parties of:

(1) the designation of impairment; and

(2) the insureds' and other parties' rights under this chapter.

(b) The association shall give notice as the commissioner directs under this section. The association shall mail the notice to the last known address, if available. If sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation is sufficient notice. (V.T.I.C. Art. 21.28-C, Secs. 8(e), 10(c).)

Source Law

> [Sec. 8]
>
> (e) The association shall give notice as the commissioner directs under Section 10(c) of this Act.
>
> [Sec. 10]
>
> (c) 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 Act. The notification shall be by mail at the last known address, if available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation is sufficient.

Revised Law

Sec. 462.105. ACCOUNTS. For purposes of administration and assessment, the association is divided into:

(1) the workers' compensation insurance account;

(2) the automobile insurance account; and

(3) the account for all other lines of insurance to which this chapter applies. (V.T.I.C. Art. 21.28-C, Sec. 6 (part).)

Source Law

> Sec. 6. . . . For purposes of administration and assessment, the association is divided into the workers' compensation insurance account, the automobile insurance account, and the account for all other lines of insurance to which this Act applies.

Revised Law

Sec. 462.106. ADMINISTRATIVE EXPENSES. (a) The association may use money in the administrative account to pay administrative costs and other general expenses of the association.

(b) The association may transfer income from investment of the association's money to the administrative account.

(c) On notification by the association of the amount of any

additional money needed for the administrative account, the association shall assess member insurers in the manner provided by Sections 462.159-462.168 for that money. The commissioner shall consider the net direct written premiums collected in this state for all lines of business covered by this chapter. An assessment for administrative expenses incurred by a supervisor or conservator appointed by the commissioner or a court-appointed receiver for a nonmember of the association or unauthorized insurer operating in this state may not exceed $1 million each calendar year. (V.T.I.C. Art. 21.28-C, Sec. 18(g).)

Source Law

> (g) Income from the investment of any of the funds of the association may be transferred to the administrative account authorized under this Act. The funds in the account may be used by the association for the purpose of meeting administrative costs and other general expenses of the association. On notification by the association of the amount of any additional funds needed for the administrative account, the association shall assess member insurers to obtain the needed funds in the manner set out in this section. The commissioner shall consider the net direct written premium collected in this state for all lines of business covered by this Act. An assessment for administrative expenses incurred by a supervisor or conservator appointed by the commissioner or a receiver appointed by a court of competent jurisdiction for a nonmember of the association or unauthorized insurer operating in this state may not exceed $1,000,000 each calendar year.

Revisor's Note

Section 18(g), V.T.I.C. Article 21.28-C, requires the Texas Property and Casualty Insurance Guaranty Association to assess member insurers "in the manner set out in this section," meaning Section 18. The provisions of Section 18 relating to assessment, together with certain provisions relating to assessments under that section, are revised as Sections 462.159-462.168 of this chapter. The revised law is drafted accordingly.

Revised Law

Sec. 462.107. EXAMINATION OF ASSOCIATION. Not later than April 30 of each year, the association shall submit an audited

financial statement for the preceding calendar year to the state auditor in a form approved by the state auditor's office. (V.T.I.C. Art. 21.28-C, Sec. 14.)

Source Law

> Sec. 14. Not later than April 30 of each year, the association shall submit an audited financial statement to the state auditor for the preceding calendar year in a form approved by the state auditor's office.

Revised Law

Sec. 462.108. DEPOSIT OF MONEY. The board may deposit the money the association collects into the Texas Treasury Safekeeping Trust Company in accordance with procedures established by the comptroller. The comptroller shall account to the association for the deposited money separately from all other money. (V.T.I.C. Art. 21.28-C, Sec. 8(j).)

Source Law

> (j) The board of directors may deposit all money collected by the association into the Texas Treasury Safekeeping Trust Company in accordance with procedures established by the comptroller. The funds deposited shall be accounted for separately from all other funds by the comptroller to the association.

Revised Law

Sec. 462.109. DELEGATION OF POWERS AND DUTIES. (a) Except as provided by Subsection (b), the plan of operation may provide that, on approval of the board and the commissioner, the association may delegate by contract any or all powers or duties of the association 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 the association's equivalent; and

(2) provides protection not substantially less favorable and effective than that provided by this chapter.

(b) The association may not delegate a power or duty under Section 462.101(a)(2), 462.151, 462.154, 462.155, or 462.302(d) under this section.

(c) The association shall:

(1) reimburse the corporation or other organization as a servicing facility would be reimbursed; and

(2) pay the corporation or other organization for the performance of any other functions of the association.

(d) A contract entered into under this section is subject to the performance standards imposed under Section 442.112. (V.T.I.C. Art. 21.28-C, Sec. 9(g).)

Source Law

(g) The plan of operation may provide that any or all powers and duties of the association, except those under Section 8(c) and 8(h)(2) of this Act, are delegated by contract 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 the performance of any other functions of the association. A delegation under this subsection takes 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 Act. A contract entered into under this subsection is subject to the performance standards imposed under Section 2(a), Article 21.28, of this code.

Revisor's Note

(1) Section 9(g), V.T.I.C. Article 21.28-C, provides that the Texas Property and Casualty Insurance Guaranty 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 Section 8(c) and 8(h)(2) of this Act." Although part of Section 8(c) is revised in this chapter as Section 462.152, the revised law omits the reference to that section because it does not contain a power or duty of the association.

(2) Section 9(g), V.T.I.C. Article 21.28-C, refers to a "corporation, association, or [other] organization." The revised law omits the reference to "association" because that term is included within the

meaning of "organization."

(3) Section 9(g), V.T.I.C. Article 21.28-C, provides that certain contracts are subject to the performance standards imposed by Section 2(a), V.T.I.C. Article 21.28. The only provisions in Section 2(a) that could be construed as performance standards are revised in Chapter 442 of this code as Section 442.112, and the revised law is drafted accordingly.

Revised Law

Sec. 462.110. EXEMPTION FROM CERTAIN FEES AND TAXES. The association is exempt from payment of all fees and of 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. 21.28-C, Sec. 15.)

Source Law

Sec. 15. 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. 462.111. ACCESS TO RECORDS OF MEMBER INSURER IN RECEIVERSHIP; ACTUARIAL AND OPERATIONAL ANALYSIS. (a) The association shall have access to the books and records of a member insurer in receivership to determine the extent of the impact on the association if the member becomes impaired.

(b) The association may:

(1) perform or cause to be performed an actuarial and operational analysis of the member insurer; and

(2) prepare a report on matters relating to the impact or potential impact on the association in the event of impairment.

(c) A report prepared under Subsection (b) is not a public document. (V.T.I.C. Art. 21.28-C, Sec. 13(a).)

Source Law

Sec. 13. (a) The association shall have access to the books and records of a member insurer in

receivership, in order to make a determination of the extent of the impact on the association in the event such member becomes impaired. The association shall have the authority to perform or cause to be performed an actuarial and operational analysis of the member insurer and prepare a report on matters relating to the impact or potential impact on the association in the event of impairment. Such reports shall not be public documents.

Revised Law

Sec. 462.112. BOARD ACCESS TO RECORDS OF IMPAIRED INSURER. The receiver or statutory successor of an impaired insurer covered by this chapter shall give the board or the board's representative:

(1) access to the insurer's records as necessary for the board to perform the board's 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. 21.28-C, Sec. 17(b) (part).)

Source Law

(b) . . . The receiver or statutory successor of an impaired insurer covered by this Act 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 17(b), V.T.I.C. Article 21.28-C, refers to the board of directors or its "authorized" representative. The revised law omits "authorized" for the reason stated in the revisor's note to Section 462.012.

Revised Law

Sec. 462.113. BOARD REPORT ON CONCLUSION OF INSOLVENCY. On the conclusion of the insolvency of a domestic insurer with respect to which the association was obligated to pay covered claims, the board may:

(1) prepare a report on the history and causes of the insolvency, based on information available to the association; and

(2) submit the report to the commissioner. (V.T.I.C. Art. 21.28-C, Sec. 13(b).)

Source Law

(b) At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may prepare a report on the history and causes of the insolvency, based on the information available to the association, and may submit the report to the commissioner.

Revised Law

Sec. 462.114. DUTY OF RECEIVER. The receiver shall periodically submit a list of claims to the association or similar organization in another state. (V.T.I.C. Art. 21.28-C, Sec. 9(e).)

Source Law

(e) A list of claims shall be submitted periodically to the association or similar organization in another state by the receiver.

[Sections 462.115-462.150 reserved for expansion]

SUBCHAPTER D. ASSESSMENTS IN GENERAL

Revised Law

Sec. 462.151. MAKING OF ASSESSMENT; AMOUNT. (a) The association shall assess member insurers the amount necessary to pay:

(1) the association's obligations under Section 462.302 and the expenses of handling covered claims subsequent to an insolvency; and

(2) other expenses authorized by this chapter.

(b) The assessment of each member insurer must be in the proportion that the net direct written premiums of the insurer for the calendar year preceding the assessment bear to the net direct written premiums of all member insurers for that year. (V.T.I.C. Art. 21.28-C, Sec. 8(c) (part).)

Source Law

(c) The association shall assess insurers amounts necessary to pay the obligations of the association under Subsection (a) of this section after an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. 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 for the calendar year preceding the assessment. . . .

Revisor's Note

(1) Section 8(c), V.T.I.C. Article 21.28-C, provides that the Texas Property and Casualty Insurance Guaranty Association "shall assess insurers" and subsequently refers to the amount of the assessment on a "member insurer." For consistency and clarity, the revised law uses the term "member insurer."

(2) Section 8(c), V.T.I.C. Article 21.28-C, references obligations of the Texas Property and Casualty Insurance Guaranty Association under Section 8(a) of that article. Section 8(a) is revised in this chapter in Section 462.302. The revised law is drafted accordingly.

Revised Law

Sec. 462.152. MAXIMUM TOTAL ASSESSMENT. (a) The total assessment of a member insurer in a year may not exceed an amount equal to two percent of the insurer's net direct written premiums for the calendar year preceding the assessment.

(b) If the maximum assessment and the association's other assets are insufficient in a year to make all necessary payments, the money available shall be prorated and the association shall pay the unpaid portion as soon as money becomes available. (V.T.I.C. Art. 21.28-C, Sec. 8(c) (part).)

Source Law

(c) . . . 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, 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. . . .

Revised Law

Sec. 462.153. REFUND OF CONTRIBUTION. The association may

refund to the member insurers in proportion to the contribution of each member insurer to the association the amount by which the association's assets exceed the association's liabilities, if at the end of a calendar year the board finds that the assets of the association exceed the liabilities of the association as estimated by the board for the next year. (V.T.I.C. Art. 21.28-C, Sec. 8(h) (part).)

Source Law

(h) [The association may:]

. . .

(6) refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

Revised Law

Sec. 462.154. NOTICE OF ASSESSMENT. The association shall notify a member insurer of an assessment not later than the 30th day before the date the assessment is due. (V.T.I.C. Art. 21.28-C, Sec. 8(c) (part).)

Source Law

(c) . . . Each member insurer shall be notified of the assessment not later than the 30th day before the date on which the assessment is due. . . .

Revised Law

Sec. 462.155. DEFERMENT. (a) The association may defer wholly or partly an assessment of a member insurer that would cause the insurer's financial statement to show amounts of capital or surplus less than the minimum amounts required for a certificate of authority in any jurisdiction in which the insurer is authorized to engage in the business of insurance.

(b) The member insurer shall pay the deferred assessment at the time payment will not reduce capital or surplus below required minimums. The payment shall be refunded to or credited against future assessments of any member insurer receiving a larger assessment because of the deferment, as elected by that insurer.

(c) During a period of deferment, the member insurer may not pay a dividend to shareholders or policyholders. (V.T.I.C. Art. 21.28-C, Sec. 8(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; provided, however, that during the period of deferment, dividends may not be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. The 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. 462.156. USE OF ASSESSMENTS. (a) The amounts provided under assessments made under this chapter supplement the marshalling of assets by the receiver under Chapter 442 to make payments on the impaired insurer's behalf.

(b) This section does not require the receiver to exhaust the assets of the impaired insurer before an assessment is made or before money derived from an assessment may be used to pay covered claims. (V.T.I.C. Art. 21.28-C, Sec. 19.)

Source Law

> Sec. 19. (a) The amounts provided under assessments made under this Act are in addition to the marshaling of assets by the receiver under Article 21.28 of this code for the purpose of making payments on behalf of an impaired insurer.
>
> (b) This section does not require the receiver to exhaust the assets of the impaired insurer before an assessment is made or before funds derived from an assessment may be used to pay covered claims.

Revised Law

Sec. 462.157. TAX CREDIT. (a) An insurer is entitled to a credit against the insurer's premium tax under Chapter 221 for the total amount of an assessment paid by the insurer under this chapter.

(b) The tax credit may be taken at a rate of 10 percent each

year for 10 successive years after the date of assessment. At the option of the insurer, the tax credit may be taken over an additional number of years.

(c) The balance of a tax credit not claimed in a particular year may be reflected in the books and records of the insurer as an admitted asset of the insurer for all purposes, including exhibition in an annual statement under Section 862.001.

(d) Available credit against premium tax allowed under this section may be transferred or assigned among insurers if:

(1) a merger, acquisition, or total assumption of reinsurance among the insurers occurs; or

(2) the commissioner by order approves the transfer or assignment. (V.T.I.C. Art. 21.28-C, Sec. 21.)

Source Law

Sec. 21. (a) One hundred percent of any assessment paid by an insurer under this Act shall be allowed to that insurer as a credit against its premium tax under Article 4.10 of this code. The tax credit referred to in this section shall be allowed at a rate of 10 percent per year for 10 successive years following the date of assessment and, at the option of the insurer, may be taken over an additional number of years. The balance of any tax credit not claimed in a particular year 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.

(b) Available credit against premium tax allowed under Subsection (a) of this section may be transferred or assigned among or between insurers if:

(1) a merger, acquisition, or total assumption of reinsurance among or between the insurers occurs; or

(2) the commissioner by order approves the transfer or assignment.

Revisor's Note

Section 21(b), V.T.I.C. Article 21.28-C, refers to the transfer or assignment of premium tax credits "among or between" insurers. The revised law omits "between" because the meaning of that term is included within the meaning of "among."

Revised Law

Sec. 462.158. ADVANCE AS LOAN. Money advanced by the association under this chapter is considered a special fund loan to

the impaired insurer for payment of covered claims and does not become an asset of the impaired insurer. The loan is repayable to the extent money from the impaired insurer is available. (V.T.I.C. Art. 21.28-C, Sec. 18(f).)

Source Law

> (f) Funds advanced by the association under this Act shall not become assets of the impaired insurer but are considered a special fund loaned to the impaired insurer for payment of covered claims. That loan is repayable to the extent available from the funds of the insurer.

Revised Law

Sec. 462.159. ESTIMATE OF ADDITIONAL MONEY NEEDED ON IMPAIRMENT OF INSURER. (a) If the commissioner determines that an insurer has become an impaired insurer, the association shall promptly estimate the amount of additional money, by lines of business, needed to supplement the immediately available assets of the impaired insurer to pay covered claims.

(b) The board shall make additional money available as the actual need arises for each impaired insurer. (V.T.I.C. Art. 21.28-C, Sec. 18(a).)

Source Law

> Sec. 18. (a) If the commissioner determines that an insurer has become an impaired insurer, the association shall promptly estimate the amount of additional funds, by lines of business, needed to supplement the assets of the impaired insurer immediately available to pay covered claims. The board shall make additional funds available as the actual need arises for each impaired insurer.

Revised Law

Sec. 462.160. ASSESSMENT FOR ADDITIONAL MONEY FOR ACCOUNTS. If the board determines that additional money is needed in any of the three accounts described by Section 462.105, the board shall make assessments as needed to produce the necessary money. (V.T.I.C. Art. 21.28-C, Sec. 18(b) (part).)

Source Law

> (b) If the board of directors determines that additional funds are needed in any of the three accounts, it shall make assessments as necessary to produce the necessary funds. . . .

Revised Law

Sec. 462.161. AMOUNT OF ASSESSMENT; PRORATION OF PAYMENT. (a) The association, in determining the proportionate amount to be paid by individual insurers under an assessment under Section 462.160, shall consider the lines of business written by the impaired insurer and shall assess individual insurers in proportion to the ratio that the total net direct written premiums collected in this state by the insurer for those lines of business bears to the total net direct written premiums collected by all insurers, other than impaired insurers, in this state for those lines of business.

(b) The association shall determine the total net direct written premiums of an individual insurer and of all insurers in the state from the insurers' annual statements for the year preceding assessment. (V.T.I.C. Art. 21.28-C, Sec. 18(b) (part).)

Source Law

> (b) . . . The association, in determining the proportionate amount to be paid by individual insurers under an assessment, shall take into consideration the lines of business written by the impaired insurer and shall assess individual insurers in proportion to the ratio that the total net direct written premium collected in this state by the insurer for those lines of business bears to the total net direct written premium collected by all insurers, other than impaired insurers, in this state for those lines of business. The association shall determine the total net direct written premium of an individual insurer and for all insurers in the state from the insurers' annual statements for the year preceding assessment. . . .

Revised Law

Sec. 462.162. MAXIMUM ASSESSMENT OF INSURER; ADDITIONAL ASSESSMENT AUTHORITY UNDER CERTAIN CIRCUMSTANCES. (a) Except as otherwise provided by this section, assessments under Section 462.160 during a calendar year may not exceed two percent of each insurer's net direct written premiums for the preceding calendar year in the lines of business for which the assessments are made.

(b) In the event of a natural disaster or other catastrophe, the association may apply to the governor, in the manner prescribed by the plan of operation, for authority to assess each member insurer that writes insurance coverage, other than automobile

insurance coverage or workers' compensation insurance coverage, an additional amount not to exceed two percent of the insurer's net direct written premiums for the preceding calendar year.

(c) If the maximum assessment in a calendar year does not provide an amount sufficient for payment of covered claims of impaired insurers, the association may make assessments in successive calendar years. (V.T.I.C. Art. 21.28-C, Sec. 18(b) (part).)

Source Law

> (b) . . . Except as otherwise provided by this subsection, assessments under this subsection during a calendar year may be made up to, but not in excess of, two percent of each insurer's net direct written premium for the preceding calendar year in the lines of business for which the assessments are being made. In the event of a natural disaster or other catastrophic event, the association may apply to the governor, in the manner prescribed by the plan of operation, for authority to assess each member insurer that writes insurance coverage, other than motor vehicle coverage or workers' compensation coverage, an additional amount not to exceed two percent of the insurer's net direct written premiums for the preceding calendar year. If the maximum assessment in any calendar year does not provide an amount sufficient for payment of covered claims of impaired insurers, assessments may be made in the next and successive calendar years.

Revisor's Note

(1) Section 18(b), V.T.I.C. Article 21.28-C, refers to "motor vehicle coverage." The revised law substitutes "automobile insurance coverage" for the reference to "motor vehicle coverage" for consistency with terminology used in this code and because "automobile insurance" is the term more commonly used to describe the kind of insurance that provides coverage for motor vehicles.

(2) Section 18(b), V.T.I.C. Article 21.28-C, provides that certain assessments may be made in "the next and successive calendar years." The revised law omits the reference to the "next" calendar year because that term is included within the meaning of the "successive" calendar years.

Revised Law

Sec. 462.163. PAYMENT OF ASSESSMENT. An insurer shall pay the amount of an assessment under Section 462.160 or 462.162(b) to the association not later than the 30th day after the date the association gives notice of the assessment. (V.T.I.C. Art. 21.28-C, Sec. 18(c).)

Source Law

> (c) It shall be the duty of each insurer to pay the amount of an assessment under Subsection (b) of this section to the association not later than the 30th day after the association gives notice of the assessment.

Revised Law

Sec. 462.164. PARTICIPATION RECEIPTS. (a) On receipt from a member insurer of payment of an assessment or partial assessment under Section 462.160 or 462.162(b), the association shall provide the insurer with a participation receipt. A participation receipt creates liability against the account described by Section 462.105 for the line or lines of business for which the assessment was made.

(b) The account from which an advance is made to an impaired insurer for the payment of covered claims is a general creditor of the impaired insurer for the money advanced. With reference to the remaining balance of an advance not used to pay covered claims, the claim of the account has preference over other general creditors. (V.T.I.C. Art. 21.28-C, Secs. 20(a), (b) (part).)

Source Law

> Sec. 20. (a) On receipt from an insurer of payment of an assessment or partial assessment required by the association under Section 18(b) of this Act, the association shall provide the insurer with a participation receipt, which shall create a liability against the account for the line or lines of business for which the assessment was made.
>
> (b) The account from which an advance is made to an impaired insurer for the payment of covered claims shall be regarded as a general creditor of the impaired insurer for the amount of funds so advanced; provided, however, that with reference to the remaining balance of any advances not expended in payment of covered claims, the claim of the account has preference over other general creditors. . . .

Revisor's Note

Section 20(a), V.T.I.C. Article 21.28-C, refers

to receipt of a payment of an assessment from an "insurer," meaning a member insurer required to pay an assessment. For consistency and clarity, the revised law uses the term "member insurer."

Revised Law

Sec. 462.165. ACCOUNTING; REPORTS; REFUND. (a) The association, with respect to an impaired insurer, shall adopt accounting procedures that reflect the use of all money and shall make a final report of the use of the money to the commissioner. The final report must state any remaining balance from the money advanced to an impaired insurer for the payment of covered claims.

(b) The association shall make interim accounting reports as required by the commissioner or requested by the conservator.

(c) As soon as practicable after completion of the final report, the association shall refund by line of business the remaining balance of those advances to the association's accounts. (V.T.I.C. Art. 21.28-C, Sec. 20(b) (part).)

Source Law

> (b) . . . The association of any impaired insurer shall adopt accounting procedures reflecting the expenditure and use of all funds and shall make a final report of the expenditure and use of the funds to the commissioner, which final report shall set forth the remaining balance, if any, from the moneys advanced. The association shall also make any interim reports concerning such accounting as may be required by the commissioner or requested by the conservator. On completion of the final report, the association shall, as soon thereafter as is practicable, refund by line of business the remaining balance of those advances to the accounts maintained by the association.

Revisor's Note

Section 20(b), V.T.I.C. Article 21.28-C, 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. 462.166. USE OF EXCESS MONEY IN ACCOUNT. (a) If the

association determines that money in the account described by Section 462.164(b) for a line of business exceeds the amount reasonably necessary for efficient future operation under this chapter, the association shall, after deducting any premium tax credit taken under Section 462.157, return the excess money pro rata to the holders of participation receipts:

(1) on which an outstanding balance exists; and

(2) that were issued for an assessment on the same line of business as the line for which the excess money is found to exist.

(b) The association shall transfer an excess amount that exists in the account described by Section 462.164(b) to the comptroller to be deposited to the credit of the general revenue fund if:

(1) after a distribution under this section the association finds that an excess amount still exists; or

(2) participation receipts on which there is an outstanding balance do not exist. (V.T.I.C. Art. 21.28-C, Sec. 20(c).)

Source Law

(c) If the association at any time determines that there exist moneys in the account for any line of business in excess of those reasonably necessary for efficient future operation under the terms of this Act, it shall cause those excess moneys 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 in Section 21 of this Act, which receipts were issued for an assessment on the same line of business as that for which the excess moneys are found to exist. If after such a distribution the association finds that an excess amount still exists in the fund, or if there are no such participation receipts on which there is an outstanding balance, it shall cause the excess amount to be deposited with the comptroller to the credit of the general revenue fund.

Revisor's Note

Section 20(c), V.T.I.C. Article 21.28-C, refers to a determination made by the Texas Property and Casualty Insurance Guaranty Association "at any time." The revised law omits the reference to "at any time"

because a provision referring to a determination refers to a determination made at any time unless the provision expressly provides otherwise.

Revised Law

Sec. 462.167. COLLECTION OF ASSESSMENTS. (a) The commissioner may collect an assessment on behalf of the association through a suit brought for that purpose.

(b) Venue for a suit under this section is in Travis County.

(c) Either party to the suit may appeal to an appellate court. The appeal is at once returnable to the appellate court. The appeal has precedence in the appellate court over all causes of a different character pending before the court.

(d) The commissioner is not required to give an appeal bond in any cause of action arising under this section. (V.T.I.C. Art. 21.28-C, Sec. 18(d).)

Source Law

(d) Assessments may be collected on behalf of the association by the commissioner through suits brought for that purpose. Venue for those suits 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 causes of a different character pending before the court. The commissioner is not required to give an appeal bond in any cause arising under this subsection.

Revisor's Note

Section 18(d), V.T.I.C. Article 21.28-C, refers to "the appellate court having jurisdiction over the cause." The reference is omitted for the reason stated in Revisor's Note (4) to Section 462.004.

Revised Law

Sec. 462.168. EXEMPTION FOR IMPAIRED INSURER. An impaired insurer is exempt from assessment from the date the insurer is designated an impaired insurer until the date the commissioner determines that the insurer is no longer an impaired insurer. (V.T.I.C. Art. 21.28-C, Sec. 18(e).)

Source Law

(e) An insurer designated as an impaired insurer by the commissioner is exempt from assessment from and after the date of the designation and until the commissioner determines that the insurer is no longer an impaired insurer.

[Sections 462.169-462.200 reserved for expansion]

SUBCHAPTER E. COVERED CLAIMS; CLAIMANTS

Revised Law

Sec. 462.201. COVERED CLAIMS IN GENERAL. A claim is a covered claim if:

(1) the claim is an unpaid claim;

(2) the claim is made under an insurance policy to which this chapter applies that is:

(A) issued by an insurer authorized to engage in business in this state; or

(B) assumed by an insurer authorized to engage in business in this state that issues an assumption certificate to the insured;

(3) the claim arises out of the policy and is within the coverage and applicable limits of the policy;

(4) the insurer that issued the policy or assumed the policy under an assumption certificate issued to the insured is an impaired insurer; and

(5) the claim:

(A) is made by a liability claimant or insured who is a resident of this state at the time of the insured event; or

(B) is a first-party claim for damage to property that is permanently located in this state. (V.T.I.C. Art. 21.28-C, Sec. 5(8) (part).)

Source Law

(8) "Covered claim" means an unpaid claim of an insured or third-party liability claimant that arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this Act applies, issued or assumed (whereby an assumption certificate is issued to the insured) by an insurer licensed to do business in this state, if that insurer becomes an impaired insurer and the third-party claimant or liability claimant or insured

is a resident of this state at the time of the insured event, or the claim is a first-party claim for damage to property that is permanently located in this state. . . .

Revisor's Note

Section 5(8), V.T.I.C. Article 21.28-C, refers to a "third-party claimant or liability claimant." The portion of Section 5(8) revised in this subchapter as Section 462.305 uses the phrase "third-party liability claimant." In addition, under Section 5(5), V.T.I.C. Article 21.28-C, revised in this chapter as Section 462.004(4), "claimant" is defined to mean "any insured making a first-party claim or any person instituting a liability claim." Throughout this chapter, the revised law uses the phrase "liability claimant" for consistency and because, in context, "third-party claimant," "liability claimant," and "third-party liability claimant" are synonymous.

Revised Law

Sec. 462.202. CLAIM FOR UNEARNED PREMIUMS. (a) A claim for unearned premiums is a covered claim. A covered claim for unearned premiums may not exceed $25,000.

(b) With respect to a covered claim for unearned premiums, a person has a covered claim under this chapter if the person is a resident of this state at the time:

(1) the policy is issued; or

(2) the insurer is determined to be an impaired insurer. (V.T.I.C. Art. 21.28-C, Sec. 5(8) (part).)

Source Law

(8) . . . "Covered claim" shall also include unearned premiums, but in no event shall a covered claim for unearned premiums exceed 25,000. . . . With respect to a covered claim for unearned premiums, both persons who were residents of this state at the time the policy was issued and persons who are residents of this state at the time the company is found to be an impaired insurer shall be considered to have covered claims under this Act. . . .

Revised Law

Sec. 462.203. CERTAIN EXPENSES OF RECEIVERSHIP OR CONSERVATORSHIP ESTATE COVERED. An administration expense incurred in processing or paying a claim against a receivership or conservatorship estate is a covered claim if the impaired insurer has insufficient assets to pay the expenses of administering the estate. (V.T.I.C. Art. 21.28-C, Sec. 5(8) (part).)

Source Law

> (8) . . . If the impaired insurer has insufficient assets to pay the expenses of administering the receivership or conservatorship estate, that portion of the expenses of administration incurred in the processing and payment of claims against the estate shall also be a covered claim under this Act.

Revised Law

Sec. 462.204. AFFILIATE MAY NOT BE CLAIMANT. A person who is an affiliate of an impaired insurer may not be a claimant of the insurer. (V.T.I.C. Art. 21.28-C, Sec. 5(5) (part).)

Source Law

> (5) . . . A person who is an affiliate of the impaired insurer may not be a claimant.

Revised Law

Sec. 462.205. DETERMINATION OF RESIDENCE OF ENTITIES. A corporation or other entity that is not an individual is considered to be a resident of the state in which the entity's principal place of business is located. (V.T.I.C. Art. 21.28-C, Sec. 5(8) (part).)

Source Law

> (8) . . . A corporation or other entity that is not an individual is considered to be a resident of the state in which the entity's principal place of business is located. . . .

Revised Law

Sec. 462.206. CLAIMS NOT COVERED: PREMIUM UNDER RETROSPECTIVE RATING PLAN. An amount sought as a return of premium under a retrospective rating plan is not a covered claim. (V.T.I.C. Art. 21.28-C, Sec. 5(8) (part).)

Source Law

> (8) . . . "Covered claim" shall not

include any amount sought as a return of premium under a retrospective rating plan or . . . .

Revised Law

Sec. 462.207. CLAIMS NOT COVERED: AMOUNTS DUE CERTAIN ENTITIES. (a) Any amount due any reinsurer, insurer, self-insurer, insurance pool, or underwriting association, as a subrogation recovery, reinsurance recovery, contribution, or indemnification, or otherwise, is not a covered claim.

(b) An impaired insurer's insured is not liable, and the reinsurer, insurer, self-insurer, insurance pool, or underwriting association is not entitled to sue or continue a suit against the insured, for a subrogation recovery, reinsurance recovery, contribution, or indemnification to the extent of the applicable liability limits of the insurance policy written and issued to the insured by the insolvent insurer. (V.T.I.C. Art. 21.28-C, Sec. 5(8) (part).)

Source Law

(8) . . . "Covered claim" shall not include . . . any amount due any reinsurer, insurer, self-insurer, insurance pool, or underwriting association, as subrogation recoveries, reinsurance recoveries, contribution, indemnification, or otherwise, and the insured of an impaired insurer is not liable, and the reinsurer, insurer, self-insurer, insurance pool, or underwriting association is not entitled to sue or continue a suit against that insured, for any subrogation recovery, reinsurance recovery, contribution, or indemnity to the extent of the applicable liability limits of the policy written and issued to the insured by the insolvent insurer. . . .

Revised Law

Sec. 462.208. CLAIMS NOT COVERED: SUPPLEMENTARY PAYMENT OBLIGATIONS. A supplementary payment obligation, including an adjustment fee or expense, attorney's fee or expense, court cost, interest or penalty, or interest or bond premium, incurred before an insurer is determined to be an impaired insurer is not a covered claim. (V.T.I.C. Art. 21.28-C, Sec. 5(8) (part).)

Source Law

(8) . . . "Covered claim" shall not include supplementary payment obligations, including adjustment fees and expenses, attorney's fees and expenses, court costs, interest and penalties, and

interest and bond premiums incurred prior to the determination that an insurer is an impaired insurer under this Act. . . .

Revised Law

Sec. 462.209. CLAIMS NOT COVERED: PREJUDGMENT OR POSTJUDGMENT INTEREST. Prejudgment or postjudgment interest that accrues after an insurer is determined to be an impaired insurer is not a covered claim. (V.T.I.C. Art. 21.28-C, Sec. 5(8) (part).)

Source Law

(8) . . . "Covered claim" shall not include any prejudgment or postjudgment interest that accrues subsequent to the determination that an insurer is an impaired insurer under this Act. . . .

Revised Law

Sec. 462.210. CLAIMS NOT COVERED: CERTAIN DAMAGES. A claim against the insured, insurer, guaranty association, receiver, special deputy receiver, or commissioner for recovery of punitive, exemplary, extracontractual, or bad-faith damages awarded in a court judgment against an insured or insurer is not a covered claim. (V.T.I.C. Art. 21.28-C, Sec. 5(8) (part).)

Source Law

(8) . . . "Covered claim" shall not include any claim for recovery of punitive, exemplary, extracontractual, or bad-faith damages, whether sought as a recovery against the insured, insurer, guaranty association, receiver, special deputy receiver, or commissioner, awarded in a court judgment against an insured or insurer. . . .

Revised Law

Sec. 462.211. CLAIMS NOT COVERED: LATE FILED CLAIMS. (a) Notwithstanding any other provision of this chapter and except as provided by Subsection (b), a claim filed with the association on a date that is later than 18 months after the date of the order of liquidation is not a covered claim.

(b) This section does not apply to a claim for workers' compensation benefits governed by Title 5, Labor Code, and the applicable rules of the Texas Workers' Compensation Commission. (V.T.I.C. Art. 21.28-C, Sec. 8(d) (part).)

Source Law

(d) . . . Notwithstanding any other provision

of this Act, a covered claim shall not include any claim filed with the guaranty association on a date that is later than eighteen months after the date of the order of liquidation, except that a claim for workers' compensation benefits is governed by Title 5, Labor Code, and the applicable rules of the Texas Workers' Compensation Commission.

Revised Law

Sec. 462.212. NET WORTH EXCLUSION. (a) The association is not liable to pay a first-party claim of an insured whose net worth on December 31 of the year preceding the date the insurer becomes an impaired insurer exceeds $50 million.

(b) For purposes of this section, an insured's net worth includes the aggregate net worth of the insured and the insured's parent, subsidiary, and affiliated companies, computed on a consolidated basis.

(c) This section does not exclude the payment of a covered claim for workers' compensation benefits otherwise payable under this chapter. (V.T.I.C. Art. 21.28-C, Sec. 11A.)

Source Law

Sec. 11A. (a) The association is not liable to pay a first-party claim of an insured whose net worth on December 31 of the year next preceding the date the insurer becomes an impaired insurer exceeds $50 million.

(b) The net worth of an insured for purposes of this section includes the aggregate net worth of the insured and all the insured's parent, subsidiary, and affiliated companies computed on a consolidated basis.

(c) This section does not exclude the payment of a covered claim for workers' compensation benefits otherwise payable under this Act.

Revisor's Note

Section 11A, V.T.I.C. Article 21.28-C, refers to December 31 of "the year next preceding." The revised law omits "next" for the reason stated in Revisor's Note (2) to Section 462.004.

Revised Law

Sec. 462.213. AMOUNT OF INDIVIDUAL COVERED CLAIM; LIMIT. (a) Except as provided by Subsection (b) and Section 462.252, an individual covered claim may not exceed $300,000.

(b) The association shall pay the full amount of a covered claim arising out of a workers' compensation claim made under a

workers' compensation insurance policy.

(c) For purposes of this section, an individual covered claim includes any derivative claims by more than one person that arise from the same occurrence. The claims shall be considered collectively as a single claim under this chapter. (V.T.I.C. Art. 21.28-C, Sec. 5(8) (part).)

Source Law

> (8) . . . Individual covered claims (including any and all derivative claims by more than one person which arise from the same occurrence, which shall be considered collectively as a single claim under this Act) shall be limited to $300,000, except that the association shall pay the full amount of any covered claim arising out of a workers' compensation claim made under a workers' compensation policy. . . .

Revised Law

Sec. 462.214. CERTAIN SHAREHOLDERS' CLAIMS: LIMIT. Notwithstanding any other provision of this chapter, the association's liability for shareholder derivative actions or other claims for economic loss incurred by a claimant in the claimant's capacity as a shareholder under an insurance policy placed in force on or after January 1, 1992, is limited to $300,000 for each policy, including defense costs, regardless of the number of claimants under each policy. (V.T.I.C. Art. 21.28-C, Sec. 5(8) (part).)

Source Law

> (8) . . . Notwithstanding any other provision of this Act, the association's liability for shareholder derivative actions or other claims for economic loss incurred by a claimant in the claimant's capacity as a shareholder under an insurance policy placed in force on or after January 1, 1992, is limited to $300,000 for each policy, inclusive of defense costs, regardless of the number of claimants under each policy. . . .

[Sections 462.215-462.250 reserved for expansion]

SUBCHAPTER F. NONDUPLICATION OF RECOVERY

Revised Law

Sec. 462.251. EXHAUSTION OF RIGHTS UNDER OTHER POLICY REQUIRED. (a) Any person who has a claim under an insurance policy, other than an impaired insurer's policy, and whose claim

arises from the same facts, injury, or loss giving rise to a claim against an impaired insurer or the insurer's insured, must first exhaust the person's rights under the insurance policy, including:

(1) a claim for benefits under a workers' compensation insurance policy or a claim for indemnity or medical benefits under a health, disability, uninsured motorist, personal injury protection, medical payment, liability, or other insurance policy; and

(2) the right to defense under the insurance policy.

(b) Subsection (a) applies without regard to whether the insurance policy is issued by a member insurer. (V.T.I.C. Art. 21.28-C, Sec. 12(a) (part).)

Source Law

> Sec. 12. (a) Any person who has a claim under an insurance policy, without regard to whether the policy is issued by a member insurer, other than a policy of an impaired insurer, that arises from the same facts, injury, or loss that gave rise to a claim against an impaired insurer or its insured, is required to first exhaust the person's rights under the policy, including any claim for indemnity or medical benefits under any workers' compensation, health, disability, uninsured motorist, personal injury protection, medical payment, liability, or other policy, and the right to defense under the policy. . . .

Revisor's Note

Section 12(a), V.T.I.C. Article 21.28-C, refers to a claim for "indemnity or medical benefits under any workers' compensation, health, disability, uninsured motorist, personal injury protection, medical payment, liability, or other policy." The revised law omits the reference to "indemnity or medical" with respect to benefits under a workers' compensation insurance policy as unnecessary and misleading. Under Section 401.011(5), Labor Code, "benefit" under a workers' compensation insurance policy is defined to mean medical benefits and other specified benefits that would be considered indemnity benefits, but are not explicitly referred to as indemnity benefits.

Revised Law

Sec. 462.252. REDUCTION IN AMOUNT OF COVERED CLAIM FOR OTHER POLICY. (a) Except as provided by Subsection (b), an amount payable as a covered claim under this chapter is reduced by the full applicable limits of another insurance policy described by Section 462.251, and the association shall receive a full credit in the amount of the full applicable limits of the other policy.

(b) A covered claim for workers' compensation benefits is subject to reduction only by a third-party liability recovery under Section 417.002, Labor Code.

(c) Subject to Section 462.255, the maximum amount payable by the association is the damages incurred by the claimant, less the association's credit or offset under this section, except that the association's liability may not exceed the lesser of:

(1) $300,000; or

(2) the limits of the insurance policy under which the claim is made. (V.T.I.C. Art. 21.28-C, Sec. 12(a) (part).)

Source Law

> (a) . . . An amount payable as a covered claim under this Act is reduced by the full applicable limits of the other insurance policy and the association shall receive a full credit in the amount of the full applicable limits, except that a covered claim for workers' compensation benefits is subject only to reduction by a third-party liability recovery under Section 417.002, Labor Code. Subject to the provisions of Subsection (a-1) below, the association's credit or setoff under this section shall be deducted from damages incurred by the claimant, and the remaining sum shall be the maximum amount payable by the association, except that the association's liability shall not exceed $300,000 or the limits of the policy under which the claim is made, whichever is less. . . .

Revisor's Note

Section 12(a), V.T.I.C. Article 21.28-C, refers to the Texas Property and Casualty Insurance Guaranty Association's "credit or setoff." Section 12(a-1), revised in this chapter as Section 462.255, refers to the same amount, but uses the phrase "credit or offset." For consistency and clarity, the revised law

substitutes "offset" for "setoff" throughout this chapter.

Revised Law

Sec. 462.253. EFFECT ON INSURED OF REDUCTION IN AMOUNT OF COVERED CLAIM. To the extent that the association's obligation is reduced by the application of Sections 462.251 and 462.252, the liability of the person insured by the impaired insurer's policy for the claim is reduced in the same amount. (V.T.I.C. Art. 21.28-C, Sec. 12(a) (part).)

Source Law

> (a) . . . To the extent that the association's obligation is reduced by the application of this subsection, the liability of the person insured by the impaired insurer's policy for the claim is reduced in the same amount.

Revised Law

Sec. 462.254. RECOVERY FROM MORE THAN ONE GUARANTY ASSOCIATION. (a) Except as provided by Subsections (b) and (c), a person who has a claim that may be recovered from more than one insurance guaranty association or the equivalent shall seek recovery first from the association of the insured's residence.

(b) A claimant shall seek recovery of a first-party claim for damage to property with a permanent location first from the association of the location of the property.

(c) A claimant shall seek recovery of a workers' compensation claim first from the association of the claimant's residence.

(d) The association has a credit or offset against the benefits under this chapter in the amount of the claimant's recovery under this section.

(e) Subject to Section 462.255, the maximum amount payable by the association is the amount of damages incurred by the claimant, less the credit or offset, except that the association's liability may not exceed $300,000. (V.T.I.C. Art. 21.28-C, Sec. 12(b).)

Source Law

(b) A person who has a claim that may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first-party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property, and if it is a workers' compensation claim the person shall seek recovery first from the association of the residence of the claimant. The association shall have a credit or setoff against any amount of benefits under this Act, in the amount of the claimant's recovery from the guaranty association or equivalent. Subject to the provisions of Subsection (b-1) below, the association's credit or setoff under this Section shall be deducted from the damages incurred by the claimant, and the remaining sum shall be the maximum amount payable by the association, except that the association's liability shall not exceed $300,000.

Revised Law

Sec. 462.255. CERTAIN CLAIMS SUBJECT TO LIEN OR SUBROGATION; LIMIT ON TOTAL RECOVERY. (a) Notwithstanding Sections 462.252(c) and 462.254(e), if a claimant is seeking recovery of insurance policy benefits that, had the impaired insurer not been insolvent, would be subject to lien or subrogation by any other insurer, including a workers' compensation insurer or health insurer, regardless of whether the other insurer is impaired, the association's credit or offset is deducted from the lesser of the damages incurred by the claimant or the limits of the policy under which the claim is made.

(b) A claimant's recovery under this chapter may not result in a total recovery to the claimant that is greater than the recovery that would have resulted had the impaired insurer not been insolvent.

(c) Subject to Sections 462.201-462.203, 462.205-462.210, 462.213, 462.214, and 462.305 of this code and Title 5, Labor Code, a claim for workers' compensation benefits under this chapter may not result in a recovery to the claimant that is less than the recovery that would have resulted had the impaired insurer not been insolvent. (V.T.I.C. Art. 21.28-C, Secs. 12(a-1), (b-1).)

Source Law

(a-1) Notwithstanding Subsection (a) of this section, if a claimant is seeking recovery of policy benefits that, but for the insolvency of the impaired insurer, would be subject to lien or subrogation by a workers' compensation insurer, health insurer or any other insurer, whether impaired or not, then the association's credit or offset shall be deducted from the damages incurred by the claimant or the limits of the policy under which the claim is made, whichever is less. In no event shall a claimant's recovery under this Act result in a total recovery to the claimant that is greater than that which would have resulted but for the insolvency of the impaired insurer. Subject to Section 5(8) of this Act and Title 5, Labor Code, a claim for workers' compensation benefits under this Act may not result in a recovery to the claimant that is less than that which would have resulted but for the insolvency of the impaired insurer.

(b-1) Notwithstanding Subsection (b) of this section, if a claimant is seeking recovery of policy benefits that, but for the insolvency of the impaired insurer, would be subject to lien or subrogation by a workers' compensation insurer, health insurer or any other insurer, whether impaired or not, then the association's credit or offset shall be deducted from the damages incurred by the claimant or the limits of the policy under which the claim is made, whichever is less. In no event shall a claimant's recovery under this Act result in a total recovery to the claimant that is greater than that which would have resulted but for the insolvency of the impaired insurer. Subject to Section 5(8) of this Act and Title 5, Labor Code, a claim for workers' compensation benefits under this Act shall not result in a recovery to the claimant that is less than that which would have resulted but for the insolvency of the impaired insurer.

Revisor's Note

Sections 12(a-1) and (b-1), V.T.I.C. Article 21.28-C, establish the manner of computing a credit or offset in specific circumstances. Section 12(a-1) states that it applies "[n]otwithstanding Subsection (a) of this section," meaning Subsection (a) of Section 12, V.T.I.C. Article 21.28-C, revised in this subchapter as Sections 462.251, 462.252, and 462.253. Section 12(b-1) states that it applies "[n]otwithstanding Subsection (b) of this section," meaning Subsection (b) of Section 12, V.T.I.C. Article 21.28-C, revised in this subchapter as Section 462.254. The revised law substitutes references to Section 462.252(c) and 462.254(e), respectively,

because these are the provisions that relate generally to computing the relevant credits or offsets.

[Sections 462.256-462.300 reserved for expansion]

SUBCHAPTER G. ASSOCIATION POWERS AND DUTIES RELATING TO COVERED CLAIMS

Revised Law

Sec. 462.301. GENERAL POWERS AND DUTIES OF ASSOCIATION IN CONNECTION WITH PAYMENT OF COVERED CLAIMS. (a) The association shall investigate and adjust, compromise, settle, and pay covered claims 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 insurer or the impaired insurer's insured was a party to determine the extent to which the settlement, release, or judgment may be properly contested. (V.T.I.C. Art. 21.28-C, Sec. 8(d) (part).)

Source Law

> (d) The association shall investigate and 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 its insureds were parties to determine the extent to which those settlements, releases, and judgments may be properly contested. . . .

Revised Law

Sec. 462.302. PAYMENT OF COVERED CLAIMS. (a) The association shall pay covered claims that exist before the designation of impairment or that arise:

(1) not later than the 30th day after the date of the designation of impairment;

(2) before the insurance policy expiration date, if that date is not later than the 30th day after the date of the designation of impairment; or

(3) before the insured replaces the insurance policy or causes the policy's cancellation, if the insured does so not later than the 30th day after the date of the designation of

impairment.

(b) The association satisfies the obligation to pay a covered claim by paying the claimant the full amount of a covered claim for benefits.

(c) The association's liability is limited to the payment of covered claims. The association is not liable for any other claim or damages against the insured, an impaired insurer, the association, the receiver, the special deputy receiver, the commissioner, or the liquidator, including a claim for:

(1) recovery of attorney's fees, prejudgment or postjudgment interest, or penalties;

(2) extracontractual damages, multiple damages, or exemplary damages; or

(3) any other amount sought in connection with the assertion or prosecution of a claim, without regard to whether the claim is a covered claim, by or on behalf of:

(A) an insured or claimant; or

(B) a provider of goods or services retained by an insured or claimant.

(d) The association shall pay claims in the order the association considers reasonable, including paying as claims are received from the claimants or in groups or categories of claims.

(e) This section does not exclude the payment of workers' compensation benefits or other liabilities or penalties authorized by Title 5, Labor Code, arising from the association's processing and paying workers' compensation benefits after the designation of impairment. (V.T.I.C. Art. 21.28-C, Secs. 8(a), (c) (part).)

Source Law

Sec. 8. (a) The association shall pay covered claims that exist before the designation of impairment or that arise within 30 days after the date of the designation of impairment, before the policy expiration date if the policy expiration date is within 30 days after the date of the designation of impairment, or before the insured replaces the policy or causes its cancellation if the insured does so within 30 days after the date of the designation. The obligation is satisfied by paying to the claimant the full amount of a covered claim for benefits. The

association's liability is limited to the payment of covered claims. The association has no liability for any other claim or damages, including claims for recovery of attorney's fees, prejudgment or postjudgment interest, or penalties, extracontractual damages, multiple damages, or exemplary damages, or any other amount sought by or on behalf of any insured or claimant or any other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claims, without regard to whether the claims are covered, against the insured or an impaired insurer, the impaired insurer, the guaranty association, the receiver, the special deputy receiver, the commissioner, or the liquidator. This subsection does not exclude the payment of workers' compensation benefits or other liabilities or penalties authorized by Title 5, Labor Code, arising from the association's processing and payment of workers' compensation benefits after the designation of impairment.

(c) . . . The association shall pay claims in any order it considers reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. . . .

Revised Law

Sec. 462.303. CERTAIN DETERMINATIONS NOT BINDING. (a) The association is not bound by:

(1) a judgment taken before the designation of impairment in which an insured under a liability insurance policy or the insurer failed to exhaust all appeals;

(2) a judgment taken by default or consent against an insured or the impaired insurer; or

(3) a judgment, settlement, or release entered into by the insured or the impaired insurer.

(b) A judgment, settlement, or release described by Subsection (a) is not evidence of liability or of damages in connection with a claim brought against the association or another party under this chapter. (V.T.I.C. Art. 21.28-C, Sec. 8(d) (part).)

Source Law

(d) . . . Any judgment taken before the designation of impairment in which an insured under a liability policy or the insurer failed to exhaust all appeals, any 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, is not binding on the association, and may not be considered as evidence of liability or of damages in connection with any claim brought against the association or any other party

under this Act. . . .

Revised Law

Sec. 462.304. SERVICING FACILITY. (a) The association shall handle claims through the association's employees or through one or more insurers or other persons designated, subject to the approval of the commissioner, as servicing facilities.

(b) A member insurer may decline designation as a servicing facility.

(c) The association shall:

(1) reimburse a servicing facility for:

(A) obligations of the association paid by the facility; and

(B) expenses incurred by the facility in handling claims for the association; and

(2) pay the other expenses of the association authorized by this chapter.

(d) The commissioner may revoke the designation of a servicing facility if the commissioner finds that servicing facility is handling claims unsatisfactorily. (V.T.I.C. Art. 21.28-C, Secs. 8(f), (g), 10(e).)

Source Law

[Sec. 8]

(f) The association shall 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, but such a designation may be declined by a member insurer.

(g) 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 and shall pay the other expenses of the association authorized by this Act.

[Sec. 10]

(e) The commissioner may revoke the designation of any servicing facility if the commissioner finds that claims are being handled unsatisfactorily.

Revised Law

Sec. 462.305. LIMITATION OF ASSOCIATION'S LIABILITY. The association is not liable to an insured or liability claimant for the association's failure to settle a liability claim within the

limits of a covered claim under this chapter. A claim described by this section for failure to settle a liability claim is not a covered claim. (V.T.I.C. Art. 21.28-C, Sec. 5(8) (part).)

Source Law

> (8) . . . "Covered claim" shall not include, and the association shall not have any liability to an insured or third-party liability claimant, for its failure to settle a liability claim within the limits of a covered claim under this Act. . . .

Revised Law

Sec. 462.306. DISCHARGE OF POLICY OBLIGATION. (a) The association shall discharge an impaired insurer's policy obligations, including the duty to defend insureds under a liability insurance policy, to the extent that the policy obligation is a covered claim under this chapter.

(b) In performing the association's statutory obligations, the association may also enforce a duty imposed on the insured or beneficiary under the terms of an insurance policy within the scope of this chapter. (V.T.I.C. Art. 21.28-C, Sec. 8(b) (part).)

Source Law

> (b) The association shall undertake to discharge the policy obligations of the impaired insurer, including the duty to defend insureds under a liability policy, to the extent that the policy obligations are covered claims under this Act. In performing its statutory obligations, the association may also enforce any duty imposed on the insured party or beneficiary under the terms of any policy of insurance within the scope of this Act. . . .

Revised Law

Sec. 462.307. ASSIGNMENT OF RIGHTS. (a) A person recovering under this chapter assigns to the association the person's rights:

(1) under the insurance policy; and

(2) to recover for the occurrence that is the basis of the claim under this chapter under an insurance policy issued by an unimpaired insurer to the extent of the person's recovery from the association.

(b) The association may pursue a claim to which the

association is subrogated under Subsection (a) in the association's own name or in the name of the person recovering under this chapter.

(c) An insured or claimant seeking the protection of this chapter shall cooperate with the association to the same extent as that person would have been required to cooperate with the impaired insurer.

(d) Except as provided by Section 462.308, the association does not have a cause of action against the impaired insurer's insured for money the association has paid, other than a cause of action that the impaired insurer would have had if the money had been paid by the impaired insurer.

(e) In the case of an impaired insurer operating on a plan with assessment liability, the payment of a claim of the association does not reduce the liability of the insured to the receiver or statutory successor for an unpaid assessment. (V.T.I.C. Art. 21.28-C, Sec. 11(a).)

Source Law

> Sec. 11. (a) A person recovering under this Act is considered to have assigned to the association the person's right under the policy, and the person's rights to recover for the occurrence made the basis of the claim under this Act under any policy of insurance issued by an unimpaired insurer to the extent of the person's recovery from the association. The association may pursue any such claims to which it is subrogated under this provision in its own name or in the name of the person recovering under this Act. Each insured or claimant seeking the protection of this Act shall cooperate with the association to the same extent as that person would have been required to cooperate with the impaired insurer. The association does not have a cause of action against the insured of the impaired insurer for any sums it has paid out except those causes of action the impaired insurer would have had if the sums had been paid by the impaired insurer and except as provided in Subsection (b) of this section. In the case of an impaired insurer operating on a plan with assessment liability, payments of claims of the association do not reduce the liability of the insureds to the receiver or statutory successor for unpaid assessments.

Revised Law

Sec. 462.308. RECOVERY FROM CERTAIN PERSONS. (a) The association is entitled to recover the amount of a covered claim and the cost of defense paid under this chapter from the person on whose

behalf the payment was made if the person is:

(1) a person:

(A) who is an affiliate of the impaired insurer; and

(B) whose liability obligations to other persons are satisfied wholly or partly by payment made under this chapter; or

(2) an insured:

(A) whose net worth on December 31 of the year preceding the date the insurer becomes an impaired insurer exceeds $50 million; and

(B) whose obligations under a liability policy or contract of insurance written, issued, and placed in force after January 1, 1992, are satisfied wholly or partly by payment made under this chapter.

(b) The association is not entitled to recover under Subsection (a)(2) against an insured who is exempt from federal income tax under Section 501(a), Internal Revenue Code of 1986, by being described by Section 501(c)(3) of that code.

(c) For purposes of Subsection (a)(2), an insured's net worth includes the aggregate net worth of the insured and the insured's parent, subsidiary, and affiliated companies, computed on a consolidated basis. (V.T.I.C. Art. 21.28-C, Sec. 11(b).)

Source Law

(b) The association is entitled to recover from the following persons the amount of any covered claim and costs of defense paid on behalf of that person under this Act:

(1) any insured, other than an insured who is exempt from federal income tax under Section 501(a) of the Internal Revenue Code of 1986 (26 U.S.C. Section 501(a)) by being described by Section 501(c)(3) of that code, whose net worth on December 31 of the year next preceding the date the insurer becomes an impaired insurer exceeds $50 million, provided that an insured's net worth on that date is considered to include the aggregate net worth of the insured and all the insured's parent, subsidiary, and affiliated companies as computed on a consolidated basis, and whose obligations under a liability policy or contract of insurance written, issued, and placed in force after January 1, 1992, are satisfied in whole or in part by payments made under this Act; and

(2) any person who is an affiliate of the impaired insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this Act.

Revisor's Note

Section 11(b), V.T.I.C. Article 21.28-C, refers to December 31 of "the year next preceding." The revised law omits "next" for the reason stated in Revisor's Note (2) to Section 462.004.

Revised Law

Sec. 462.309. STAY OF PROCEEDINGS; CERTAIN DECISIONS NOT BINDING. (a) To permit the association to properly defend a pending cause of action, a proceeding in which an impaired insurer 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) a subsequent period as determined by the court, if any.

(b) The stay applies to each party to the proceeding and the proceeding is stayed for all purposes.

(c) A deadline imposed under the Texas Rules of Civil Procedure or the Texas Rules of Appellate Procedure is tolled during the stay.

(d) The court in which the delinquency proceeding is pending has exclusive jurisdiction regarding the application, enforcement, and extension of the stay and may issue an injunction or another similar order to enforce the stay.

(e) The commissioner may bring an ancillary delinquency proceeding under Sections 442.751, 442.752, and 442.754 for the limited purpose of determining the application, enforcement, and extension of the stay to an impaired insurer that is not domiciled in this state.

(f) With respect to a covered claim arising from a judgment,

order, decision, verdict, or finding based on the default of an impaired insurer or an impaired insurer's failure to defend the insured, the association, on the association's own behalf or on behalf of an insured and on application, shall be entitled to:

(1) have the court or administrator that made the judgment, order, decision, verdict, or finding set aside the judgment, order, decision, verdict, or finding; and

(2) defend the claim on the merits. (V.T.I.C. Art. 21.28-C, Secs. 17(a), (b) (part).)

Source Law

> Sec. 17. (a) 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 as to all parties and for all purposes 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 association of all pending causes of action. A deadline imposed under the Texas Rules of Civil Procedure or the Texas Rules of Appellate Procedure is tolled during the stay. The court in which the delinquency proceeding is pending has exclusive jurisdiction regarding the application, enforcement, and extension of the stay and may issue injunctions or other similar orders to enforce the stay. If the impaired insurer is not domiciled in this state, the commissioner may bring an ancillary delinquency proceeding under Section 13, Article 21.28 of this code, for the limited purpose of determining the application, enforcement, and extension of the stay.
>
> (b) 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 shall be entitled, upon application, 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. 462.310. SETTLEMENT BY ASSOCIATION BINDING; PRIORITY OF CLAIM AND EXPENSES. (a) The settlement of a covered claim by the association or a similar organization in another state binds the receiver or statutory successor of an impaired insurer.

(b) The court having jurisdiction shall give the covered claim the same priority against assets of the impaired insurer that

the claim would have had in the absence of this chapter.

(c) The expenses of the association or a similar organization in another state in handling claims have the same priority as the receiver's expenses. (V.T.I.C. Art. 21.28-C, Sec. 11(c).)

Source Law

> (c) The receiver or statutory successor of an impaired insurer is bound by settlements of covered claims by the association or a similar organization in another state. The court having jurisdiction shall grant those claims priority equal to that which the claimant would have been entitled to in the absence of this Act against the assets of the impaired insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the receiver's expenses.

Revisor's Note

Section 11(c), V.T.I.C. Article 21.28-C, 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 462.004.

Revised Law

Sec. 462.311. REPORT TO RECEIVER. The association shall periodically file with the receiver of an impaired insurer 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 impaired insurer. (V.T.I.C. Art. 21.28-C, Sec. 11(d).)

Source Law

> (d) 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 462.312-462.350 reserved for expansion]

SUBCHAPTER H. RELEASE FROM RECEIVERSHIP

Revised Law

Sec. 462.351. ISSUANCE OF POLICIES AFTER RELEASE FROM RECEIVERSHIP. (a) Except as provided by Subsection (b), an impaired insurer placed in receivership for which money has been

advanced under this chapter may not be authorized, on release from receivership, to issue new or renewal insurance policies until the insurer repays the advances to the association.

(b) On application of the association and after hearing, the commissioner may permit the insurer to issue new insurance policies in accordance with the insurer's plan of operation for repayment of advances.

(c) The commissioner, in approving the plan of operation, may place restrictions on the issuance of new or renewal insurance policies as the commissioner considers necessary to implement the plan. (V.T.I.C. Art. 21.28-C, Sec. 22.)

Source Law

> Sec. 22. An impaired insurer placed in receivership for which advances have been made under this Act may not be authorized, on release from receivership, to issue new or renewal insurance policies until the impaired insurer has repaid in full to the association the funds advanced by it. However, the commissioner may, on application of the association and after hearing, permit the issuance of new policies in accordance with a plan of operations by the released insurer for repayment of advances. The commissioner, in approving the plan, may place restrictions on the issuance of new or renewal policies as the commissioner considers necessary to the implementation of the plan.

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CHAPTER 463. LIFE, ACCIDENT, HEALTH, AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 463.001. SHORT TITLE. This chapter may be cited as the Life, Accident, Health, and Hospital Service Insurance Guaranty Association Act. (V.T.I.C. Art. 21.28-D, Sec. 1.)

Source Law

Art. 21.28-D

Sec. 1. This Act shall be known and may be cited as the Life, Accident, Health, and Hospital Service Insurance Guaranty Association Act.

Revised Law

Sec. 463.002. PURPOSE. The purpose of this chapter is to protect, subject to certain limitations, a person specified by Section 463.201 against failure in the performance of a contractual obligation under a life, accident, or health insurance policy or annuity contract with respect to which this chapter provides coverage as determined under Subchapter E, because of the impairment or insolvency of the member insurer that issued the policy or contract. (V.T.I.C. Art. 21.28-D, Sec. 2 (part).)

Source Law

Sec. 2. The purpose of this Act is to protect, subject to certain limitations, the persons specified in Section 3(a) of this Act against failure in the performance of contractual obligations, under life, accident, and health insurance policies and annuity contracts specified in Section 3(b) of this Act, because of the impairment or insolvency of the member insurer that issued the policies or contracts. . . .

Revisor's Note

Section 2, V.T.I.C. Article 21.28-D, refers to life, accident, and health insurance policies and annuity contracts "specified in Section 3(b) of this Act" in describing the policies and contracts with respect to which Article 21.28-D provides coverage.

However, other provisions of Article 21.28-D, including other provisions of Sections 3 and 5, also determine the policies and contracts with respect to which the article provides coverage. The relevant provisions are revised in Subchapter E of this chapter. For the convenience of the reader and to more accurately describe the policies and contracts with respect to which this chapter provides coverage, the revised law substitutes a reference to a policy or contract "with respect to which this chapter provides coverage as determined under Subchapter E" for the quoted language. Similar changes are made throughout this chapter.

Revised Law

Sec. 463.003. DEFINITIONS. In this chapter:

(1) "Association" means the Life, Accident, Health, and Hospital Service Insurance Guaranty Association.

(2) "Board" means the board of directors of the association.

(3) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or part of a policy or contract or certificate, for which coverage is provided under Subchapter E.

(4) "Covered policy" means a policy or contract with respect to which this chapter provides coverage as determined under Subchapter E.

(5) "Impaired insurer" means a member insurer that:

(A) is placed under an order of supervision, liquidation, rehabilitation, or conservation under Chapter 441 or 442 and is designated by the commissioner as an impaired insurer; or

(B) is determined in good faith by the commissioner to be unable or potentially unable to fulfill the insurer's contractual obligations.

(6) "Insolvent insurer" means a member insurer that:

(A) has a minimum free surplus, if a mutual insurance company, or required capital, if a stock insurance company, that is impaired to an extent prohibited by law; and

(B) the commissioner designates as an insolvent insurer.

(7) "Member insurer" means an insurer that is required to participate in the association under Section 463.052.

(8) "Person" means an individual, corporation, partnership, association, or voluntary organization.

(9) "Premium" means an amount received on a covered policy, less any premium, consideration, or deposit returned on the policy, and any dividend or experience credit on the policy. The term does not include:

(A) an amount received for a part of a policy or contract for which coverage is not provided under Section 463.202, except that assessable premiums may not be reduced because of:

(i) an interest limitation provided by Section 463.203(b)(3); or

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

(B) premiums in excess of $5 million on an unallocated annuity contract not issued under a governmental retirement plan established under Section 401, 403(b), or 457, Internal Revenue Code of 1986; or

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

(i) provide welfare benefits to designated welfare recipients; or

(ii) implement Title 2, Human Resources Code, or the Social Security Act (42 U.S.C. Section 301 et seq.).

(10) "Resident" means a person who resides in this state at the time a member insurer that owes a contractual

obligation to the person is determined to be impaired or insolvent. For the purposes of this subdivision:

(A) a person is considered to be a resident of only one state; and

(B) a person other than an individual is considered to be a resident of the state in which the person's principal place of business is located.

(11) "Supplemental contract" means an agreement for the distribution of policy or contract proceeds.

(12) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate. (V.T.I.C. Art. 21.28-D, Secs. 5(2), (3) (part), (4), (5), (6), (7) (part), (9), (10), (11), (12), (13); New.)

Source Law

Sec. 5. As used in this Act:

> (2) "Association" means the Life, Accident, Health, and Hospital Service Insurance Guaranty Association created under Section 6 of this Act.
>
> (3) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under Section 3 of this Act. . . .
>
> (4) "Covered policy" means any policy or contract within the scope of this Act under Section 3 of this Act.
>
> (5) "Impaired insurer" means:
>
> (A) a member insurer that is placed by the commissioner under an order of supervision, liquidation, rehabilitation, or conservation under the provisions of Article 21.28 or 21.28-A, Insurance Code, and that has been designated an "impaired insurer" by the commissioner; or
>
> (B) a member insurer determined in good faith by the commissioner to be unable or potentially unable to fulfill its contractual obligations.
>
> (6) "Insolvent insurer" means a member insurer whose minimum free surplus, if a mutual company, or whose required capital, if a stock company, becomes impaired to the extent prohibited by law and that has been designated an "insolvent insurer" by the commissioner.
>
> (7) "Member insurer" means any insurer [licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Section 3 of this Act, and]

. . . .

(9) "Person" means any individual, corporation, partnership, association, or voluntary organization.

(10) "Premiums" means amounts received on covered policies or contracts less premiums, considerations, and deposits returned on those policies or contracts, and less dividends and experience credits on those policies or contracts. "Premiums" does not include amounts received for policies or contracts or for the portions of any policies or contracts for which coverage is not provided under Section 3(b) of this Act, except that assessable premiums shall not be reduced on account of Section 3(c)(3) of this Act relating to interest limitations and Section 5(3) of this Act relating to limitations with respect to any one individual, any one participant, any one annuitant, and any one contract holder. "Premiums" does not include premiums in excess of five million dollars on any unallocated annuity contract not issued under a governmental retirement plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code (26 U.S.C. Sections 401, 403(b) and 457). "Premiums" also does 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.

(11) "Resident" means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. A person may be a resident of only one state, which in the case of a person other than a natural person is its principal place of business.

(12) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.

(13) "Unallocated annuity contract" means any annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Revisor's Note

(1) Section 5(1), V.T.I.C. Article 21.28-D, defines "account" to mean certain specific accounts created under this chapter. The revised law omits the definition and incorporates the substance of the definition in the references to "account." The omitted law reads:

> (1) "Account" means the four accounts created under Section 6 of this Act.

(2) Section 5(2), V.T.I.C. Article 21.28-D, refers to the Life, Accident, Health, and Hospital Service Insurance Guaranty Association "created under Section 6 of this Act." The revised law omits the quoted language as executed.

(3) The definition of "board" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

(4) Sections 5(3) and (4), V.T.I.C. Article 21.28-D, refer to coverage provided under "Section 3 of this Act" and within "the scope of this Act under Section 3 of this Act," respectively. Because Section 3, Article 21.28-D, is revised as part of Subchapter E of this chapter, the revised law substitutes "Subchapter E" for those references and similar references throughout this chapter. Although portions of Subchapter E are derived from provisions other than Section 3, the other provisions included in Subchapter E are related to the determination of whether coverage is provided, and the scope of this law, under Section 3, and it is appropriate to include those provisions in the substituted cross-reference.

(5) Section 5(5), V.T.I.C. Article 21.28-D, refers to an insurer being placed "by the commissioner" under an order of supervision, liquidation, rehabilitation, or conservation. The revised law omits the reference to the commissioner of insurance with respect to an order of liquidation as inaccurate because that order is issued by a court, not the commissioner. The revised law also omits the reference to the commissioner with respect to orders of supervision, rehabilitation, and conservation as unnecessary because the commissioner is the only

person authorized to issue those orders.

(6) Section 5(6), V.T.I.C. Article 21.28-D, refers to a "mutual company" and a "stock company." For consistent use of terminology in this code, the revised law substitutes "mutual insurance company" and "stock insurance company" for "mutual company" and "stock company," respectively.

(7) Section 5(10), V.T.I.C. Article 21.28-D, refers to "covered policies or contracts." Throughout this chapter, the revised law omits "or contract[s]" in this context because the definition of "covered policy" in Section 5(4), Article 21.28-D, revised in this section as Subdivision (4), includes a contract.

(8) Section 5(11), V.T.I.C. Article 21.28-D, refers to a "natural person." Throughout this chapter, the revised law substitutes "individual" for "natural person" for consistency with the terminology used in this code.

Revised Law

Sec. 463.004. CONSTRUCTION. This chapter shall be liberally construed to implement the purpose of this chapter described by Section 463.002. Section 463.002 shall be used to aid and guide interpretation of this chapter. (V.T.I.C. Art. 21.28-D, Sec. 4.)

Source Law

Sec. 4. This Act shall be liberally construed to effect the purpose under Section 2 of this Act. Section 2 of this Act shall be used as an aid and guide to interpretation.

Revised Law

Sec. 463.005. IMMUNITY. (a) The following persons are not liable, and a cause of action does not arise against any of the following persons, for a good faith act or omission in exercising powers and performing duties under this chapter:

(1) the commissioner or the commissioner's

representative;

(2) the association or the association's agent or employee;

(3) a member insurer or the insurer's agent or employee;

(4) a board member;

(5) the receiver; and

(6) a special deputy receiver or the special deputy receiver's agent or employee.

(b) Immunity under Subsection (a) extends to participation in an organization of one or more state associations that have similar purposes and to a similar organization and the organization's agent or employee.

(c) The attorney general shall defend any action to which this section applies that is brought against the commissioner or the commissioner's representative, the association or the association's agent or employee, a member insurer or the insurer's agent or employee, a board member, or a special deputy receiver or the special deputy receiver's agent or employee, including an action brought 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 with respect to an issue other than the applicability or effect of the immunity created by this section. The attorney general is not required to defend the association or the association's agent or employee, a member insurer or the insurer's agent or employee, a board member, or a special deputy receiver or the special deputy receiver's agent or employee 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 this section. The association may contract with the attorney general under Chapter 771, Government Code, for legal services not covered by this subsection. (V.T.I.C. Art. 21.28-D, Sec. 17.)

Source Law

Sec. 17. (a) There is no liability on the part of and no cause of action of any nature arises against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, the receiver, the special deputy or its agents or employees, or the commissioner or the commissioner's representatives, for any good faith action or omission in the performance of powers and duties under this Act. This immunity extends to the participation in any organization of one or more other state associations of similar purposes and to any similar organization and its agents or employees.

(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 to 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 17(b), V.T.I.C. Article 21.28-D, requires the attorney general to defend certain actions 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 to its agents or employees, or the commissioner or the commissioner's representatives." The subsection further states defense of "any person or entity" is not required with respect to an issue other than the applicability or effect of the immunity created by Section 17. The revised law omits the reference to "entity" because

"person," as defined by Section 5(9), V.T.I.C. Article 21.28-D, revised in this chapter as Section 463.003(8), describes all of the types of entities to which the required defense would apply.

(2) Section 17(b), V.T.I.C. Article 21.28-D, 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. 463.006. RULES. The commissioner shall adopt reasonable rules as necessary to carry out and supplement this chapter and the purposes of this chapter. (V.T.I.C. Art. 21.28-D, Sec. 21.)

Source Law

Sec. 21. 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

(1) Section 21, V.T.I.C. Article 21.28-D, 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. Accordingly, the revised law substitutes a reference to the commissioner for the reference to the State Board of Insurance.

(2) Section 21, V.T.I.C. Article 21.28-D, 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 463.007-463.050 reserved for expansion]

SUBCHAPTER B. GOVERNANCE OF AND PARTICIPATION IN ASSOCIATION

Revised Law

Sec. 463.051. PURPOSE AND REGULATION OF ASSOCIATION. (a) The Life, Accident, Health, and Hospital Service Insurance Guaranty Association is a nonprofit legal entity existing to pay benefits and continue coverage as provided by this chapter.

(b) The association is subject to the applicable provisions of this code and other insurance laws of this state and the immediate supervision of the commissioner. The commissioner may examine and regulate the association in the same manner as an insurer under this code. (V.T.I.C. Art. 21.28-D, Secs. 2 (part), 6(a) (part), (b), 15 (part).)

Source Law

> Sec. 2. . . . To provide this protection, an association of insurers is created to pay benefits and to continue coverages as limited in this Act, and . . . .
>
> Sec. 6. (a) The Life, Accident, Health, and Hospital Service Insurance Guaranty Association is a nonprofit legal entity. . . .
>
> (b) The association is under the immediate supervision of the commissioner and is subject to the applicable provisions of this code and any other law governing insurance in this state.
>
> Sec. 15. The association shall be subject to examination and regulation by the commissioner in the same manner as other insurers under this code. . . .

Revised Law

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

requirement to participate applies regardless of whether the insurer's certificate of authority in this state is suspended, revoked, not renewed, or voluntarily withdrawn.

(b) The following do not participate as member insurers:

(1) a health maintenance organization;

(2) a fraternal benefit society;

(3) a mandatory state pooling plan;

(4) a reciprocal or interinsurance exchange; and

(5) an entity similar to an entity described by Subdivision (1), (2), (3), or (4). (V.T.I.C. Art. 21.28-D, Secs. 5(7) (part), 6(a) (part).)

Source Law

Sec. 5. As used in this Act:

(7) ["Member insurer" means any insurer] licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Section 3 of this Act, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, including a mutual assessment corporation, a local mutual association, a statewide mutual assessment company, and a stipulated premium company licensed to do business in this state, but does not include:

(A) a health maintenance organization;

(B) a fraternal benefit society;

(C) a mandatory state pooling plan;

(D) an insurance exchange; or

(E) any entity similar to any of those described by Paragraphs (A)-(D) of this subdivision.

Sec. 6. (a) . . . All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. . . .

Revisor's Note

(1) Section 5(7), V.T.I.C. Article 21.28-D, refers to an insurer that is "licensed or that holds a certificate of authority" to engage in the business of insurance in certain states. Throughout this chapter, the revised law omits references to "license" and "licensed" and, where applicable, substitutes "authorized" for "licensed" and "certificate of

authority" for "license" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

(2) Section 5(7), V.T.I.C. Article 21.28-D, refers to a "mutual assessment corporation," a "local mutual association," and an "insurance exchange," meaning entities operating under Chapters 887, 886, and 942, respectively. The terms most frequently used to refer to those entities are "mutual assessment company," "local mutual aid association," and "reciprocal or interinsurance exchange." For consistent use of terminology in this code, the revised law substitutes "mutual assessment company," "local mutual aid association," and "reciprocal or interinsurance exchange" for "mutual assessment corporation," "local mutual association," and "insurance exchange," respectively.

Revised Law

Sec. 463.053. BOARD OF DIRECTORS. (a) The association's powers are exercised through a board of directors consisting of nine individuals appointed by the commissioner as provided by this section.

(b) The commissioner shall appoint three board members from officers or employees of the 50 member insurers having the largest total direct premium income according to the most recent financial statement on file on the date of appointment.

(c) To give fair representation to member insurers, the commissioner shall appoint two board members from member insurers other than insurers described by Subsection (b), considering the varying categories of premium income and geographical location.

(d) The commissioner shall appoint four board members who are public representatives. (V.T.I.C. Art. 21.28-D, Secs. 6(a) (part), 7(a) (part).)

Source Law

Sec. 6. (a) . . . The association . . . shall exercise its powers through a board of directors established under Section 7 of this Act. . . .

Sec. 7. (a) The commissioner shall appoint a board of directors of the association consisting of nine members, three of whom shall be chosen from employees or officers chosen from the 50 member companies having the largest total direct premium income based on the latest financial statement on file at date of appointment, two of whom shall be chosen from the other companies to give fair representation to member insurers based on due consideration of their varying categories of premium income and geographical location, and four of whom shall be representatives of the general public. . . .

Revised Law

Sec. 463.054. ELIGIBILITY TO SERVE AS PUBLIC REPRESENTATIVE. To be eligible to serve as a public representative, an individual may not:

(1) be an officer, director, or employee of an insurer, insurance agency, agent, broker, solicitor, adjuster, or other business entity regulated by the department;

(2) be a person required to register under Chapter 305, Government Code; or

(3) be related within the second degree by affinity or consanguinity to a person described by Subdivision (1) or (2). (V.T.I.C. Art. 21.28-D, Sec. 7(a) (part).)

Source Law

(a) . . . 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 department;

(2) a person required to register with the secretary of state under Chapter 305, Government Code; or

(3) related to a person described by Subparagraph (1) or (2) of this paragraph within the second degree of affinity or consanguinity.

Revisor's Note

Section 7(a), V.T.I.C. Article 21.28-D, refers to a person "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, a person 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. 463.055. TERM; VACANCY. (a) Board members serve staggered six-year terms, with the terms of three members expiring each odd-numbered year. A member may be reappointed.

(b) A board member shall serve until a successor is appointed.

(c) If a board member who is an officer or employee of a member insurer ceases to be an officer or employee of the insurer, 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. 21.28-D, Sec. 7(a) (part).)

Source Law

(a) . . . Members serve for six-year staggered terms, with the terms of three members expiring each odd-numbered year. All directors shall serve until their successors are appointed, except that in the case of any vacancy, the unexpired term of office shall be filled by the appointment of a director by the commissioner. If a director ceases to be an officer or employee of a member insurer during the director's term of office, that office becomes vacant until the director's successor is appointed. All directors are eligible to succeed themselves in office. . . .

Revisor's Note

(1) Section 7(a), V.T.I.C. Article 21.28-D, refers to members of the association's board of directors as "member[s]" and "director[s]." For consistency, the revised law uses "board member" in each instance.

(2) Section 7(a), V.T.I.C. Article 21.28-D,

provides that if a board member ceases to be an officer or employee of a member insurer during the board member's term of office, that office becomes vacant. The revised law limits the application of the provision to members who are officers or employees of a member insurer, because some members, such as public representatives, are not required to be officers or employees of a member insurer.

Revised Law

Sec. 463.056. COMPENSATION OF BOARD MEMBERS. A board member may not receive compensation from the association for the member's services but may be reimbursed from the association's assets for expenses incurred as a board member. (V.T.I.C. Art. 21.28-D, Sec. 7(c).)

Source Law

(c) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board may not otherwise be compensated by the association for their services.

Revised Law

Sec. 463.057. 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. 21.28-D, Sec. 7(b).)

Source Law

(b) 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).

Revisor's Note

Section 7(b), V.T.I.C. Article 21.28-D, 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). 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 in Subchapter B, Chapter 572, Government Code. For this reason, the revised law substitutes "Subchapter B, Chapter 572, Government Code" for the reference to Sections 3 and 4. Although Subchapter B, Chapter 572, Government Code, revises provisions in addition to Sections 3 and 4, it is appropriate to refer to the other provisions for the purposes of the substituted cross-reference.

Revised Law

Sec. 463.058. CONFLICT OF INTEREST. (a) In this section, "transaction on behalf of an impaired insurer" includes a reinsurance agreement, transaction, merger, purchase, sale, contribution, or exchange of assets, insurance policies, or property made by the association or a supervisor, conservator, or receiver on behalf of an impaired insurer.

(b) A board member may not:

(1) receive money or another thing of value for negotiating, procuring, participating in, recommending, or aiding a transaction on behalf of an impaired insurer; or

(2) as a principal, coprincipal, agent, or beneficiary, have a pecuniary interest in a transaction on behalf of an impaired insurer.

(c) For the purposes of this section, a board member is considered to receive a thing of value or have a pecuniary interest in a transaction on behalf of an impaired insurer regardless of whether the receipt or interest is direct, indirect, or through a substantial interest in a corporation, firm, or other business unit. (V.T.I.C. Art. 21.28-D, Sec. 7(d).)

Source Law

(d) A director of the association may not receive any money or valuable thing directly, indirectly, or through any substantial interest in any other corporation, firm, or business unit for negotiating, procuring, participating, recommending,

or aiding in a transaction, reinsurance agreement, merger, purchase, sale, contribution, or exchange of assets, policies of insurance, or property made by the association or the supervisor, conservator, or receiver on behalf of an impaired insurer. A director of the association may not have a pecuniary interest, as principal, co-principal, agent, or beneficiary, directly, indirectly, or through any substantial interest in any other corporation, firm, or business unit, in the transaction, reinsurance agreement, merger, purchase, sale, contribution, or exchange.

[Sections 463.059-463.100 reserved for expansion]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF ASSOCIATION

Revised Law

Sec. 463.101. GENERAL POWERS AND DUTIES. (a) The association may:

(1) enter into contracts as necessary or proper to carry out this chapter and the purposes of this chapter;

(2) sue or be sued, including taking:

(A) necessary or proper legal action to:

(i) recover an unpaid assessment under Subchapter D; or

(ii) settle a claim or potential claim against the association; or

(B) necessary legal action to avoid payment of an improper claim;

(3) borrow money to effect the purposes of this chapter;

(4) exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life, accident, or health insurance company or a group hospital service corporation, except that the association may not issue an insurance policy or annuity contract other than to perform the association's obligations under this chapter; and

(5) to further the association's purposes, exercise the association's powers, and perform the association's duties, join an organization of one or more state associations that have similar purposes.

(b) If not in default, a note or other evidence of

indebtedness of the association is a legal investment for a domestic insurer and may be carried as an admitted asset. (V.T.I.C. Art. 21.28-D, Secs. 8(v) (part), (w).)

Source Law

(v) The association may:

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

(2) sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under Section 9 of this Act and to settle claims or potential claims against it;

(3) borrow money to effect the purposes of this Act, and any notes or other evidence of indebtedness of the association not in default are legal investments for domestic insurers and may be carried as admitted assets;

. . .

(5) take legal action as may be necessary to avoid payment of improper claims; and

(6) exercise, for the purposes of this Act and to the extent approved by the commissioner, the powers of a domestic life, accident, health, or hospital service insurer, but the association may not issue insurance policies or annuity contracts other than those issued to perform its obligations under this Act.

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

Revisor's Note

(1) Section 8(v)(2), V.T.I.C. Article 21.28-D, provides that the association may recover certain unpaid assessments "under Section 9," Article 21.28-D. Other provisions of Article 21.28-D refer to the procedures for assessments under Section 9. Section 9 is revised in Subchapter D of this chapter, and although Subchapter D is derived from provisions of Article 21.28-D other than Section 9, the revised law substitutes a reference to Subchapter D for references to Section 9 throughout this chapter because the other provisions from which Subchapter D is derived are related to the assessment procedures provided by Section 9, and it is appropriate to include those provisions in the references in the revised law.

(2) Section 8(v)(6), V.T.I.C. Article 21.28-D,

refers to a "hospital service insurer," meaning an entity operating under Chapter 842. The term most frequently used to refer to that entity is "group hospital service corporation." For consistent use of terminology in this code, the revised law substitutes "group hospital service corporation" for "hospital service insurer."

Revised Law

Sec. 463.102. PLAN OF OPERATION; AMENDMENTS. (a) The association shall perform the association's functions under a plan of operation approved by the commissioner. The plan of operation must:

(1) establish:

(A) procedures for handling the assets of the association;

(B) the amount and method of reimbursing board members under Section 463.056;

(C) regular places and times for board meetings, including telephone conference calls;

(D) procedures for maintaining records of all financial transactions of the association, the association's agents, and the board; and

(E) additional procedures for assessments under Subchapter D; and

(2) contain additional provisions necessary or proper for the execution of the association's powers and duties.

(b) The association may amend the plan of operation. An amendment must be approved by the commissioner and takes effect on:

(1) the date the commissioner approves the amendment; or

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

(c) Each member insurer shall comply with the plan of

operation. (V.T.I.C. Art. 21.28-D, Secs. 6(a) (part), 10(a), (b), (c).)

Source Law

Sec. 6. (a) . . . The association shall perform its functions under the plan of operation established and approved under Section 10 of this Act and . . . .

Sec. 10. (a) The association operates under a plan of operation approved by the commissioner. The association may amend the plan, subject to the approval of the commissioner. An amendment to the plan becomes effective on the date on which the commissioner approves the amendment, or on the 30th day after the date the amendment is submitted to the commissioner for approval, if the commissioner does not approve or disapprove the amendment before that date.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation must, in addition to requirements of this Act:

(1) establish procedures for handling the assets of the association;

(2) establish the amount and method of reimbursing members of the board of directors under Section 7 of this Act;

(3) establish regular places and times for meetings, including telephone conference calls, of the board of directors;

(4) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) establish any additional procedures for assessments under Section 9 of this Act; and

(6) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

Revisor's Note

Section 10(c), V.T.I.C. Article 21.28-D, provides that a plan of operation must contain certain provisions "in addition to requirements of this Act." The revised law omits the quoted language as unnecessary 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.

Revised Law

Sec. 463.103. PERSONNEL. The association may employ or

retain employees or contractors to handle the association's financial transactions and to perform other functions under this chapter. (V.T.I.C. Art. 21.28-D, Sec. 8(v) (part).)

Source Law

(v) The association may:

. . .

(4) employ or retain employees or contractors to handle the financial transactions of the association and to perform other functions under this Act;

. . .

Revised Law

Sec. 463.104. ASSOCIATION RECORDS. (a) The association shall maintain a record of each negotiation or meeting in which the association or the association's representative discusses the association's activities in carrying out the powers and duties under Section 463.101, 463.103, 463.109, or 463.111(c) or Subchapter F.

(b) A record under Subsection (a) may be made public only on:

(1) termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer;

(2) termination of the impairment or insolvency of the insurer; or

(3) order of a court.

(c) This section does not limit the association's duty to report on the association's activities as required by Section 463.110. (V.T.I.C. Art. 21.28-D, Sec. 14(b).)

Source Law

(b) 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 Section 8 of this Act. 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 15 of this

Act.

Revisor's Note

(1) Section 14(b), V.T.I.C. Article 21.28-D, refers to the association's powers and duties under Section 8, Article 21.28-D. Throughout this chapter, in reference to the association's powers and duties, the revised law substitutes "Section 463.101, 463.103, 463.109, or 463.111(c) [or] Subchapter F" for references to Section 8. Although some provisions of Section 8 are revised in provisions of this chapter not included in the substituted references, those provisions do not involve powers or duties of the association. In addition, although Subchapter F is derived from provisions of Article 21.28-D other than Section 8, it is appropriate to refer to Subchapter F in its entirety because those provisions do not involve powers or duties of the association.

(2) Section 14(b), V.T.I.C. Article 21.28-D, refers to an order of a court "of competent jurisdiction." Throughout this chapter, the revised law omits the quoted language as unnecessary for the reasons that follow. General laws of civil jurisdiction applicable to a court of this state, another state, or the United States define the scope of the jurisdiction of the court to which the law applies. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts in this state. A general reference in law to an action taken by a court with respect to a matter is not a grant of jurisdiction over that matter; rather, inherent in the reference to the court taking the action is the assumption that the court has jurisdiction over the matter with respect to which the action was taken. Any challenge to the court's jurisdiction over the matter

would be instituted under the appropriate jurisdictional provision governing that court.

Revised Law

Sec. 463.105. ACCOUNTS. For the purposes of administration and assessment, the association shall maintain:

(1) an accident, health, and hospital services insurance account;

(2) a life insurance account;

(3) an annuity account; and

(4) an administrative account. (V.T.I.C. Art. 21.28-D, Sec. 6(a) (part).)

Source Law

(a) . . . For purposes of administration and assessment, the association shall maintain four accounts:

(1) the accident, health, and hospital services insurance account;

(2) the life insurance account;

(3) the annuity account; and

(4) the administrative account.

Revised Law

Sec. 463.106. 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 is delegated to a corporation or other organization that:

(1) performs in two or more states functions similar to those of the association or the association's equivalent; and

(2) provides protection not substantially less favorable and effective than that provided by this chapter.

(b) A power or duty under Section 463.261(c) or Subchapter D, other than a duty under Section 463.161(c), may not be delegated under this section.

(c) The corporation or other organization to which a power or duty is delegated shall be:

(1) reimbursed for a payment made on behalf of the association; and

(2) paid for performing any other function of the

association. (V.T.I.C. Art. 21.28-D, Sec. 10(d).)

Source Law

(d) The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8(u) and 9 of this Act, are delegated to a corporation, association, or other organization that performs functions similar to those of this association, or its equivalent, in two or more states. The corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function 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 Act.

Revisor's Note

Section 10(d), V.T.I.C. Article 21.28-D, refers to a "corporation, 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. 463.107. 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 property. (V.T.I.C. Art. 21.28-D, Sec. 16.)

Source Law

Sec. 16. 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.

Revisor's Note

Section 16, V.T.I.C. Article 21.28-D, refers to taxes levied 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. 463.108. DETECTION AND PREVENTION OF IMPAIRMENT AND INSOLVENCY. On a majority vote, the board:

(1) may make recommendations to the commissioner for detecting and preventing insurer insolvencies; and

(2) shall notify the commissioner of information indicating that a member insurer may be impaired or insolvent. (V.T.I.C. Art. 21.28-D, Secs. 12(e), (g).)

Source Law

(e) The board of directors, on majority vote, shall notify the commissioner of information indicating a member insurer may be an impaired or insolvent insurer.

(g) The board of directors, on majority vote, may make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

Revised Law

Sec. 463.109. ASSOCIATION APPEARANCE BEFORE COURT; INTERVENTION. (a) The association may appear before a court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter. The association's right to appear applies to:

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

(2) the determination of the insurer's policies or contracts and contractual obligations; and

(3) any other matter germane to the association's powers and duties.

(b) The association may appear or intervene before a court in another state with jurisdiction over:

(1) an impaired or insolvent insurer concerning which the association is or may become obligated; or

(2) a third party against whom the association may have rights through subrogation of the insurer's policyholders. (V.T.I.C. Art. 21.28-D, Sec. 8(s).)

Source Law

(s) The association may appear before any court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this Act. This right extends to all matters germane to the powers and duties of the association, including proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association may appear or intervene before a court in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over a third party against whom the association may have rights through subrogation of the insurer's policyholders.

Revised Law

Sec. 463.110. ANNUAL REPORT. Not later than the 120th day after the last day of each association fiscal year, the board shall submit to the commissioner:

(1) a financial report in a form approved by the commissioner; and

(2) a report of the association's activities during the preceding fiscal year. (V.T.I.C. Art. 21.28-D, Sec. 15 (part).)

Source Law

Sec. 15. . . . The board of directors shall submit to the commissioner each year, not later than the 120th day after the last day of the association's fiscal year, a financial report in a form approved by the commissioner and a report of the association's activities during the preceding fiscal year.

Revised Law

Sec. 463.111. BOARD AND ASSOCIATION ADVICE AND ASSISTANCE. (a) On a majority vote, the board may report and make recommendations to the commissioner on any matter germane to:

(1) the solvency, liquidation, rehabilitation, or conservation of a member insurer; or

(2) the solvency of an insurer seeking to engage in the business of insurance in this state.

(b) A report or recommendation under Subsection (a) is not a public document, and Chapter 552, Government Code, does not apply to the report or recommendation until the insurer that is the

subject of the report or recommendation is designated as impaired.

(c) 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 or insolvent insurer. (V.T.I.C. Art. 21.28-D, Secs. 8(r), 12(d).)

Source Law

[Sec. 8]

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

[Sec. 12]

(d) The board of directors, on majority vote, may make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. These reports and recommendations are not public documents and are not subject to the open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes), until such time as an insurer is declared to be impaired.

Revisor's Note

Section 12(d), V.T.I.C. Article 21.28-D, refers to the open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes). That act was codified in 1993 as Chapter 552, Government Code. The revised law is drafted accordingly.

Revised Law

Sec. 463.112. BOARD ACCESS TO RECORDS. The receiver or statutory successor of an impaired insurer shall give the board or a representative of the board:

(1) access to the insurer's records as necessary for the board to carry out the board's 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. 21.28-D, Sec. 18 (part).)

Source Law

Sec. 18. . . . The receiver or statutory successor of an impaired insurer covered by this Act 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

(1) Section 18, V.T.I.C. Article 21.28-D, refers to an impaired insurer "covered by this Act," meaning Article 21.28-D, revised as this chapter. The revised law omits the quoted language as unnecessary because the definition of "impaired insurer" in Section 5(5), Article 21.28-D, revised in this chapter as Section 463.003(5), requires the insurer to be a "member insurer." "Member insurer" is in turn defined by Section 5(7), Article 21.28-D, revised in this chapter in Sections 463.003(7) and 463.052, as an insurer authorized to engage in insurance business with respect to which this chapter provides coverage. Therefore, an insurer cannot be an impaired insurer for purposes of this chapter unless the insurer is "covered by" this chapter.

(2) Section 18, V.T.I.C. Article 21.28-D, 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. 463.113. BOARD REPORT AT CONCLUSION OF INSOLVENCY. (a) At the conclusion of an insurer insolvency in which the association was obligated to pay a covered claim, the board shall prepare and submit to the commissioner a report containing any information the board possesses concerning the history and causes of the insolvency.

(b) The board:

(1) shall cooperate with the boards of directors of guaranty associations in other states to prepare a report on the history and causes of the insolvency of a particular insurer; and

(2) may adopt by reference a report prepared by any of those associations. (V.T.I.C. Art. 21.28-D, Sec. 12(h).)

Source Law

> (h) The board of directors, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, shall prepare a report to the commissioner containing any information as it has in its possession bearing on the history and causes of the insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and may adopt by reference any report prepared by the other associations.

Revised Law

Sec. 463.114. SUMMARY DOCUMENT; DISCLAIMER. (a) The association shall prepare a summary document describing the general purposes and limitations of this chapter and amend the document as necessary to comply with this chapter. The document must clearly and conspicuously contain on the document's face a disclaimer that:

(1) states the name and address of the association and department;

(2) warns the policy or contract holder that:

(A) the association may not cover the policy; or

(B) coverage, if available, is subject to substantial limitations and exclusions and requires continuous residence in this state;

(3) states that an insurer and the insurer's agent are prohibited by law from using the association's existence to sell, solicit, or induce the purchase of any kind of insurance;

(4) warns the policy or contract holder not to rely on association coverage in selecting an insurer; and

(5) provides other information the commissioner prescribes.

(b) The association shall submit the document to the

commissioner for approval.

(c) At the expiration of the 60th day after approval of the document, an insurer may not deliver a policy or contract with respect to which this chapter provides coverage as determined under Subchapter E to a policy or contract holder before a copy of the summary document is delivered to the policy or contract holder. The document must also be available on request of a policyholder.

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

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

(f) The commissioner shall specify by rule the form and content of the disclaimer required by Subsection (a) and the notice required by Subsection (e). (V.T.I.C. Art. 21.28-D, Secs. 19(b), (c), (d).)

Source Law

> (b) The association shall prepare a summary document describing the general purposes and current limitations of the Act and complying with Subsection (c) of this section. This document shall be submitted to the commissioner for approval. Unless Subsection (d) of this section applies, at the expiration of the 60th day after the date on which the commissioner approves the document, an insurer may not deliver a policy or contract described in Section 3 of this Act to a policy or contract holder unless the summary document is delivered to the policy or contract holder before or at the time of delivery of the policy or contract. The document shall be available on request by a policyholder. The distribution, delivery, or contents or interpretation of this document does not

guarantee that the policy or the contract or the holder of the contract or policy is covered in the event of the impairment or insolvency of a member insurer. The document shall be revised by the association as amendments to the Act may require. Failure to receive this document does not give the policyholder, contract holder, certificate holder, or insured any greater rights than those stated in this Act.

(c) The document prepared under Subsection (b) of this section must contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

(1) state the name and address of the association and insurance department;

(2) warn the policy or contract holder that the association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state;

(3) state that the insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(4) state that the policy or contract holder should not rely on coverage under the association when selecting an insurer; and

(5) provide other information as directed by the commissioner.

(d) An insurer or agent may not deliver a policy or contract described in Section 3(b) of this Act and excluded under Section 3(c) of this Act from coverage under this Act unless the insurer or agent, before or at the time of delivery, gives the policy or contract holder a separate written notice that clearly and conspicuously discloses that the policy or contract is not covered by the association. The commissioner shall by rule specify the form and content of the notice.

[Sections 463.115-463.150 reserved for expansion]

SUBCHAPTER D. ASSESSMENTS

Revised Law

Sec. 463.151. MAKING AND PAYMENT OF ASSESSMENT. (a) The association shall assess member insurers, separately for each account under Section 463.105, in the amounts and at the times the board determines necessary to provide money for the association to exercise the association's powers, perform the association's duties, and carry out the purposes of this chapter. The association may not make an assessment to meet the requirements of the association with respect to an impaired or insolvent insurer until the assessment is necessary to carry out the purposes of this chapter. The board shall classify assessments under Section 463.152 and determine the amount of assessments with reasonable

accuracy, recognizing that exact determinations may not always be possible.

(b) An assessment is due on the date the association specifies, which may not be earlier than the 30th day after the date the association gives written notice of the assessment to member insurers. Interest accrues on an unpaid amount at a rate of 10 percent beginning on the due date.

(c) An insurer whose certificate of authority to engage in business in this state is revoked or surrendered remains liable for any unpaid assessment made before the date of the revocation or surrender. (V.T.I.C. Art. 21.28-D, Secs. 2 (part), 9(a), (g), (l).)

Source Law

> Sec. 2. . . . members of the association are subject to assessment to provide funds to carry out the purpose of this Act.
>
> Sec. 9. (a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall determine the amount necessary and the association shall assess the member insurers, separately for each account established by Section 6(a) of this Act, at such times and for such amounts as the board of directors finds necessary. All assessments are due on a date specified by the association that may not be earlier than the 30th day after the date on which prior written notice is given to the member insurers. Interest accrues on the unpaid amount at a rate of 10 percent beginning on the due date.
>
> (g) Assessments for funds to meet the requirements of the association with respect to an insolvent or impaired insurer may not be made until necessary to implement the purposes of this Act. Classification of assessments under Subsection (b) of this section and computation of assessments under this section shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.
>
> (l) Any insurer whose certificate of 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.

Revisor's Note

(1) Sections 2 and 9(g), V.T.I.C. Article 21.28-D, refer to "funds" to carry out the purpose of the article and to meet the association's

requirements. 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 9(l), V.T.I.C. Article 21.28-D, refers to a certificate of authority being "canceled" and to "such cancellation." The revised law substitutes "revoked" for "canceled" and "revocation" for "cancellation" because, in context, the terms are synonymous, and "revoked" and "revocation" are more commonly used.

Revised Law

Sec. 463.152. CLASSES OF ASSESSMENTS. (a) Assessments are classified as Class A or Class B assessments.

(b) Class A assessments are made to pay:

(1) the association's administrative costs;

(2) administrative expenses that:

(A) are properly incurred under this chapter; and

(B) relate to an unauthorized insurer or to an entity that is not a member insurer; and

(3) other general expenses not related to a particular impaired or insolvent insurer.

(c) Class B assessments are made to the extent necessary for the association to carry out the association's powers and duties under Sections 463.101, 463.103, 463.109, and 463.111(c) and Subchapter F with regard to an impaired or insolvent insurer. (V.T.I.C. Art. 21.28-D, Sec. 9(b).)

Source Law

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

(1) Class A assessments are made to meet administrative costs of the association, administrative expenses properly incurred under this Act relating to any unauthorized insurer or nonmember of the association, and other general expenses not related to a particular insolvent or impaired insurer; and

(2) Class B assessments are made to the extent necessary to carry out the powers and duties of

the association under Section 8 with regard to an insolvent or impaired insurer.

Revised Law

Sec. 463.153. AMOUNT OF ASSESSMENTS. (a) The board shall determine the amount of a Class A assessment for each account under Section 463.105, considering with respect to member insurers one or more of the following as shown by annual statements for the year preceding the date of the assessment:

(1) annual premium receipts;

(2) admitted assets; or

(3) insurance in force.

(b) Class B assessments against a member insurer for each account under Section 463.105 shall be made in the proportion that premiums received on all business by the insurer on policies covered by each account bear to the premiums received on all business by all assessed member insurers. The amount of a Class B assessment shall be divided among the separate accounts in the proportion that the premiums on the policies covered by each account were received by the impaired or insolvent insurer from all covered policies during the year preceding the date of the impairment, as shown in the annual statements for the year preceding the date of the assessment.

(c) The total amount of assessments on a member insurer for each account under Section 463.105 may not exceed one percent of the insurer's premiums on the policies covered by the account in a single calendar year. If the maximum assessment and the other assets of the association do not provide in a year an amount sufficient to carry out the association's responsibilities, the association shall make necessary additional assessments as soon as this chapter permits. (V.T.I.C. Art. 21.28-D, Secs. 9(c), (d), (f), (h) (part), (i) (part).)

Source Law

(c) The amount of a Class A assessment for each account is determined by the board of directors taking into consideration one or more of the following: annual premium receipts, admitted assets, or insurance in force, as reflected in the annual statements for the

year preceding the assessment.

(d) The amount of a Class B assessment shall be divided among the separate accounts as reflected in the annual statements for the year preceding the assessment in the same proportion that the premiums from the policies covered by each account were received by the insolvent or impaired insurer from all covered policies during the year preceding impairment.

(f) Class B assessments against member insurers for each account shall be in the proportion that premiums received on all business by each assessed member insurer on policies covered by each account bear to the premiums received on all business by all assessed member insurers.

(h) . . . The total of all assessments on a member insurer for each account may not exceed one percent of the insurer's premiums on the policies covered by the account in any one calendar year.

(i) . . . If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this Act.

Revised Law

Sec. 463.154. DEFERMENT. The association may wholly or partly defer an assessment of a member insurer if the association believes payment of the assessment would endanger the ability of the insurer to fulfill the insurer's contractual obligations. The amount of the assessment that is deferred may be assessed against the other member insurers in a manner consistent with this subchapter. (V.T.I.C. Art. 21.28-D, Secs. 9(h) (part), (i) (part).)

Source Law

(h) The association may defer, in whole or in part, the assessment of a member insurer if, in the opinion of the association, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. . . .

(i) If an assessment against a member insurer is deferred under Subsection (h) of this section, in whole or in part, the amount by which the assessment is deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this subsection. . . .

Revisor's Note

Section 9(i), V.T.I.C. Article 21.28-D, requires certain additional assessments to be made in a manner consistent with the basis for assessments set forth in "this subsection." The basis for assessments is not

contained, however, in Section 9(i), but in the other provisions of Section 9, which are revised in this subchapter. The revised law is drafted accordingly.

Revised Law

Sec. 463.155. DEPOSIT OF ASSESSMENTS. The association may deposit assessments into the Texas Treasury Safekeeping Trust Company in accordance with procedures established by the comptroller. The comptroller shall account to the association for the deposited money separately from all other money. (V.T.I.C. Art. 21.28-D, Sec. 9(n).)

Source Law

(n) All assessments collected by the association may be deposited into the Texas Treasury Safekeeping Trust Company in accordance with procedures established by the comptroller. The funds deposited shall be accounted for separately from all other funds by the comptroller to the association.

Revisor's Note

Section 9(n), V.T.I.C. Article 21.28-D, allows the association to deposit all assessments "collected by the association." The revised law omits the quoted language as unnecessary because the association could not deposit assessments the association did not collect.

Revised Law

Sec. 463.156. CERTIFICATE OF CONTRIBUTION. The association shall issue to each member insurer that pays a Class B assessment a certificate of contribution, in a form the commissioner prescribes, for the amount paid. All outstanding certificates are of equal priority regardless of the amount of the assessment paid or the date the certificate is issued. (V.T.I.C. Art. 21.28-D, Sec. 9(k).)

Source Law

(k) The association shall issue to each insurer paying a Class B assessment under this Act a certificate of contribution, in a form prescribed by the commissioner, for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or date of issue.

Revisor's Note

Section 9(k), V.T.I.C. Article 21.28-D, refers to certificates of contribution of "equal dignity and priority." The reference to "dignity" is omitted from the revised law because, in this context, "dignity" is included within the meaning of "priority."

Revised Law

Sec. 463.157. REFUNDS. (a) The board may refund to member insurers the amount by which the association's assets, including any net realized gains and income from investments, exceed the amount the board determines is necessary to carry out the association's obligations regarding that amount during the next year.

(b) A refund must be made:

(1) by an equitable method established in the plan of operation; and

(2) in proportion to the contribution of each member insurer.

(c) The board may retain a reasonable amount to provide for the association's continuing expenses and for future losses if refunds are impractical. (V.T.I.C. Art. 21.28-D, Sec. 9(j).)

Source Law

(j) The board of directors may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer, the amount by which the assets exceed the amount the board of directors finds is necessary to carry out during the coming year the obligations of the association with regard to that amount, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained to provide funds for the continuing expenses of the association and for future losses if refunds are impractical.

Revised Law

Sec. 463.158. USE OF ASSESSMENTS. Money from assessments supplements the marshalling of an impaired insurer's assets to make payments on the insurer's behalf. (V.T.I.C. Art. 21.28-D, Sec. 9(m).)

Source Law

(m) The amounts provided according to assessments made under this section are supplemental to the marshaling of assets for the purpose of making payments on behalf of an impaired insurer.

Revised Law

Sec. 463.159. FAILURE TO PAY; COLLECTION BY COMMISSIONER. On failure of a member insurer to pay an assessment when due, the commissioner may either:

(1) suspend or revoke, after notice and hearing, the insurer's certificate of authority to engage in the business of insurance in this state; or

(2) levy a forfeiture in an amount not less than $100 each month or more than five percent of the unpaid assessment each month. (V.T.I.C. Art. 21.28-D, Sec. 11(c) (part).)

Source Law

(c) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or . . . . As an alternative, the commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture may not exceed five percent of the unpaid assessment per month and may not be less than $100 per month.

Revised Law

Sec. 463.160. PREMIUM TAX CREDIT FOR CLASS A ASSESSMENT. The amount of a Class A assessment paid by a member insurer shall be allowed as a credit on the amount of premium taxes due in the same manner as a credit is allowed under Section 401.151(e). (V.T.I.C. Art. 21.28-D, Sec. 9(e).)

Source Law

(e) Class A assessments shall be allowed as a credit on the amount of premium taxes in the manner provided by Article 1.16 of this code.

Revisor's Note

Section 9(e), V.T.I.C. Article 21.28-D, refers to a credit allowed under "[V.T.I.C.] Article 1.16." The portion of Article 1.16 that provides for a credit is revised as Section 401.151(e) of this code. The

revised law is drafted accordingly.

Revised Law

Sec. 463.161. PREMIUM TAX CREDIT FOR CLASS B ASSESSMENT. (a) A member insurer is entitled to show as an admitted asset a certificate of contribution in the form the commissioner approves under Section 463.156. Unless the commissioner requires a longer period, the certificate may be shown at:

(1) for the calendar year of issuance, an amount equal to the certificate's original face value approved by the commissioner; and

(2) beginning with the year following the calendar year of issuance, an amount equal to the certificate's original face value, reduced by 10 percent a year for each year after the year of issuance, for a period of 10 years.

(b) An amount written off during a calendar year under Subsection (a) shall be allowed as a credit against the member insurer's premium tax owed for business engaged in during that year. The insurer is not required to write off in a single year an amount that exceeds the amount of premium tax owed for the business described by this subsection.

(c) The association shall pay to the commissioner, and the commissioner shall deliver to the comptroller for deposit to the credit of the general revenue fund, any amount owed as a refund from the association under Section 463.157 that was written off and used for a tax credit under this section. (V.T.I.C. Art. 21.28-D, Secs. 13(a), (b), (c).)

Source Law

Sec. 13. (a) Unless a longer period of time has been required by the commissioner, a member insurer shall at its option have the right to show a certificate of contribution as an admitted asset in the form approved by the commissioner under Section 9(k) of this Act at percentages of the original face amount approved by the commissioner, for calendar years as follows:

100 percent for the calendar year of issuance, which shall be reduced 10 percent a year for each year thereafter for a period of 10 years.

(b) The insurer may offset the amount written off by it in a calendar year under Subsection (a) of

this section against its premium tax liability to this state accrued with respect to business transacted in that year. An insurer may not be required to write off in any one year, an amount in excess of its premium tax liability to this state accruing within the year.

(c) Any sums acquired by refund, pursuant to Section 9(j) of this Act, from the association which have theretofore been written off by contributing insurers and offset against premium taxes as provided in Subsection (b) of this section, and are not then needed for purposes of this Act, shall be paid by the association to the commissioner and by him deposited with the comptroller for credit to the general fund of this state.

Revisor's Note

Section 13(c), V.T.I.C. Article 21.28-D, refers to "sums acquired by refund, pursuant to Section 9(j) of this Act, from the association." Section 9(j) is revised in this chapter as Section 463.157. Because the purpose of Section 13(c) is to allow the association to transfer to the comptroller an amount owed as a refund to a member insurer, without requiring payment of that refund to the insurer, the refund is never actually "acquired" by the insurer. Accordingly, the revised law substitutes "owed as" for "acquired by."

In addition, Section 13(c) limits the amount of the transfer to the amount of the refund "not then needed for purposes of this Act." Section 9(j) provides that the board of directors may refund to member insurers amounts that are not needed to implement the association's obligations. Amounts that are needed could not be owed to member insurers as refunds. Therefore, the revised law omits the quoted restriction in Section 13(c) as unnecessary because it describes circumstances that cannot occur under the other provisions of Article 21.28-D.

Revised Law

Sec. 463.162. ASSIGNMENT OR TRANSFER OF CREDIT. (a) A member insurer may assign or transfer a credit against premium tax to another member insurer if:

(1) an acquisition, merger, or total assumption of reinsurance occurs between the insurers; or

(2) the commissioner by order approves the assignment or transfer.

(b) Not later than the later of November 1 or the 60th day after the date of the assignment or transfer, each member insurer shall:

(1) report the assignment or transfer to the comptroller on a form the comptroller prescribes; and

(2) include with the report any documents from the commissioner that show approval of the assignment or transfer. (V.T.I.C. Art. 21.28-D, Secs. 13(d), (e).)

Source Law

> (d) A member insurer may assign or transfer a credit against premium tax to another member insurer if:
>
> (1) an acquisition, merger, or total assumption of reinsurance has occurred between the insurers; or
>
> (2) the commissioner by order approves the assignment or transfer.
>
> (e) Not later than November 1 or the 60th day after the date of an assignment or transfer under Subsection (d) of this section, whichever is later, each member insurer shall report, on a form prescribed by the comptroller, the assignment or transfer to the comptroller. The member insurer shall provide with the report any documents from the commissioner that show approval of the assignment or transfer.

Revised Law

Sec. 463.163. INSURED'S LIABILITY UNDER ASSESSMENT PLAN. This chapter does not reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability. (V.T.I.C. Art. 21.28-D, Sec. 14(a).)

Source Law

> Sec. 14. (a) This Act does not reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

[Sections 463.164-463.200 reserved for expansion]

SUBCHAPTER E. COVERAGE PROVIDED BY ASSOCIATION

Revised Law

Sec. 463.201. INSUREDS COVERED. (a) This chapter provides coverage for a policy described by Section 463.202 to a person who is:

(1) subject to Subsection (b), an owner of or certificate holder under a policy or contract specified by Section 463.202, or a contract holder under an unallocated annuity contract; or

(2) a beneficiary, assignee, or payee, other than a certificate holder under a group policy or contract who is not a resident, of a person described by Subdivision (1).

(b) Coverage under Subsection (a)(1) applies to a person who is not a resident, only if:

(1) the insurer that issued the policy or contract is domiciled in this state;

(2) the insurer never held a certificate of authority in the state in which the person resides;

(3) the state in which the person resides has an association similar to the association; and

(4) the person is not eligible for coverage by the association in the state in which the person resides. (V.T.I.C. Art. 21.28-D, Sec. 3(a).)

Source Law

Sec. 3. (a) This Act provides coverage for a policy or contract specified in Subsection (b) of this section to:

(1) a person, other than a nonresident certificate holder under a group policy or contract, who is the beneficiary, assignee, or payee of a person covered under Paragraph (2) of this subsection; and

(2) a person who is an owner of or certificate holder under the policy or contract; or, in the case of an unallocated annuity contract, to the person who is the contract holder, and who:

(A) is a resident; or

(B) is not a resident, but only if:

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

(ii) the insurers never held a license or certificate of authority in the states in which the persons reside;

(iii) the states have

associations similar to the association created by this Act; and

(iv) the person is not eligible for coverage by the associations.

Revised Law

Sec. 463.202. POLICIES AND CONTRACTS COVERED. (a) Except as limited by this chapter, the coverage provided by this chapter to a person specified by Section 463.201 applies with respect to the following policies and contracts issued by a member insurer:

(1) a direct, nongroup life, health, accident, annuity, or supplemental policy or contract;

(2) a certificate under a direct group policy or contract;

(3) a group hospital service contract; and

(4) an unallocated annuity contract.

(b) The coverage provided by this chapter also applies with respect to all other insurance coverage written by the following entities authorized to engage in business in this state:

(1) a mutual assessment company;

(2) a local mutual aid association;

(3) a statewide mutual assessment company; and

(4) a stipulated premium company.

(c) For the purposes of this section, an annuity contract or a certificate under a group annuity contract includes:

(1) a guaranteed investment contract;

(2) a deposit administration contract;

(3) an allocated or unallocated funding agreement;

(4) a structured settlement agreement;

(5) a lottery contract; and

(6) an immediate or deferred annuity contract. (V.T.I.C. Art. 21.28-D, Sec. 3(b).)

Source Law

(b) This Act provides coverage to the persons specified in Subsection (a) of this section for direct, non-group life, health, accident, annuity, and supplemental policies or contracts, for certificates under direct group policies and contracts, group hospital service contracts, and for unallocated annuity contracts issued by member insurers, except as

limited by this Act. This Act also provides coverage for all other insurance coverages written by mutual assessment corporations, local mutual aid associations, statewide mutual assessment companies, and stipulated premium companies licensed to do business in this state. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts, and any immediate or deferred annuity contracts.

Revisor's Note

Section 3(b), V.T.I.C. Article 21.28-D, refers to "mutual assessment corporations." The revised law substitutes "mutual assessment company" for "mutual assessment corporations" for the reason stated in Revisor's Note (6) to Section 463.003.

Revised Law

Sec. 463.203. POLICIES AND CONTRACTS EXCLUDED. (a) In this section, "Moody's Corporate Bond Yield Average" means the monthly average corporates as published by Moody's Investors Service, Inc., or any successor to that entity.

(b) This chapter does not provide coverage for:

(1) any part of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy or contract holder;

(2) a policy or contract of reinsurance, unless an assumption certificate has been issued;

(3) any part of a policy or contract to the extent that the rate of interest on which that part is based:

(A) as averaged over the period of four years before the date the association became obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for the same four-year period or for a lesser period if the policy or contract was issued less than four years before the date the association became obligated; and

(B) on and after the date the association became obligated with respect to the policy or contract, exceeds the rate

of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(4) a plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to the entity's employees or members to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or similar entity 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);

(B) a minimum premium group insurance plan;

(C) a stop-loss group insurance plan; or

(D) an administrative services-only contract;

(5) any part of a policy or contract to the extent that the part provides dividends or experience rating credits or provides that fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of the policy or contract;

(6) a policy or contract issued in this state by a member insurer at a time the insurer was not authorized to issue the policy or contract in this state;

(7) an unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;

(8) any part of an unallocated annuity contract that is not issued to or in connection with a specific employee, a benefit plan for a union or association of individuals, or a governmental lottery; or

(9) any part of a financial guarantee, funding agreement, or guaranteed investment contract that:

(A) does not contain a mortality guarantee; and

(B) is not issued to or in connection with a specific employee, a benefit plan, or a governmental lottery. (V.T.I.C. Art. 21.28-D, Secs. 3(c), 5(8).)

Source Law

[Sec. 3]

(c) This Act does not provide coverage for:

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

(2) a policy or contract of reinsurance, unless assumption certificates have been issued;

(3) a portion of a policy or contract to the extent that the rate of interest on which it is based:

(A) averaged over the period of four years before the date on which the association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for a lesser period if the policy or contract was issued less than four years before the association became obligated; and

(B) on and after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(4) a plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or similar entity under:

(A) a multiple employer welfare arrangement as defined by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002);

(B) a minimum premium group insurance plan;

(C) a stop-loss group insurance plan; or

(D) an administrative services-only contract;

(5) a portion of a policy or contract, to the extent that it provides dividends or experience rating credits, or provides that fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of the policy or contract;

(6) a policy or contract issued in this state by a member insurer at a time when it was not licensed to issue the policy or contract in this state;

(7) an unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;

(8) a portion of an unallocated annuity contract that is not issued to or in connection with a specific employee, benefit plan for a union or association of natural persons, or a government lottery; and

(9) any portion of a financial guarantee, funding agreement, or guaranteed investment contract which (1) contains no mortality guarantees and (2) is not issued to or in connection with a specific employee, benefit plan, or a governmental lottery.

Sec. 5. As used in this Act:

(8) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor to that entity.

Revisor's Note

Section 3(c)(4), V.T.I.C. Article 21.28-D, refers to benefits, "including but not limited to" certain benefits. 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, 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. 463.204. OBLIGATIONS EXCLUDED. A contractual obligation does not include:

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

(2) an amount in excess of:

(A) $100,000 in the aggregate under one or more annuity contracts issued to the same holder of individual annuity policies or to the same annuitant or participant under group annuity policies; or

(B) $5 million in unallocated annuity contract benefits with respect to a single contract holder regardless of the number of those contracts;

(3) an amount in excess of $200,000 in the aggregate under one or more accident, health, or accident and health insurance policies on a single life; or

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

(A) agreed to or assumed by an insurer or insured; or

(B) imposed by a court. (V.T.I.C. Art. 21.28-D, Sec. 5(3) (part).)

Source Law

Sec. 5. As used in this Act:

(3) . . . A contractual obligation does not include:

(A) death benefits in an amount in excess of $300,000 or a net cash surrender or net cash withdrawal value in an amount in excess of $100,000 in the aggregate under one or more covered policies on any one life;

(B) an amount in excess of $100,000 in the aggregate under one or more annuity contracts within the scope of this Act issued to the same holder of individual annuity policies or to the same annuitant or participant under group annuity policies or an amount in excess of $5,000,000 in unallocated annuity contract benefits with respect to any one contract holder irrespective of the number of such contracts;

(C) an amount in excess of $200,000 in the aggregate under one or more accident and health, accident, or health insurance policies on any one life; or

(D) punitive, exemplary, extracontractual, or bad faith damages, whether agreed to or assumed by an insurer or insured or imposed by a court of competent jurisdiction.

Revised Law

Sec. 463.205. PROTECTION PROVIDED BY OTHER JURISDICTION. This chapter does not provide coverage for a resident with respect to an impaired or insolvent insurer domiciled in another jurisdiction if guaranty protection is provided to the resident by the law of that jurisdiction. (V.T.I.C. Art. 21.28-D, Sec. 8(o).)

Source Law

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

Revisor's Note

(1) Section 8(o), V.T.I.C. Article 21.28-D, refers to "residents of this state." The revised law omits "of this state" because "resident," as defined by Section 5(11), V.T.I.C. Article 21.28-D, revised in

this chapter as Section 463.003(10), means certain residents of this state.

(2) Section 8(o), V.T.I.C. Article 21.28-D, refers to a "state or jurisdiction." The revised law omits the reference to "state" because "state" is included within the meaning of "jurisdiction."

[Sections 463.206-463.250 reserved for expansion]

SUBCHAPTER F. POWERS AND DUTIES OF ASSOCIATION RELATING TO IMPAIRED OR INSOLVENT INSURER

Revised Law

Sec. 463.251. IMPAIRED DOMESTIC INSURER. (a) This section applies only to a member insurer that is an impaired domestic insurer.

(b) With the commissioner's approval, the association may:

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

(2) provide money, pledges, notes, guarantees, or other means proper to:

(A) implement Subdivision (1); and

(B) ensure payment of the insurer's contractual obligations until action is taken under Subdivision (1); or

(3) loan money to the insurer.

(c) In taking action under Subsection (b), the association may impose any condition that:

(1) does not impair the insurer's contractual obligations; and

(2) is approved by:

(A) the commissioner; and

(B) the insurer, except in a conservation or rehabilitation ordered by a court. (V.T.I.C. Art. 21.28-D, Sec. 8(a).)

Source Law

Sec. 8. (a) If a member insurer is an impaired

domestic insurer, the association may, subject to the approval of the commissioner, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer that are approved by the commissioner, and that are, except in cases of court-ordered conservation or rehabilitation, also approved by the impaired insurer:

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

(2) provide the moneys, pledges, notes, guarantees, or other means as are proper to effectuate Subdivision (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under Subdivision (1) of this subsection; or

(3) loan money to the impaired insurer.

Revised Law

Sec. 463.252. IMPAIRED DOMESTIC, FOREIGN, OR ALIEN INSURER NOT PAYING CLAIMS. (a) This section applies only to a member insurer that:

(1) is an impaired domestic, foreign, or alien insurer; and

(2) is not timely paying claims.

(b) Subject to Subsection (d), the association shall:

(1) with respect to the insurer, take one or more actions that the association is authorized to take under Section 463.251 with respect to an impaired domestic insurer, subject to the conditions of that section; or

(2) provide substitute benefits instead of the insurer's contractual obligations as provided by Subsection (c).

(c) A policy or contract owner who claims emergency or hardship may petition for substitute benefits under standards the association proposes and the commissioner approves. Substitute benefits are available only for a health claim, periodic annuity benefit payment, death benefit, supplemental benefit, or cash withdrawal.

(d) The association is required to take action under this section only if:

(1) the laws of the insurer's state of domicile provide that, until all payments of or on account of the insurer's

contractual obligations are made by all guaranty associations and all expenses of the associations and interest on those payments and expenses have been repaid to the associations or a plan of repayment by the insurer has been approved by the associations:

(A) the delinquency proceeding may not be dismissed;

(B) the insurer and the insurer's assets may not be returned to the control of the insurer's shareholders or private management; and

(C) the insurer may not solicit or accept new business or have any suspended or revoked certificate of authority restored;

(2) the insurer is a domestic insurer that has been placed under an order of rehabilitation by a court in this state; or

(3) the insurer is a foreign or alien insurer and:

(A) the insurer has been prohibited from soliciting or accepting new business in this state;

(B) the insurer's certificate of authority has been suspended or revoked in this state; and

(C) a petition for rehabilitation or liquidation has been filed in a court in the insurer's state of domicile by the insurance official of that state. (V.T.I.C. Art. 21.28-D, Secs. 8(b), (c).)

Source Law

(b) If a member insurer is an impaired insurer, whether domestic, foreign or alien, and the insurer is not paying claims timely, subject to the conditions specified in Subsection (c) of this section, the association shall:

(1) take any of the actions specified in Subsection (a) of this section, subject to the conditions in that subsection; or

(2) provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition for substitute benefits under claims of emergency or hardship under standards proposed by the association and approved by the commissioner.

(c) The association is subject to Subsection (b)

of this section only if:

(1) the laws of the impaired insurer's state of domicile provided that, until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses of the associations and interest on all those payments and expenses have been repaid to the guaranty associations or a plan of repayment by the impaired insurer has been approved by the guaranty associations:

(A) the delinquency proceeding may not be dismissed;

(B) the impaired insurer and its assets may not be returned to the control of its shareholders or private management; and

(C) the impaired insurer may not solicit or accept new business or have any suspended or revoked license restored; and

(2) the impaired insurer is a domestic insurer, and has been placed under an order of rehabilitation by a court of competent jurisdiction in this state; or

(3) the impaired insurer is a foreign or alien insurer and:

(A) it has been prohibited from soliciting or accepting new business in this state;

(B) its certificate of authority has been suspended or revoked in this state; and

(C) a petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state.

Revisor's Note

Section 8(c), V.T.I.C. Article 21.28-D, refers to the "commissioner of the state" of domicile of an impaired insurer. The revised law substitutes "insurance official" for "commissioner" because that official might not be called "commissioner" in that state.

Revised Law

Sec. 463.253. INSOLVENT INSURER. (a) This section applies only to a member insurer that is an insolvent insurer.

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

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

(2) ensure payment of the insurer's contractual obligations. (V.T.I.C. Art. 21.28-D, Sec. 8(d).)

Source Law

(d) Except as provided by Subsection (e) of this section, if a member insurer is an insolvent insurer, the association shall provide the moneys, pledges, guarantees, or other means as are reasonably necessary to discharge the duties of the insolvent insurer and:

(1) guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent insurer; or

(2) assure payment of the contractual obligations of the insolvent insurer.

Revisor's Note

Section 8(d), V.T.I.C. Article 21.28-D, provides that the section applies "[e]xcept as provided by Subsection (e) of this section." The revised law omits the quoted language as unnecessary because Section 8(e), Article 21.28-D, as revised in this chapter in Section 463.254, applies to Section 8(d) by its own terms.

Revised Law

Sec. 463.254. LIFE OR HEALTH INSURANCE POLICIES OR CONTRACTS. (a) This section applies only when the association is taking an action under Section 463.252(b)(2) or 463.253 with respect to a life or health insurance policy or contract.

(b) The association, in accordance with Subsections (c) and (d), as applicable, shall ensure payment of benefits identical to the benefits that would have been payable under the policy or contract of the insurer, at premiums identical to the premiums that would have been applicable under that policy or contract, except for terms of conversion and renewability.

(c) For a group policy or contract, the association shall ensure payment of benefits under Subsection (b) for claims incurred before the later of:

(1) the earlier of the next renewal date under the policy or contract or the 45th day after the date the association becomes obligated with respect to the policy or contract; or

(2) the 30th day after the date the association becomes obligated with respect to the policy or contract.

(d) For an individual policy, the association shall ensure payment of benefits under Subsection (b) for claims incurred before the later of:

(1) the earlier of the next renewal date under the policy, if any, or the first anniversary of the date the association becomes obligated with respect to the policy; or

(2) the 30th day after the date the association becomes obligated with respect to the policy.

(e) The association shall diligently attempt to provide each known insured or group policyholder with notice before the 30th day before the date the benefits are terminated.

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

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

(2) each individual who:

(A) was formerly insured under a group policy or contract; and

(B) is not eligible for replacement group coverage.

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

(1) was not entitled to unilaterally change a provision of the policy; or

(2) was entitled only to change a premium by class.

(h) Substitute coverage is available for a group policy or contract under Subsection (f) only if the formerly insured individual was entitled under law or the terminated policy or contract to convert group coverage to individual coverage.

(i) To provide substitute coverage under Subsection (f), the association may offer to reissue the terminated coverage or

issue an alternative policy. The association shall offer the reissued or alternative policy without requiring evidence of insurability. The reissued or alternative policy may not provide for a waiting period or exclusion that would not have applied under the terminated policy. The association may reinsure a reissued or alternative policy. (V.T.I.C. Art. 21.28-D, Secs. 8(e), (f).)

Source Law

(e) When proceeding under Subsections (b)(2) or (d) of this section, with respect to only life and health insurance policies the association shall:

(1) assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability that would have been payable under the policies of the insolvent insurer, for claims incurred:

(A) with respect to a group policy or contract, the later of:

(i) the earlier of the next renewal date under the policy or contract or the 45th day after the date the association becomes obligated with respect to the policy; or

(ii) the 30th day after the date the association becomes obligated with respect to the policy; or

(B) with respect to an individual policy, the later of:

(i) the earlier of the next renewal date under the policy, if any, or the date one year after the date the association becomes obligated with respect to the policy; or

(ii) the 30th day after the date the association becomes obligated with respect to the policy;

(2) make diligent efforts to provide all known insureds or group policyholders notice before the 30th day before the benefits provided are terminated; and

(3) with respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, substitute coverage on an individual basis in accordance with the provisions of Subsection (f) of this section, if the insureds had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.

(f) In providing the substitute coverage required under Subsection (e)(3) of this section, the association may offer either to reissue the terminated coverage or to issue an alternative policy. Alternative or reissued policies shall be offered without requiring evidence of insurability, and may not provide for any waiting period or exclusion that would not have applied under the terminated policy. The association may reinsure any alternative or

reissued policy.

Revisor's Note

(1) Section 8(e)(1), V.T.I.C. Article 21.28-D, refers to policies of an "insolvent" insurer. The revised law omits the reference to "insolvent" because Section 8(e) by its own terms applies to insurers covered by Section 8(b)(2) or (d) of that article, revised in this chapter as Sections 463.252(b)(2) and 463.253, and Section 8(b)(2) applies to impaired insurers rather than insolvent insurers.

(2) Section 8(e)(1), V.T.I.C. Article 21.28-D, in connection with group coverage, refers to a "policy or contract" in some instances, and only to a "policy" in other instances. The revised law substitutes "policy or contract" for "policy" when used in the context of group insurance for consistent use of terminology in this chapter.

Revised Law

Sec. 463.255. POLICY OR CONTRACT WITH GUARANTEED INTEREST RATE. In taking an action under Section 463.252(b)(2) or 463.253 with respect to a policy or contract with a guaranteed minimum interest rate, the association shall ensure the payment or crediting of a rate of interest consistent with Section 463.203(b)(3). (V.T.I.C. Art. 21.28-D, Sec. 8(l).)

Source Law

(l) When proceeding under Subsection (b)(2) or (d) of this section with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with Section 3(c)(3) of this Act.

Revised Law

Sec. 463.256. ALTERNATIVE POLICY. (a) An alternative policy issued by the association must:

(1) be approved by the commissioner;

(2) provide coverage of a kind that the association determines is similar to the coverage of the policy issued by the

impaired or insolvent insurer;

(3) contain at least the minimum provisions required by the statutes of this state; and

(4) provide benefits that are not unreasonable in relation to the premium charged.

(b) The association shall set the premium according to a table of rates the association adopts. The premium:

(1) must reflect:

(A) the amount of insurance provided; and

(B) each insured's age and class of risk; and

(2) may not reflect any change in an insured's health occurring after the original policy was most recently underwritten.

(c) The association may adopt various kinds of alternative policies to issue at a later date without regard to any particular impairment or insolvency. (V.T.I.C. Art. 21.28-D, Secs. 8(g), (h), (i).)

Source Law

(g) An alternative policy adopted by the association is subject to the approval of the commissioner. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(h) An alternative policy issued by the association must contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates adopted by the association. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but may not reflect any changes in the health of the insured after the original policy was last underwritten.

(i) An alternative policy issued by the association must provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

Revised Law

Sec. 463.257. IMPOSITION OF LIEN OR MORATORIUM. To carry out the association's duties under this chapter and with the court's approval, the association may:

(1) impose a permanent policy or contract lien in connection with any guarantee, assumption, or reinsurance

agreement if the association determines that:

(A) the amounts that may be assessed under this chapter are insufficient to ensure full and prompt performance of the association's duties under this chapter; or

(B) adverse economic or financial conditions affecting member insurers make imposition of the lien in the public interest; or

(2) in addition to any contractual provision for deferral of cash or policy loan value, impose a temporary moratorium or lien on payment of cash values and policy loans or the exercise of any other right to withdraw money held in connection with a policy or contract. (V.T.I.C. Art. 21.28-D, Sec. 8(p).)

Source Law

> (p) In carrying out its duties under this section, the association may, subject to approval by the court:
>
> (1) impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement if the association finds that the amounts that can be assessed under this Act are less than the amounts needed to assure full and prompt performance of the association's duties under this Act, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to make the imposition of the permanent policy or contract liens in the public interest; or
>
> (2) impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value.

Revised Law

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

(1) reflect the amount of insurance provided and the insured's age and class of risk; and

(2) be approved by the commissioner or a court. (V.T.I.C. Art. 21.28-D, Sec. 8(j).)

Source Law

> (j) If the association elects to reissue terminated coverage at a premium rate different from

that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the commissioner or by a court of competent jurisdiction.

Revised Law

Sec. 463.259. PREMIUM DUE DURING RECEIVERSHIP. After a court enters an order of receivership with respect to an insolvent insurer, a premium due for coverage issued by the insurer is owned by and is payable at the direction of the association. The association is liable for an unearned premium owed to a policy or contract owner that arises after the court enters the order. (V.T.I.C. Art. 21.28-D, Sec. 8(n).)

Source Law

(n) Premiums due for coverage after entry of an order of receivership of an insolvent insurer belong to and are payable at the direction of the association, and the association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

Revised Law

Sec. 463.260. LIMITS ON AND TERMINATION OF ASSOCIATION OBLIGATION. (a) The association is not liable for benefits that exceed the contractual obligations for which the insurer is liable or would have been liable if not impaired or insolvent.

(b) The association's obligations with respect to coverage under a policy of an impaired or insolvent insurer or under a reissued or alternative policy terminate on the date the coverage or policy is replaced by another similar policy by the policyholder, the insured, or the association.

(c) If a premium is not paid before the 32nd day after the date the premium is due under a guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage, the association's obligations under the policy, contract, or coverage terminate, except with respect to a claim incurred or any net cash surrender value due as provided by this chapter. (V.T.I.C. Art. 21.28-D, Secs. 3(d), 8(k), (m).)

Source Law

[Sec. 3]

(d) The benefits for which the association may become liable may not exceed the contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer.

[Sec. 8]

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

(m) Failure to pay premiums before the 32nd day after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under the policy or coverage under this Act with respect to that policy or coverage, except with respect to any claims incurred or any net cash surrender value due in accordance with the provisions of this Act.

Revisor's Note

Section 8(m), V.T.I.C. Article 21.28-D, in connection with a failure to pay certain premiums, refers to a "policy or contract or substitute coverage," and subsequently refers to "the policy or coverage" and "that policy or coverage." The revised law substitutes "policy, contract, or coverage" for "policy or coverage" for consistency of terminology.

Revised Law

Sec. 463.261. ASSIGNMENT OF RIGHTS. (a) A person receiving a benefit under this chapter, including a payment of or on account of a contractual obligation, continuation of coverage, or provision of substitute or alternative coverage, is considered to have assigned to the association the rights under, and any cause of action relating to, the covered policy to the extent of the benefit received. The association may require a payee, policy or contract owner, beneficiary, insured, or annuitant to assign the person's rights and cause of action to the association as a condition of receiving a right or benefit under this chapter.

(b) The association's subrogation rights under Subsection (a) have the same priority against the assets of the impaired or insolvent insurer as that held by the person entitled to receive a

benefit under this chapter.

(c) The association has all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to the policy or contract. (V.T.I.C. Art. 21.28-D, Secs. 8(t), (u).)

Source Law

> (t) A person receiving benefits under this Act is considered to have assigned the rights under, and any causes of action relating to, the covered policy or contract to the association to the extent of the benefits received under this Act, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The association may require an assignment to it of the rights and cause of action by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition to the receipt of a right or benefit under this Act. The subrogation rights of the association under this subsection have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this Act.
>
> (u) The association has all common-law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to such a policy or contract.

[Sections 463.262-463.300 reserved for expansion]

SUBCHAPTER G. OPERATION OF IMPAIRED OR INSOLVENT INSURER

Revised Law

Sec. 463.301. ISSUANCE OR RENEWAL OF POLICIES FOLLOWING CONSERVATORSHIP OR RECEIVERSHIP. (a) If an assessment has been made under this chapter for the insurer or guaranty fees have been provided for the insurer, an impaired insurer placed in conservatorship or receivership may not issue a new or renewal insurance policy on release from the conservatorship or receivership until the insurer has repaid in full the amount of guaranty fees provided by the association.

(b) Notwithstanding Subsection (a), on application of the association and after hearing, the commissioner may permit the insurer to issue new policies as provided by a plan of operation by the insurer for repayment. In approving the plan, the commissioner

may restrict the issuance of new or renewal policies as necessary to implement the plan.

(c) The commissioner shall give 10 days' notice of the hearing to the association. The association and the member insurers that paid assessments in relation to the impaired insurer are entitled to appear at and participate in the hearing.

(d) Money recovered against an impaired insurer under this section shall be repaid to the member insurers that paid assessments in relation to the impaired insurer on return of the member insurers' certificates of contribution. (V.T.I.C. Art. 21.28-D, Sec. 14(k).)

Source Law

> (k) An impaired insurer 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, 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, on application of the association and after hearing, permit the issuance of new policies in accordance with a plan of operation by the released insurer for repayment. The commissioner may, in approving such plan, place restrictions on the issuance of new or renewal policies as necessary to the implementation of the plan. The commissioner shall give 10 days' notice of a hearing under this subsection to the association, and 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.

Revised Law

Sec. 463.302. DISTRIBUTIONS TO SHAREHOLDERS AND AFFILIATES. (a) An impaired or insolvent insurer may not make a distribution to shareholders until the association has recovered the total amount of valid claims for money spent in carrying out the association's powers and performing the association's duties under Section 463.101, 463.103, 463.109, or 463.111(c) or Subchapter F with respect to that insurer, plus interest on that amount.

(b) Except as otherwise provided by this section, a receiver

appointed under an order of receivership for an insurer domiciled in this state may recover on behalf of the insurer from an affiliate that controlled the insurer the amount of any distribution, other than a stock dividend the insurer paid on the insurer's capital 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 insurer when a 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 insurer 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 insurer to pay the insurer's contractual obligations.

(e) The receiver may not recover a distribution to shareholders under Subsection (b) if the insurer shows that, at the time the distribution was paid, the distribution was lawful and reasonable 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 the insurer's contractual obligations. (V.T.I.C. Art. 21.28-D, Secs. 14(e), (f), (g), (h), (i), (j).)

Source Law

> (e) 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 Section 8 of this Act with respect to the insurer

have been recovered with interest by the association.

(f) 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 of Subsections (g), (h), and (i) of this section.

(g) A distribution to stockholders is not recoverable under Subsection (f) of this section if the insurer shows that when paid the distribution was lawful and reasonable, 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.

(h) A person that was an affiliate that controlled the insurer at the time distributions subject to Subsection (f) 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, they are jointly and severally liable.

(i) The maximum amount recoverable under Subsections (f) and (h) 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.

(j) If a person liable under Subsection (h) of this section is insolvent, all 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. 463.303. 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 insurer.

(b) To carry out the association's obligations under this chapter, the association is considered a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies, less any amount to which the association is entitled as subrogee under Section 463.261.

(c) 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 chapter. (V.T.I.C. Art. 21.28-D, Sec. 14(c).)

Source Law

(c) To carry out its obligations under this Act, 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 to which the association is entitled as subrogee under Sections 8(t) and (u) of this Act. 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 Act. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets that the reserves that should have been established for the policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

Revised Law

Sec. 463.304. DISTRIBUTION OF OWNERSHIP RIGHTS OF INSOLVENT INSURER. In making an equitable distribution of the ownership rights of an insolvent insurer before the termination of a receivership, the court:

(1) shall consider the welfare of the policyholders of the continuing or successor insurer; and

(2) may consider the contributions of the respective parties, including the association, the shareholders and policyholders of the insolvent insurer, and any other party with a bona fide interest. (V.T.I.C. Art. 21.28-D, Sec. 14(d).)

Source Law

(d) Before the termination of any receivership, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policyholders of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In making this determination, the court shall consider the welfare of the policyholders of the continuing or successor insurer.

[Sections 463.305-463.350 reserved for expansion]

SUBCHAPTER H. POWERS AND DUTIES OF COMMISSIONER AND DEPARTMENT

Revised Law

Sec. 463.351. NOTICE OF COMMISSIONER ACTIONS. (a) The commissioner shall:

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

(A) revokes or suspends a member insurer's certificate of authority; or

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

(i) restrict the insurer's premium writing;

(ii) withdraw from this state;

(iii) reinsure all or part of the insurer's business;

(iv) obtain additional contributions to surplus; or

(v) increase capital, surplus, or another account for the security of policyholders or creditors;

(2) report to the board when the commissioner:

(A) takes an action described by Subdivision (1) or receives from another insurance official a report indicating that a similar action has been taken in another state; or

(B) has reasonable cause to believe from a completed or continuing examination that a member insurer may be impaired or insolvent; and

(3) provide to the board the National Association of Insurance Commissioners Insurance Regulatory Information System ratios and listings of insurers not included in those ratios.

(b) A report under Subsection (a)(2)(A) must contain all significant details of the action taken or report received.

(c) The board may use information described by this section to carry out the board's duties under this chapter. The board shall

keep a report made under this section and the contents of the report confidential until the commissioner or other lawful authority makes the report and the contents public. (V.T.I.C. Art. 21.28-D, Secs. 12(a), (b).)

Source Law

Sec. 12. (a) The commissioner shall:

(1) notify the commissioners of all the other states, territories of the United States, and the District of Columbia by mail not later than the 30th day after the commissioner takes any of the following actions against a member insurer:

(A) revokes a license;

(B) suspends a license; or

(C) makes any formal order that the insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors;

(2) report to the board of directors when the commissioner has taken any of the actions set forth in Subdivision (1) of this subsection or has received a report from any other commissioner indicating that a similar action has been taken in another state; the report to the board of directors must contain all significant details of the action taken or the report received from the other commissioner;

(3) report to the board of directors when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer; and

(4) furnish to the board of directors the National Association of Insurance Commissioners Insurance Regulatory Information System ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners.

(b) The board may use the information described by Subsection (a) of this section in carrying out its duties and responsibilities under this Act. 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.

Revisor's Note

(1) Sections 12(a)(1) and (2), V.T.I.C. Article 21.28-D, refer to the "commissioners of all the other states, territories of the United States, and the District of Columbia" and to "any other commissioner." The revised law substitutes "insurance official[s]" for "commissioner[s]" because those officials might not be called "commissioners" in other jurisdictions.

(2) Section 12(b), V.T.I.C. Article 21.28-D,

refers to the board's "duties and responsibilities." Throughout this chapter, the revised law omits the reference to "responsibilities" in this context because "responsibilities" is included within the meaning of "duties."

Revised Law

Sec. 463.352. ADVICE FROM BOARD. The commissioner may seek the board's advice and recommendations on a matter affecting the commissioner's duties regarding the financial condition of:

(1) a member insurer; or

(2) an insurer applying for a certificate of authority to engage in the business of insurance in this state. (V.T.I.C. Art. 21.28-D, Sec. 12(c).)

Source Law

(c) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

Revisor's Note

Section 12(c), V.T.I.C. Article 21.28-D, refers to an insurer "seeking admission to transact insurance business in this state." The revised law substitutes "applying for a certificate of authority to engage in the business of insurance in this state" for the quoted language because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business in this state.

Revised Law

Sec. 463.353. EXAMINATION. (a) The board by majority vote may request the commissioner to order an examination of a member insurer that the board in good faith believes may be impaired or insolvent. The commissioner shall keep the request on file. The request is open for public inspection before release of the examination report to the public.

(b) Not later than the 30th day after the date the commissioner receives the request, the commissioner shall begin the examination. The examination may be conducted:

(1) as a National Association of Insurance Commissioners examination; or

(2) by a person the commissioner designates.

(c) The association shall pay the cost of the examination.

(d) The commissioner shall notify the board when the examination is completed. The examination report shall be treated in the same manner as other examination reports. The report may not be released to the board before the report is released to the public, except that the commissioner may comply with Section 463.351. (V.T.I.C. Art. 21.28-D, Sec. 12(f).)

Source Law

(f) The board of directors, on majority vote, may request that the commissioner order an examination of any member insurer that the board in good faith believes may be an impaired or insolvent insurer. Not later than the 30th day after the receipt of the request, the commissioner shall begin the examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by persons designated by the commissioner. The cost of the examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall the examination report be released to the board of directors before its release to the public, but this does not preclude the commissioner from complying with Subsection (a) of this section. The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it is open to public inspection before the release of the examination report to the public.

Revised Law

Sec. 463.354. DEMAND TO CURE IMPAIRMENT. (a) When an impairment is declared and the amount of the impairment is determined, the commissioner shall serve a demand on the impaired insurer to cure the impairment within a reasonable time.

(b) Notice of the demand under Subsection (a) to the impaired insurer constitutes notice to any shareholders of the insurer.

(c) Failure of the impaired insurer to comply promptly with

the demand does not excuse the association from exercising the association's powers and performing the association's duties under this chapter. (V.T.I.C. Art. 21.28-D, Sec. 11(b).)

Source Law

> (b) When an impairment is declared and the amount of the impairment is determined, the commissioner shall serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer constitutes notice to its shareholders, if any. The failure of the insurer to promptly comply with the demand does not excuse the association from the performance of its powers and duties under this Act.

Revised Law

Sec. 463.355. FAILURE TO COMPLY WITH PLAN OF OPERATION. On failure of a member insurer to comply with the plan of operation, the commissioner may suspend or revoke, after notice and hearing, the insurer's certificate of authority to engage in the business of insurance in this state. (V.T.I.C. Art. 21.28-D, Sec. 11(c) (part).)

Source Law

> (c) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that . . . fails to comply with the plan of operation. . . .

Revised Law

Sec. 463.356. ASSUMPTION OF POWERS AND DUTIES OF ASSOCIATION. The commissioner may assume the powers and duties of the association under this chapter with respect to impaired or insolvent insurers if the association does not within a reasonable period act as provided by:

(1) Section 463.252(b)(2);

(2) Section 463.253; and

(3) Section 463.254. (V.T.I.C. Art. 21.28-D, Sec. 8(q).)

Source Law

> (q) If the association fails to act within a reasonable period of time as provided in Subsections (b)(2), (d), and (e) of this section, the commissioner may assume the powers and duties of the association under this Act with respect to impaired or insolvent

insurers.

Revised Law

Sec. 463.357. NOTIFICATION OF EFFECT OF CHAPTER. The commissioner, as receiver of an impaired insurer, may notify all interested persons of the effect of this chapter. (V.T.I.C. Art. 21.28-D, Sec. 11(e).)

Source Law

(e) The commissioner, as receiver of an impaired insurer, may notify all interested persons of the effect of this Act.

Revised Law

Sec. 463.358. STATEMENT OF PREMIUMS. On request, the commissioner shall provide the association with a statement of the premiums in this state and any other appropriate state for each member insurer. (V.T.I.C. Art. 21.28-D, Sec. 11(a).)

Source Law

Sec. 11. (a) In addition to the duties and powers enumerated elsewhere in this Act, the commissioner shall provide the association, on request, with a statement of the premiums in this and any other appropriate states for each member insurer.

Revisor's Note

Section 11(a), V.T.I.C. Article 21.28-D, provides that the commissioner shall provide the association certain information "[i]n addition to the duties and powers enumerated elsewhere in this Act." The revised law omits the quoted language for the reason stated in the revisor's note to Section 463.102.

[Sections 463.359-463.400 reserved for expansion]

SUBCHAPTER I. APPEALS AND OTHER ACTIONS

Revised Law

Sec. 463.401. APPEAL TO COMMISSIONER. (a) Not later than the 60th day after the date of a final action of the association or the board, a member insurer may appeal the action to the commissioner.

(b) A member insurer appealing an assessment shall pay the assessment to the association. The association may use the money to

meet the association's obligations while the appeal is pending. If the appeal on the assessment is upheld, the association shall return to the insurer the amount paid in error or in excess of the amount the commissioner determines the insurer was obligated to pay. (V.T.I.C. Art. 21.28-D, Sec. 11(d).)

Source Law

> (d) An action of the board of directors or the association may be appealed to the commissioner by a member insurer if the appeal is taken before the 61st day after the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and 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 member company.

Revised Law

Sec. 463.402. VENUE. Venue for an action against the association under this chapter is in Travis County. (V.T.I.C. Art. 21.28-D, Sec. 20(a).)

Source Law

> Sec. 20. (a) Venue in a suit against the association arising under this article is in Travis County.

Revised Law

Sec. 463.403. APPEAL BOND. The association is not required to give an appeal bond in an appeal of a cause of action under this chapter. (V.T.I.C. Art. 21.28-D, Sec. 20(b).)

Source Law

> (b) The association is not required to give an appeal bond in an appeal of a cause of action under this article.

Revised Law

Sec. 463.404. 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 insurer 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 brought by the receiver, is stayed for:

(1) a six-month period beginning on the later of the

date the insurer is designated as impaired 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 insurer or the insurer's failure to defend an insured, the association on the association's 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 is entitled to defend the claim on the merits. (V.T.I.C. Art. 21.28-D, Sec. 18 (part).)

Source Law

> Sec. 18. 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. . . .

[Sections 463.405-463.450 reserved for expansion]

SUBCHAPTER J. PROHIBITED PRACTICES

Revised Law

Sec. 463.451. PROHIBITED USE OF PROTECTION PROVIDED BY CHAPTER. (a) A person may not make, publish, disseminate, circulate, or place before the public, or directly or indirectly cause to be made, published, disseminated, circulated, or placed before the public, a written or oral advertisement, announcement, or statement that uses the existence of the association to sell, solicit, or induce the purchase of a kind of insurance with respect to which this chapter provides coverage.

(b) This section applies to an advertisement, announcement,

or statement made, published, disseminated, circulated, or placed before the public:

(1) in a newspaper, magazine, or other publication;

(2) in a notice, circular, pamphlet, letter, or poster;

(3) over a radio or television station; or

(4) in any other manner.

(c) Except as provided by Section 463.114, 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.

(d) This section does not apply to the association or any other entity that does not sell or solicit insurance. (V.T.I.C. Art. 21.28-D, Sec. 19(a).)

Source Law

Sec. 19. (a) A person may not make, publish, disseminate, circulate, or place before the public or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, that uses the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by this Act. This section does not apply to the association or any other entity which does not sell or solicit insurance. The use of the protection afforded by this Act, other than as provided by this section, by any person in the sale of insurance constitutes unfair competition and unfair practices under Article 21.21 of this code, and is subject to the sanctions imposed under that article.

Revisor's Note

Section 19(a), V.T.I.C. Article 21.28-D, provides that certain unfair actions committed by a person are governed by V.T.I.C. Article 21.21. Article 21.21 is revised in various provisions of this code. The relevant provisions are revised in Chapter 541 of this code. Accordingly, the revised law substitutes "Chapter 541" for the reference to Article 21.21. In addition, Section 19(a) provides that the

person who commits the unfair action "is subject to the sanctions imposed under 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.

[Chapters 464-480 reserved for expansion]

SUBTITLE E. REQUIREMENTS OF OTHER JURISDICTIONS

CHAPTER 481. VOLUNTARY DEPOSITS

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CHAPTER 481. VOLUNTARY DEPOSITS

Revised Law

Sec. 481.001. DEPOSIT WITH COMPTROLLER. (a) An insurer organized and engaged in business under this code that is required by another state, country, or province as a condition of engaging in an insurance business in that state, country, or province to make or maintain a deposit with an officer of any state, country, or province may, at the insurer's discretion, voluntarily deposit with the comptroller cash or securities in an amount that is sufficient to satisfy the conditions of the other state, country, or province.

(b) Any securities deposited must be approved by the commissioner as being of a type and character in which the insurer is authorized by law to invest. (V.T.I.C. Art. 1.10, Sec. 17(a) (part).)

Source Law

Sec. 17. (a) In the event any insurance company organized and doing business under the provisions of this Code shall be required by any other state, country or province as a requirement for permission to do an insurance business therein to make or maintain a deposit with an officer of any state, country, or province, such company, at its discretion, may voluntarily deposit with the Comptroller such securities as may be approved by the Commissioner of Insurance to be of the type and character authorized by law to be legal investments for such company, or cash, in any amount sufficient to enable it to meet such requirements. . . .

Revisor's Note

Section 17(a), V.T.I.C. Article 1.10, refers to securities authorized by law to be "legal" investments for an insurer. The revised law omits the reference to "legal" as unnecessary because an investment authorized by law would necessarily be a legal investment.

Revised Law

Sec. 481.002. APPLICABILITY OF CHAPTER TO CERTAIN DEPOSITS. A voluntary deposit held by the comptroller or the department that was made by an insurer in this state before May 8, 1959, to gain admission to another state may, at the insurer's option, be considered to be held under this chapter. (V.T.I.C. Art. 1.10, Sec. 17(b).)

Source Law

(b) Any voluntary deposit held by the Comptroller or the Department heretofore made by any insurance company in this State, and which deposit was made for the purpose of gaining admission to another state, may be considered, at the option of such company, to be hereinafter held under the provisions of this Act.

Revisor's Note

Section 17(b), V.T.I.C. Article 1.10, refers to a voluntary deposit "heretofore" made by an insurer. The revised law substitutes a reference to a voluntary deposit made before May 8, 1959, because that is the effective date of that section.

Revised Law

Sec. 481.003. DUTIES OF COMPTROLLER. The comptroller shall receive a deposit made by an insurer as described by this chapter and hold it exclusively for the protection of all policyholders or creditors of the insurer, wherever they are located, or for the protection of the insurer's policyholders or creditors in a particular state, country, or province, as designated by the insurer at the time the insurer makes the deposit. (V.T.I.C. Art. 1.10, Sec. 17(a) (part).)

Source Law

> (a) . . . The Comptroller is hereby authorized and directed to receive such deposit and hold it exclusively for the protection of all policyholders or creditors of the company wherever they may be located, or for the protection of the policyholders or creditors of a particular state, country or province, as may be designated by such company at the time of making such deposit. . . .

Revisor's Note

Section 17(a), V.T.I.C. Article 1.10, provides that the comptroller is "authorized and directed" to receive certain deposits. The revised law substitutes "shall" for the quoted language for consistency with other law because "directed" imposes a duty and Texas statutes generally impose a duty by using the term "shall." See Section 311.016, Government Code (Code Construction Act). "Authorized" is omitted because a person is necessarily authorized to engage in an activity that the person has a statutory duty to undertake.

Revised Law

Sec. 481.004. ACCESS TO DEPOSIT. In accordance with reasonable rules adopted by the comptroller and the commissioner, the proper officer of an insurer making a deposit as described by this chapter may at a reasonable time:

(1) examine the deposit;

(2) detach coupons from the securities; and

(3) collect interest on the deposit. (V.T.I.C. Art. 1.10, Sec. 17(a) (part).)

Source Law

> (a) . . . The proper officer of each insurance company making such deposit shall be permitted at all reasonable times to examine such securities and to detach coupons therefrom, and to collect interest thereon, under such reasonable rules and regulations as may be prescribed by the Comptroller and the Commissioner of Insurance. . . .

Revisor's Note

Section 17(a), V.T.I.C. Article 1.10, 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. 481.005. SITUS OF DEPOSIT FOR TAX PURPOSES. For purposes of state, county, or municipal taxation, the situs of deposited securities is the municipality and county in which the principal business office of the insurer making the deposit is fixed by the insurer's charter. (V.T.I.C. Art. 1.10, Sec. 17(a) (part).)

Source Law

> (a) . . . For the purpose of state, county and municipal taxation, the situs of any securities deposited with the Comptroller hereunder shall be in the city and county where the principal business office of such company is fixed by its charter.

Revisor's Note

Section 17(a), V.T.I.C. Article 1.10, refers to a "city." The revised law substitutes the term "municipality" for "city" because that is the term used in the Local Government Code.

Revised Law

Sec. 481.006. WITHDRAWAL OF DEPOSIT. (a) An insurer that makes a deposit as described by this chapter may, at the insurer's option, withdraw all or part of the deposit if:

(1) the insurer first deposits with the comptroller other securities of like class as, and of an amount and value equal to, the securities proposed to be withdrawn; and

(2) the withdrawal and substitution are approved by the commissioner.

(b) An insurer, without making a substitute deposit under Subsection (a), may not withdraw all or part of a deposit made as described by this chapter for the protection of the insurer's policyholders or creditors in a particular state, country, or province that requires the deposit unless:

(1) the insurer files with the commissioner evidence that satisfies the commissioner that the insurer has withdrawn from business and does not have any unsecured liabilities outstanding or potential policyholder liabilities or obligations in the other state, country, or province; and

(2) the commissioner approves the withdrawal.

(c) An insurer, without making a substitute deposit under Subsection (a), may not withdraw all or part of a deposit made as described by this chapter for the protection of all of the insurer's policyholders or creditors, wherever they are located, unless:

(1) the insurer files with the commissioner evidence that satisfies the commissioner that the insurer does not have any unsecured liabilities outstanding or potential policy liabilities or obligations anywhere; and

(2) the commissioner approves the withdrawal. (V.T.I.C. Art. 1.10, Sec. 17(a) (part).)

Source Law

> (a) . . . The company may, at its option, withdraw such deposit or any part thereof, first having deposited with the Comptroller, in lieu thereof, other securities of like class and of equal amount and value to those withdrawn, which withdrawal and substitution must be approved by the Commissioner of Insurance. . . . Any deposit so made for the protection of policyholders or creditors of a particular state, country or province shall not be withdrawn, except by substitution as provided above, by the company, except upon filing with the Commissioner of Insurance evidence satisfactory to him that the company has withdrawn from business, and has

no unsecured liabilities outstanding or potential policyholder liabilities or obligations in such other state, country or province requiring such deposit, and upon the filing of such evidence the company may withdraw such deposit at any time upon the approval of the Commissioner of Insurance. Any deposit so made for the protection of all policyholders or creditors wherever they may be located shall not be withdrawn, except by substitution as provided above, by the company except upon filing with the Commissioner of Insurance evidence satisfactory to him that the company does not have any unsecured liabilities outstanding or potential policy liabilities or obligations anywhere, and upon filing such evidence the company may withdraw such deposit upon the approval of the Commissioner of Insurance. . . .

Revised Law

Sec. 481.007. WITHDRAWAL OF DEPOSIT AFTER MERGER, CONSOLIDATION, OR TOTAL REINSURANCE. When two or more insurers that have two or more deposits made for identical purposes as described by this chapter or former Article 4739, Revised Statutes, merge, consolidate, or enter into a total reinsurance contract by which the ceding insurer is dissolved and the ceding insurer's assets and liabilities are acquired or assumed by the surviving insurer, the new, surviving, or reinsuring insurer may withdraw all of the deposits, except for the deposit of the greatest amount and value. The new, surviving, or reinsuring insurer must demonstrate that the deposits are duplicated and that the insurer is the owner of the deposits. (V.T.I.C. Art. 1.10, Sec. 17(c).)

Source Law

(c) When two or more companies merge or consolidate or enter a total reinsurance contract by which the ceding company is dissolved and its assets acquired and liabilities assumed by the surviving company, and the companies have on deposit with the Comptroller two or more deposits made for identical purposes under this section or Article 4739, Revised Statutes, as amended, and now repealed, all such deposits, except the deposit of greatest amount and value, may be withdrawn by the new surviving or reinsuring company, upon proper showing of duplication of such deposits and that the company is the owner thereof.

Revised Law

Sec. 481.008. RETURN OF DEPOSIT. An insurer that has made a deposit as described by this chapter or former Article 4739, Revised Statutes, is entitled to a return of the deposit if the insurer applies for the return of the deposit and demonstrates to

the commissioner that the deposit is no longer required under the laws of any state, country, or province in which the insurer sought or gained admission to engage in business based on a certificate of the deposit. (V.T.I.C. Art. 1.10, Sec. 17(d).)

Source Law

> (d) Any company which has made a deposit or deposits under this section or Article 4739, Revised Statutes, as amended and now repealed, shall be entitled to a return of such deposits upon proper application therefor and a showing before the Commissioner that such deposit or deposits are no longer required under the laws of any state, country or province in which such company sought or gained admission to do business upon the strength of a certificate of such deposit.

Revisor's Note

Section 17(d), V.T.I.C. Article 1.10, refers to the making of a "proper" application for the return of certain deposits. The revised law omits "proper" as unnecessary because the word does not add to the clear meaning of the law. A document purporting to be an application is not an application if it does not meet the requirements for an application under that section.

Revised Law

Sec. 481.009. DELIVERY OF DEPOSIT BY COMPTROLLER. On being provided a certified copy of the commissioner's order issued under Section 481.007 or 481.008, the comptroller shall release, transfer, and deliver the deposit to the owner of the deposit in accordance with the order. (V.T.I.C. Art. 1.10, Sec. 17(e).)

Source Law

> (e) Upon being furnished a certified copy of the Commissioner's order issued under Subsection (c) or (d) above, the Comptroller shall release, transfer and deliver such deposit or deposits to the owner as directed in said order.

[Chapters 482-490 reserved for expansion]

SUBTITLE F. REINSURANCE

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CHAPTER 491. GENERAL REINSURANCE REQUIREMENTS

SUBCHAPTER A. REINSURANCE

Revised Law

Sec. 491.001. INAPPLICABILITY OF SUBCHAPTER. This subchapter does not apply to:

(1) life insurance;

(2) health insurance;

(3) annuity contracts;

(4) title insurance;

(5) workers' compensation insurance;

(6) employers' liability insurance coverage; or

(7) any policy or kind of coverage for which the maximum possible loss to the insurer is not readily ascertainable on the policy's issuance. (V.T.I.C. Art. 21.72, Sec. 3.)

Source Law

Sec. 3. This article does not apply to:
(1) life insurance;
(2) health insurance;
(3) annuity contracts;
(4) title insurance;
(5) workers' compensation insurance;
(6) employers' liability insurance

coverage; or

(7) any policy or type of coverage as to which the maximum possible loss to the insurer is not readily ascertainable on issuance of the policy.

Revised Law

Sec. 491.002. REINSURANCE PERMITTED. An insurer or reinsurer authorized to engage in the business of insurance or reinsurance in this state may reinsure all or part of a single risk in another solvent insurer. (V.T.I.C. Art. 21.72, Sec. 2.)

Source Law

Sec. 2. An insurance or reinsurance company authorized to transact insurance or reinsurance in this state may reinsure the whole or any part of an individual risk in another solvent insurer.

Revised Law

Sec. 491.003. RISK LIMITATION FOR DOMESTIC OR FOREIGN INSURER. An insurer incorporated under the laws of this state, another state, or the United States and authorized to engage in business in this state may not expose itself to a loss or hazard on a single risk in an amount that exceeds 10 percent of the insurer's surplus for policyholders unless the insurer reinsures the excess in another solvent insurer. (V.T.I.C. Art. 21.72, Sec. 1(a).)

Source Law

Art. 21.72

Sec. 1. (a) An insurance company incorporated under the laws of this state, another state, or the United States and authorized to do business in this state may not expose itself to any loss or hazard on any one risk in an amount that exceeds 10 percent of the company's surplus as regards policyholders unless the excess is reinsured by the company in another solvent insurer.

Revised Law

Sec. 491.004. RISK LIMITATION FOR ALIEN INSURER. An insurer incorporated under the laws of a jurisdiction other than this state, another state, or the United States and authorized to engage in business in this state may not, unless the insurer reinsures the excess in another solvent insurer, expose itself to a loss or hazard on a single risk in an amount that exceeds the sum of:

(1) 10 percent of the insurer's deposit with the statutory officer in the state through which the insurer is

authorized to engage in business in the United States; and

(2) 10 percent of the other surplus for policyholders of the insurer's United States branch. (V.T.I.C. Art. 21.72, Sec. 1(b).)

Source Law

(b) An insurance company incorporated under a jurisdiction other than that of this state, another state, or the United States and authorized to do business in this state may not expose itself to any loss or hazard on any one risk in an amount that exceeds 10 percent of the company's deposit with the statutory officer in the state through which the company gains admission to the United States, together with 10 percent of the other surplus to policyholders of the company's United States branch, unless the excess is reinsured by the company in another solvent insurer.

Revised Law

Sec. 491.005. COMPLIANCE WITH OTHER LAW. Reinsurance that is required or permitted by this subchapter must comply with Chapter 493. (V.T.I.C. Art. 21.72, Sec. 4.)

Source Law

Sec. 4. Any reinsurance required or permitted by this article must comply with Article 5.75-1 of this code.

Revisor's Note

V.T.I.C. Article 21.72 refers to V.T.I.C. Article 5.75-1, which is revised in this code as Chapter 493 and as Sections 492.051(b) and (c). The revised law omits the reference to Sections 492.051(b) and (c) because those provisions apply only to life insurance companies and are inapplicable to reinsurance required or permitted by this subchapter under Section 3, V.T.I.C. Article 21.72, revised in this chapter as Section 491.001.

[Sections 491.006-491.050 reserved for expansion]

SUBCHAPTER B. COMPUTATION OF REINSURANCE RESERVE

Revised Law

Sec. 491.051. COMPUTATION OF RESERVE FOR INSURER WITH NO BASIS PRESCRIBED BY LAW. For an insurer engaged in the business of

a kind of insurance in this state, for which no basis is prescribed by law, the department shall compute the reinsurance reserve on the basis prescribed by Section 862.102 for an insurer writing fire insurance. (V.T.I.C. Art. 1.10, Sec. 3.)

Source Law

> 3. Shall Calculate Reserve. For every company transacting any kind of insurance business in this State, for which no basis is prescribed by law, the Department shall calculate the reinsurance reserve upon the same basis prescribed in Section 862.102 of this code as to companies transacting fire insurance business.

Revised Law

Sec. 491.052. COMPUTATION OF REINSURANCE RESERVES FOR CERTAIN INSURERS. (a) On December 31 of each year, or as soon as practicable after that date, the department shall, in accordance with Section 491.051, compute the reinsurance reserve for all unexpired risks of each insurer organized under the laws of this state or engaged in the business of insurance in this state.

(b) This section does not apply to:

(1) life insurance;

(2) fire insurance;

(3) marine insurance;

(4) inland marine insurance;

(5) lightning insurance; or

(6) tornado insurance. (V.T.I.C. Art. 1.10, Sec. 4.)

Source Law

> 4. To Calculate Re-insurance Reserve. On the thirty-first day of December of each and every year, or as soon thereafter as may be practicable, the Department shall have calculated in the Department the re-insurance reserve for all unexpired risks of all insurance companies organized under the laws of this state, or transacting business in this state, transacting any kind of insurance other than life, fire, marine, inland, lightning or tornado insurance, which calculation shall be in accordance with the provisions of Paragraph 3 hereof.

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CHAPTER 492. REINSURANCE FOR LIFE, HEALTH, AND ACCIDENT INSURANCE COMPANIES AND RELATED ENTITIES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 492.001. DEFINITIONS. In this chapter:

(1) "Assuming insurer" means an insurer that, under a reinsurance contract, incurs an obligation to a ceding insurer, the performance of which is contingent on the ceding insurer's incurring liability or loss under the ceding insurer's insurance contract with a third person.

(2) "Qualified United States financial institution" means an institution that:

(A) is organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed, under the laws of the United States or any state of the United States; and

(B) is regulated, supervised, and examined by a federal or state authority that has regulatory authority over banks and trust companies. (V.T.I.C. Art. 3.10, Secs. (e) (part), (k).)

Source Law

(e) Qualified United States Financial Institutions. (1) For the purposes of Subsection (d)(3), a "qualified United States financial institution" means an institution that:

(A) is 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 thereof;

(B) is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

. . .

(2) A "qualified United States financial institution" means, . . . an institution that:

(A) is organized, or, in the case of a United States branch or agency office of a foreign banking organization, licensed, under the laws of the United States or any state thereof and . . . ; and

(B) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(k) "Assuming insurer" means the insurer who under a contract of reinsurance incurs to the ceding insurer an obligation of which the performance is contingent on incurring of liability or loss by the ceding insurer under its contract or contracts of insurance made with third persons.

Revised Law

Sec. 492.002. APPLICABILITY OF CHAPTER. (a) Except as provided by Subsection (b), this chapter applies to:

(1) all life, health, and accident insurance companies regulated by the department, including:

(A) a stock or mutual life, health, or accident insurance company;

(B) a fraternal benefit society; and

(C) a nonprofit hospital, medical, or dental service corporation, including a group hospital service corporation operating under Chapter 842; and

(2) a health maintenance organization operating under Chapter 843.

(b) This chapter does not apply to a ceding insurer domiciled in another state that regulates credit for reinsurance under statutes, rules, or regulations substantially similar in substance or effect to this chapter if the ceding insurer on request provides the commissioner with:

(1) evidence of the similarity in the form of those statutes, rules, or regulations; and

(2) an interpretation of the statutes, rules, or regulations and the standards used by the state of domicile. (V.T.I.C. Art. 3.10, Sec. (a) (part).)

Source Law

(a) . . . This article applies to all insurers regulated by the State Board of Insurance, including any stock and mutual life, accident, and health insurers, fraternal benefit societies, health maintenance organizations operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), and nonprofit hospital, medical, or dental service corporations, including companies subject to Chapter 20 of this

code. . . . This article does not apply to ceding insurers domiciled in another state that regulates credit for reinsurance under statutes, rules, or regulations substantially similar in substance or effect to this article. To qualify for this exception, the ceding insurer must provide the Commissioner on request with evidence of the similarity in the form of statutes, rules, or regulations, and an interpretation of the statutes, rules, or regulations and the standards used by the state of domicile. . . .

Revisor's Note

(1) Section (a), V.T.I.C. Article 3.10, 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) Section (a), V.T.I.C. Article 3.10, provides that V.T.I.C. Article 3.10 applies to "all insurers regulated by the State Board of Insurance, including any stock and mutual life, accident, and health insurers, fraternal benefit societies, health maintenance organizations operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), and nonprofit hospital, medical, or dental service corporations, including companies subject to Chapter 20 of this code." It is clear from the article's placement in V.T.I.C. Chapter 3, and from the specific listing of types of insurers, that "all insurers regulated by the State Board of Insurance" means "all life, health, and accident insurance companies." In addition, reinsurance for other types of insurers is governed by other statutes (for example, V.T.I.C. Article 5.75-1, revised in relevant part as Chapter 493 of this code, regulates reinsurance for property and casualty insurers). The revised law is drafted accordingly.

(3) Section (a), V.T.I.C. Article 3.10, refers

to "companies subject to Chapter 20 of this code." V.T.I.C. Chapter 20 was revised as Chapter 842 of this code, and the term used in that chapter for an entity organized under the chapter is "group hospital service corporation." The revised law is drafted accordingly.

Revised Law

Sec. 492.003. RULES. The commissioner may adopt rules implementing this chapter. (V.T.I.C. Art. 3.10, Sec. (f).)

Source Law

(f) The Board may adopt rules and regulations implementing the provisions of this law.

Revisor's Note

Section (f), V.T.I.C. Article 3.10, authorizes the State Board of Insurance to adopt "rules and regulations" to implement "this law," meaning Article 3.10, revised in this chapter. For the reason stated in Revisor's Note (1) to Section 492.002, the commissioner of insurance has the authority formerly granted to the board. The revised law omits as unnecessary the reference to "regulations" because a rule is defined under Section 311.005(5), Government Code (Code Construction Act), to include a regulation, and that definition applies to the revised law. In addition, while Sections 492.051(b) and (c) of this chapter are derived from a law other than Article 3.10, it is appropriate in the revised law to refer to rules implementing "this chapter" because including those sections in that reference has no substantive effect. Section 492.051(c) is a specific rulemaking provision that is applicable to Section 492.051(b) without regard to the general rulemaking provision revised as this section.

Revisor's Note
(End of Subchapter)

Section (a), V.T.I.C. Article 3.10, 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:

> (a) . . . This article is supplementary to and cumulative of other provisions of this code and other insurance laws of this state relating to reinsurance to the extent those provisions are not in conflict with this article.

[Sections 492.004-492.050 reserved for expansion]

SUBCHAPTER B. REINSURANCE

Revised Law

Sec. 492.051. REINSURANCE AUTHORIZED. (a) An insurer authorized to engage in the business of insurance in this state may reinsure in any solvent assuming insurer any risk or part of a risk that both insurers are authorized to assume.

(b) A life insurance company authorized to engage in business in this state may provide reinsurance on the same basis as an insurer described by Section 493.051(b).

(c) The commissioner may adopt necessary and reasonable rules under Subsection (b) to protect the public interest. (V.T.I.C. Art. 3.10, Sec. (a) (part); Art. 5.75-1, Secs. (l), (m).)

Source Law

> Art. 3.10. (a) Any insurer authorized to do the business of insurance in this state may reinsure in any solvent assuming insurer, any risk or part of a risk which both are authorized to assume; . . . .

[Art. 5.75-1]

> (l) A life insurance company authorized to do business in this state may provide reinsurance on the same basis as companies described in Subsection (k) of this article.
>
> (m) The State Board of Insurance may adopt necessary and reasonable rules under this article to protect the public interest.

Revised Law

Sec. 492.052. LIMITATION ON REINSURANCE OF ENTIRE OUTSTANDING BUSINESS. (a) An insurer may not reinsure the

insurer's entire outstanding business in an assuming insurer unless the assuming insurer is authorized to engage in the business of insurance in this state.

(b) Before the date of reinsurance:

(1) the reinsurance contract must be submitted to the commissioner; and

(2) the commissioner must approve the contract as fully protecting the interests of all policyholders. (V.T.I.C. Art. 3.10, Sec. (a) (part).)

Source Law

> (a) . . . No such insurer shall have the power to reinsure its entire outstanding business to an assuming insurer unless the assuming insurer is licensed in this state and until the contract therefor shall be submitted to the Commissioner and approved by him as protecting fully the interests of all policy holders. . . .

Revisor's Note

Section (a), V.T.I.C. Article 3.10, refers to an insurer "licensed" in this state. The revised law substitutes "authorized" for "licensed" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business. Similar changes have been made throughout this chapter.

Revised Law

Sec. 492.053. LIMITATION ON REINSURANCE OF RISKS OF INSURER WITH LESS THAN MINIMUM CAPITAL AND SURPLUS. An insurer operating under Section 841.204 may not reinsure any risk or part of a risk in an insurer that is not authorized to engage in the business of insurance in this state. (V.T.I.C. Art. 3.10, Sec. (a) (part).)

Source Law

> (a) . . . provided further, no insurer operating under Section 2(a) of Article 3.02 shall reinsure any risk or part of a risk with any insurer which is not licensed to engage in the business of insurance in this state. . . .

Revised Law

Sec. 492.054. FILING OF REINSURANCE SCHEDULES. The

commissioner shall require each insurer to file reinsurance schedules:

(1) when the insurer makes the insurer's annual report; and

(2) at other times as the commissioner directs. (V.T.I.C. Art. 3.10, Sec. (i).)

Source Law

(i) The State Board of Insurance shall require schedules of reinsurance to be filed by every insurer at the time of making the annual report and at such other times as the Board may direct.

Revised Law

Sec. 492.055. ACCOUNTING FOR REINSURANCE CONTRACTS. (a) An insurer shall account for reinsurance contracts and shall record the contracts in the insurer's financial statements in a manner that accurately reflects the effect of the contracts on the insurer's financial condition.

(b) A reinsurance contract may contain a provision allowing the offset of mutual debts and credits between the ceding insurer and the assuming insurer, whether arising out of one or more reinsurance contracts.

(c) The commissioner may adopt reasonable rules relating to:

(1) the accounting and financial statement requirements of this section and the treatment of reinsurance contracts between insurers, including minimum risk transfer standards, asset debits or credits, reinsurance debits or credits, and reserve debits or credits relating to the transfer of all or any part of an insurer's risks or liabilities by reinsurance contracts; and

(2) any contingencies arising from reinsurance contracts.

(d) A rule adopted under Subsection (c) after September 1, 1995, applies to:

(1) a reinsurance contract entered into on or after

the effective date of the rule; and

(2) a reinsurance contract that is amended on or after the effective date of the rule. (V.T.I.C. Art. 3.10, Sec. (l).)

Source Law

(l) An insurer shall account for reinsurance agreements and shall record those reinsurance agreements in the insurer's financial statement in a manner that accurately reflects the effect of the reinsurance agreements on the financial condition of the company. The State Board of Insurance may adopt reasonable rules relating to the accounting and financial statement requirements of this section and the treatment of reinsurance agreements between insurance companies, including minimum risk transfer standards, asset debits or credits, reinsurance debits or credits, and reserve debits or credits relating to the transfer of all or any part of an insurer's risks or liabilities by reinsurance agreements and any contingencies arising from reinsurance agreements. Rules adopted subsequent to September 1, 1995, shall apply to reinsurance agreements entered into on or after the effective date of such rules, and to reinsurance agreements that are amended on or after the effective date of such rules. A reinsurance agreement may contain a provision that allows the offset of mutual debts and credits between a ceding insurer and the assuming insurer, whether arising out of one or more reinsurance agreements.

Revisor's Note

Section (l), V.T.I.C. Article 3.10, refers to "reinsurance agreements." For consistent use of terminology throughout this code, the revised law substitutes "contract" for "agreement." Similar changes have been made throughout this chapter.

Revised Law

Sec. 492.056. LIMITATION ON RIGHTS AGAINST REINSURER. A person does not have a right against a reinsurer that is not specifically stated in:

(1) the reinsurance contract; or

(2) a specific agreement between the reinsurer and the person. (V.T.I.C. Art. 3.10, Sec. (h).)

Source Law

(h) A person does not have any rights against a reinsurer that are not specifically set forth in the contract of reinsurance or in a specific agreement between the reinsurer and the person.

[Sections 492.057-492.100 reserved for expansion]

SUBCHAPTER C. CREDIT FOR REINSURANCE

Revised Law

Sec. 492.101. EXCLUSIVE PROCEDURE FOR TAKING CREDIT FOR REINSURANCE. A ceding insurer may take a credit for reinsurance, as an asset or as a deduction from liability, only as provided by this chapter. (V.T.I.C. Art. 3.10, Sec. (a) (part).)

Source Law

> (a) . . . provided, however, no credit for reinsurance, either as an asset or a deduction of liability, may be taken by the ceding insurer except as provided in this article, and, . . . .

Revised Law

Sec. 492.102. CREDIT FOR REINSURANCE GENERALLY. (a) A ceding insurer may be allowed credit for reinsurance ceded, as an asset or as a deduction from liability, only if the reinsurance is ceded to an assuming insurer that:

(1) is authorized to engage in the business of insurance or reinsurance in this state;

(2) is accredited as a reinsurer in this state, as provided by Section 492.103; or

(3) subject to Subchapter D, maintains, in a qualified United States financial institution that has been granted the authority to operate with fiduciary powers, a trust fund to pay valid claims of:

(A) the assuming insurer's United States policyholders and ceding insurers; and

(B) the policyholders' and ceding insurers' assigns and successors in interest.

(b) Notwithstanding Subsection (a), a ceding insurer may be allowed credit for reinsurance ceded to an assuming insurer that does not meet the requirements of that subsection, but only with respect to the insurance of risks located in a jurisdiction in which the reinsurance is required by the jurisdiction's law, including regulations, to be ceded to an assuming insurer that does not meet the requirements of that subsection. (V.T.I.C. Art. 3.10, Secs.

(b) (part), (e) (part).)

Source Law

(b) Credit for reinsurance shall be allowed a ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when:

(1) the reinsurance is ceded to an assuming insurer which is licensed to transact insurance or reinsurance in this state; or

(2) the reinsurance is ceded to an assuming insurer which is accredited as a reinsurer in this state. . . . or

(3) the reinsurance is ceded to an assuming insurer which maintains a trust fund in a qualified United States financial institution, as defined in Subsection (e)(2), for the payment of the valid claims of its United States policy holders and ceding insurers, their assigns, and successors in interest. . . . or

(4) the reinsurance is ceded to an assuming insurer not meeting the requirements of Subdivision (1), (2), or (3), but only with respect to the insurance of risks located in a jurisdiction where such reinsurance is required by applicable law or regulation of that jurisdiction to be ceded to an assuming insurer that does not meet the requirements of Subdivision (1), (2), or (3) of this subsection.

(e) . . .

(2) [A "qualified United States financial institution" means,] for the purposes of those provisions of this law specifying those institutions that are eligible to act as a fiduciary of a trust, [an institution that:

(A) is organized, or, in the case of a United States branch or agency office of a foreign banking organization, licensed, under the laws of the United States or any state thereof and] has been granted the authority to operate with fiduciary powers[; and

(B) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.]

Revisor's Note

Section (b)(4), V.T.I.C. Article 3.10, refers to reinsurance required by "applicable" law. Because reinsurance necessarily can be required only by an applicable law, the revised law omits "applicable" as unnecessary.

Revised Law

Sec. 492.103. ACCREDITED REINSURER. For purposes of Section 492.102(a)(2), an insurer is accredited as a reinsurer in this state if the insurer:

(1) submits to this state's jurisdiction;

(2) submits to this state's authority to examine the insurer's books and records;

(3) is domiciled and authorized to engage in the business of insurance or reinsurance in at least one state or, if the insurer is a United States branch of an alien assuming insurer, is entered through and authorized to engage in the business of insurance or reinsurance in at least one state;

(4) annually files with the department a copy of the annual statement the insurer files with the insurance department of the insurer's state of domicile; and

(5) maintains a surplus as regards policyholders in an amount of at least $20 million. (V.T.I.C. Art. 3.10, Sec. (b) (part).)

Source Law

(b) . . .

(2) . . . An accredited reinsurer is one which: submits to this state's jurisdiction; submits to this state's authority to examine its books and records; is domiciled and licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer is entered through and licensed to transact insurance or reinsurance in at least one state; files annually a copy of its annual statement, filed with the insurance department of its state of domicile, with the State Board of Insurance; and maintains a surplus as regards policy holders in an amount not less than $20 million; . . . .

Revised Law

Sec. 492.104. CREDIT FOR FUNDS SECURING REINSURANCE OBLIGATIONS. (a) Subject to Subsection (b), any asset or deduction from liability for reinsurance ceded to an assuming insurer that does not meet the requirements of Section 492.102 shall be allowed in an amount that does not exceed the liabilities carried by the ceding insurer and in the amount of funds held by or on behalf of the ceding insurer under a reinsurance contract with the assuming insurer, including funds held in trust for the ceding insurer, as security for the payment of obligations under the contract.

(b) The funds held as security:

(1) must be held in the United States subject to

withdrawal solely by and under the exclusive control of the ceding insurer or, in the case of a trust, held in a qualified United States financial institution that has been granted the authority to operate with fiduciary powers; and

(2) may be in the form of:

(A) cash;

(B) securities that:

(i) are readily marketable over a national exchange;

(ii) have a maturity date of not later than one year;

(iii) are listed by the Securities Valuation Office of the National Association of Insurance Commissioners; and

(iv) qualify as admitted assets;

(C) subject to Section 492.105, a clean, irrevocable, unconditional letter of credit, issued or confirmed by a qualified United States financial institution that has been determined by the commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner; or

(D) another form of security acceptable to the commissioner. (V.T.I.C. Art. 3.10, Secs. (d) (part), (e) (part).)

Source Law

(d) Any asset or reduction from liability for the reinsurance ceded to an assuming insurer not meeting the requirements of Subsection (b) shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer, and such asset or reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder, if such security is held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer or, in the case of a trust, held

in a qualified United States financial institution, as defined in Subsection (e). This security may be in the form of:

(1) cash;

(2) securities readily marketable over a national exchange with a maturity date of not later than one year listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets;

(3) clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in Subsection (e)(1).

. . .

(4) any other form of security acceptable to the Commissioner.

(e)(1) [For the purposes of Subsection (d)(3), a "qualified United States financial institution" means an institution that:

(A) is 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 thereof;

(B) is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and]

(C) has been determined by either the Commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commissioner.

[(2) A "qualified United States financial institution" means, for the purposes of those provisions of this law specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(A) . . . has been granted the authority to operate with fiduciary powers; and . . . .]

Revisor's Note

Section (d), V.T.I.C. Article 3.10, refers to a "reduction from liability" for reinsurance and to "such . . . reduction." The revised law substitutes "deduction" for "reduction" because the reference to "reduction" is a typographical error. Throughout V.T.I.C. Article 3.10, revised in this chapter, references are otherwise consistently made to a "deduction from liability" for reinsurance.

Revised Law

Sec. 492.105. ACCEPTABILITY OF CERTAIN LETTERS OF CREDIT. A letter of credit issued or confirmed by an institution that meets

the standards prescribed by Section 492.104(b)(2)(C) as of the date the letter is issued or confirmed, but later fails to meet those standards, continues to be acceptable as security under Section 492.104 until the earliest of:

(1) the letter's expiration;

(2) the letter's extension, renewal, modification, or amendment after the date the institution fails to meet those standards; or

(3) the expiration of the three-month period after the date the institution fails to meet those standards. (V.T.I.C. Art. 3.10, Sec. (d) (part).)

Source Law

(d) . . .

(3) . . .

Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs; provided, however, the letter of credit must be replaced within three months after the date of the institution's failure to meet applicable standards of issuer acceptability.

. . . .

Revised Law

Sec. 492.106. CREDIT FOR REINSURANCE: DIRECT PAYMENT ON LIABILITY REQUIRED. A ceding insurer may not be given credit for reinsurance ceded, as an asset or as a deduction from liability, in an accounting or financial statement unless the reinsurance is payable by the assuming insurer:

(1) on the liability of the ceding insurer under the contracts reinsured, without diminution because of the ceding insurer's insolvency; and

(2) directly to the ceding insurer or to the ceding insurer's domiciliary liquidator or receiver. (V.T.I.C. Art. 3.10, Sec. (j).)

Source Law

(j) Credit may not be given in the accounting and financial statements, either as an asset or a

deduction from liability, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contracts reinsured without diminution because of the insolvency of the ceding insurer and is payable directly to the ceding insurer or to its domiciliary liquidator or receiver.

Revised Law

Sec. 492.107. REQUEST FOR INFORMATION FROM ASSUMING INSURER. (a) The commissioner may request that an assuming insurer not meeting the requirements of Section 492.102 file:

(1) financial statements certified and audited by an independent certified public accountant;

(2) a certified copy of the certificate or letter of authority from the domiciliary jurisdiction; and

(3) information on the principals and management of the assuming insurer.

(b) If an assuming insurer does not comply with a request under this section, the commissioner may issue a directive prohibiting all authorized insurers from taking credit for business ceded to the assuming insurer after the effective date of the directive.

(c) An unauthorized insurer that is included in the most recent quarterly listing published by the International Insurers Department of the National Association of Insurance Commissioners is considered to have complied with a request under this section. (V.T.I.C. Art. 3.10, Sec. (m).)

Source Law

(m) The Commissioner may request the filing of financial statements certified and audited by an independent certified public accountant, certified copies of the certificate or letter of authority from the domiciliary jurisdiction, and information on the principals and management of any assuming insurer that does not meet the requirements of Subsection (b) of this article. The failure of an assuming insurer that does not meet the requirements of Subsection (b) of this article to comply with a request for information by the Commissioner may result in the Commissioner issuing a directive prohibiting all licensed insurers from taking credit for business ceded with any such assuming insurer after the effective date of such directive. A nonlicensed insurer that is included in the most recent quarterly listing published by the Non-admitted Insurers Information Office of the National Association of Insurance Commissioners is

considered to have complied with a request for information from the Commissioner.

Revisor's Note

Section (m), V.T.I.C. Article 3.10, refers to the "Non-admitted Insurers Information Office" of the National Association of Insurance Commissioners. The name of that office has been changed to the International Insurers Department. The revised law is drafted accordingly.

[Sections 492.108-492.150 reserved for expansion]

SUBCHAPTER D. REQUIREMENTS FOR TRUST CREDIT ALLOWANCE

Revised Law

Sec. 492.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a trust that is used to qualify for a reinsurance credit under Section 492.102(a)(3) and to the assuming insurer that maintains the trust fund. (New.)

Revisor's Note

The revision of the requirements for a trust that is used to satisfy the conditions for taking a credit for reinsurance and the related duties of the assuming insurer have been compiled in this subchapter for clarity. This section is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the section throughout the subchapter.

Revised Law

Sec. 492.152. COMPOSITION OF TRUST. (a) If the assuming insurer is a single insurer, the trust must:

(1) consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States; and

(2) include a trusteed surplus of at least $20 million.

(b) If the assuming insurer is a group of insurers that includes an unincorporated individual insurer:

(1) the trust must:

(A) consist of a trusteed account representing the group's liabilities attributable to business written in the United States; and

(B) include a trusteed surplus of at least $100 million; and

(2) the group shall make available to the department an annual certification by the group's domiciliary regulator and its independent public accountants of each underwriter's solvency. (V.T.I.C. Art. 3.10, Sec. (b) (part).)

Source Law

(b) . . .

(3) . . . In the case of a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, include a trusteed surplus of not less than $20 million. In the case of a group of insurers, which group includes unincorporated individual insurers, the trust shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, include a trusteed surplus of not less than $100 million and the group shall make available to the State Board of Insurance an annual certification by the group's domiciliary regulator and its independent public accountants of the solvency of each underwriter. . . .

Revised Law

Sec. 492.153. FORM OF TRUST. The trust must be established in a form approved by the commissioner. (V.T.I.C. Art. 3.10, Sec. (b) (part).)

Source Law

(b) . . .

(3) . . . Such trust shall be established in a form approved by the State Board of Insurance. . . .

Revised Law

Sec. 492.154. TERMS OF TRUST. (a) The trust instrument must provide that contested claims are valid and enforceable on the final order of any court in the United States.

(b) The trust must vest legal title to the trust's assets in the trustees of the trust for:

(1) the trust's United States policyholders and ceding insurers; and

(2) the policyholders' and ceding insurers' assigns and successors in interest.

(c) The trust must remain in effect as long as the assuming insurer has outstanding obligations under a reinsurance contract subject to the trust. (V.T.I.C. Art. 3.10, Sec. (b) (part).)

Source Law

(b) . . .

(3) . . . The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in the trustees of the trust for its United States policy holders and ceding insurers, their assigns, and successors in interest. . . . The trust described herein must remain in effect for as long as the assuming insurer shall have outstanding obligations due under the reinsurance agreements subject to the trust. . . .

Revisor's Note

Section (b)(3), V.T.I.C. Article 3.10, refers to a court "of competent jurisdiction." The revised law omits the quoted language as unnecessary because the general laws of civil jurisdiction govern which courts have jurisdiction over the matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts. Similar changes have been made throughout this chapter.

Revised Law

Sec. 492.155. REPORTS AND CERTIFICATION. (a) Not later than February 28 of each year, the trustees of the trust shall:

(1) report to the department in writing, showing the balance of the trust and listing the trust's investments at the end of the preceding year; and

(2) certify the date of termination of the trust, if termination is planned, or certify that the trust will not expire before December 31 of the year of the report.

(b) To enable the commissioner to determine the sufficiency

of the trust fund under Section 492.102(a)(3), the assuming insurer shall report to the department not later than March 1 of each year information substantially the same as the information required to be reported by an authorized insurer on the National Association of Insurance Commissioners' Annual Statement form. (V.T.I.C. Art. 3.10, Sec. (b) (part).)

Source Law

(b) . . .

(3) . . . The trusteed assuming insurer shall report annually not later than March 1 to the State Board of Insurance information substantially the same as that required to be reported on the NAIC Annual Statement form by licensed insurers to enable the State Board of Insurance to determine the sufficiency of the trust fund. . . . Not later than February 28 of each year the trustees of the trust shall report to the State Board of Insurance in writing setting forth the balance of the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31; . . .

Revised Law

Sec. 492.156. CERTAIN TRUSTEED ASSUMING INSURERS: REQUIREMENTS FOR REINSURANCE CONTRACT. (a) A ceding insurer may not be allowed credit under Section 492.102(a)(3) for reinsurance ceded to an assuming insurer that is not authorized or accredited to engage in the business of insurance or reinsurance in this state unless the assuming insurer agrees in the reinsurance contract:

(1) that, if the assuming insurer fails to perform the assuming insurer's obligations under the reinsurance contract, the assuming insurer, at the request of the ceding insurer, will:

(A) submit to the jurisdiction of a court in any state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of that court or, if the court's decision is appealed, of the appellate court; and

(2) to designate the commissioner or an attorney as an agent for service of process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

(b) This section is not intended to conflict with or override a provision in a reinsurance contract that requires the parties to arbitrate the parties' disputes. (V.T.I.C. Art. 3.10, Sec. (c).)

Source Law

> (c) If the assuming insurer is not licensed or accredited to transact insurance or reinsurance in this state, the credit permitted by Subsection (b)(3) of this article shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:
>
> (1) that in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any State of the United States, will comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or of any Appellate Court in the event of an appeal; and
>
> (2) to designate the State Board of Insurance or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding company. This provision, however, is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement.

Revisor's Note

Section (c)(2), V.T.I.C. Article 3.10, refers to a "true and lawful attorney" for service of "lawful" process. The revised law omits the references to "true" and "lawful" as unnecessary because those terms do not add to the clear meaning of the law. The revised law substitutes "agent" for "attorney" because agent is the term more commonly used to refer to a person designated for service of process.

Revised Law

Sec. 492.157. EXAMINATION OF TRUST AND ASSUMING INSURER. The trust and the assuming insurer are subject to examination as determined by the commissioner. (V.T.I.C. Art. 3.10, Sec. (b) (part).)

Source Law

> (b) . . .
>
> (3) . . . The trust and the assuming

insurer shall be subject to examination as determined by the State Board of Insurance. . . .

Revisor's Note
(End of Chapter)

Section (g), V.T.I.C. Article 3.10, provides that Sections (a)-(f) of that article apply to a reinsurance contract that has "an inception, anniversary, or renewal date not less than four months after the effective date of this statute." Article 3.10 was substantially revised and Section (g) was added by Chapter 1082, Acts of the 71st Legislature, Regular Session, 1989. Those changes took effect September 1, 1989. The revised law omits Section (g) as executed because any reinsurance contract entered into on or before January 1, 1990, has expired or been renewed or the first anniversary of the contract has occurred. The omitted law reads:

> (g) Subsections (a) through (f) of this article shall apply to all reinsurance agreements having an inception, anniversary, or renewal date not less than four months after the effective date of this statute.

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CHAPTER 493. REINSURANCE FOR PROPERTY AND CASUALTY INSURERS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 493.001. DEFINITIONS. In this chapter:

(1) "Assuming insurer" means an insurer that, under a reinsurance contract, incurs an obligation to a ceding insurer, the performance of which is contingent on the ceding insurer incurring liability or loss under the ceding insurer's insurance contract with a third person.

(2) "Qualified United States financial institution" means an institution that:

(A) is organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed, under the laws of the United States or any state of the United States; and

(B) is regulated, supervised, and examined by a federal or state authority that has regulatory authority over banks and trust companies. (V.T.I.C. Art. 5.75-1, Secs. (e)(1) (part), (2) (part), (j).)

Source Law

> (e) Qualified United States Financial Institutions. (1) For the purposes of Subsection (d)(3), a "qualified United States financial institution" means an institution that:
>
> (A) is 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 thereof;
>
> (B) is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; . . .
>
> (2) A "qualified United States financial institution" means, . . . an institution that:
>
> (A) is organized, or, in the case of a United States branch or agency office of a foreign banking organization, licensed, under the laws of the United States or any state thereof and . . .; and
>
> (B) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.
>
> (j) "Assuming insurer" means the insurer who under a contract of reinsurance incurs to the ceding insurer an obligation of which the performance is contingent on incurring of liability or loss by the ceding insurer under its contract or contracts of insurance made with third persons.

Revised Law

Sec. 493.002. APPLICABILITY OF CHAPTER. (a) Except as provided by Subsection (b), this chapter applies to all insurers, including:

(1) a stock or mutual property and casualty insurance company;

(2) a Mexican casualty insurance company;

(3) a Lloyd's plan;

(4) a reciprocal or interinsurance exchange;

(5) a nonprofit legal service corporation;

(6) a county mutual insurance company;

(7) a farm mutual insurance company;

(8) a risk retention group; and

(9) any insurer writing a line of insurance regulated by Title 10.

(b) This chapter does not apply to a ceding insurer domiciled in another state that regulates credit for reinsurance under statutes, rules, or regulations substantially similar in substance and effect to this chapter if the ceding insurer on request provides the commissioner with:

(1) evidence of the similarity in the form of those statutes, rules, or regulations; and

(2) an interpretation of the standards used by the state of domicile. (V.T.I.C. Art. 5.75-1, Sec. (a) (part).)

Source Law

> (a) . . . This article applies to all insurers, including stock and mutual property and casualty insurers, Mexican casualty companies, Lloyd's plan insurers, reciprocal or interinsurance exchanges, nonprofit legal service corporations, county mutual insurance companies, farm mutual insurance companies, risk retention groups, or any insurer writing any line of insurance regulated by this chapter. . . . This article does not apply to ceding insurers domiciled in another state that regulates credit for reinsurance under statutes, rules, or regulations substantially similar in substance and effect to this article. To qualify for this exception, the ceding insurer must provide the Commissioner on request with evidence of the similarity in the form of statutes, rules, or regulations and an interpretation of the standards used by the state of domicile. . . .

Revisor's Note

(1) V.T.I.C. Article 5.75 provides that the "subchapter," meaning Subchapter F, V.T.I.C. Chapter 5, applies to certain kinds of insurance and insurers. The text of the article was originally enacted by Section 4, Chapter 539, Acts of the 51st Legislature, Regular Session, 1949, and was codified in 1951 as

Article 5.75 in Subchapter F, V.T.I.C. Chapter 5. The original 1949 enactment provided that the "act" applied to certain kinds of insurance and insurers and consisted only of the provisions revised as Chapter 1805. Although V.T.I.C. Article 5.75-1, which was enacted by Chapter 117, Acts of the 54th Legislature, Regular Session, 1955, as Article 5.76 and was later renumbered, is currently included in Subchapter F, that article was not included in the 1949 enactment from which Article 5.75 is derived. In addition, Article 5.75-1 includes specific applicability provisions. It is clear from the history of Subchapter F and the language of Article 5.75-1 that the legislature did not intend for the reference in Article 5.75 to "[t]his subchapter" to refer to Article 5.75-1. The revised law is drafted accordingly.

(2) Section (a), V.T.I.C. Article 5.75-1, refers to a "Lloyd's plan insurer." For consistent use of terminology in this code, the revised law substitutes "Lloyd's plan" for "Lloyd's plan insurer."

(3) Section (a), V.T.I.C. Article 5.75-1, refers to any line of insurance regulated by "this chapter," meaning V.T.I.C. Chapter 5, which regulates lines of property and casualty insurance. That chapter has been revised in part in various titles of this code. The relevant provisions of Chapter 5 that regulate those lines of property and casualty insurance are revised in Title 10 of this code. For that reason, throughout this chapter, the revised law substitutes a reference to "Title 10" for the reference to "this chapter."

Revised Law

Sec. 493.003. RULES. The commissioner may adopt necessary

and reasonable rules under this chapter to protect the public interest. (V.T.I.C. Art. 5.75-1, Sec. (m).)

Source Law

> (m) The State Board of Insurance may adopt necessary and reasonable rules under this article to protect the public interest.

Revisor's Note

Section (m), V.T.I.C. Article 5.75-1, 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. Throughout this chapter, references to the board have been changed appropriately.

Revisor's Note
(End of Subchapter)

Section (a), V.T.I.C. Article 5.75-1, 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:

> (a) . . . This Article is supplementary to and cumulative of other provisions of this Code pertaining to reinsurance to the extent those provisions are not in conflict with this article.

[Sections 493.004-493.050 reserved for expansion]

SUBCHAPTER B. REINSURANCE

Revised Law

Sec. 493.051. REINSURANCE AUTHORIZED. (a) An insurer authorized to engage in the business of insurance in this state may reinsure, in any solvent assuming insurer, any risk or part of a risk that both insurers are authorized by law to assume.

(b) An insurer authorized to engage in business in this state that writes any line of insurance regulated by Title 10 may

provide reinsurance under this chapter while the insurer is in compliance with law. (V.T.I.C. Art. 5.75-1, Secs. (a) (part), (k).)

Source Law

> Art. 5.75-1. (a) Any insurer licensed to do the business of insurance in this state may reinsure in any solvent assuming insurer any risk or part of a risk that both are authorized to assume under authority of law. . . .
>
> (k) Each company authorized to do business in this state, writing any line of insurance regulated by this chapter, and while in compliance with all laws applicable to it, may provide reinsurance as provided by Subsection (a) of this article.

Revisor's Note

(1) Section (a), V.T.I.C. Article 5.75-1, refers to an insurer "licensed to do the business of insurance in this state." The revised law substitutes "authorized" for "licensed" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business. Similar changes have been made throughout this chapter.

(2) Section (k), V.T.I.C. Article 5.75-1, refers to compliance of an insurer with "all laws applicable to it." Because an insurer can comply only with laws applicable to the insurer, the revised law omits as unnecessary the reference to the law being "applicable" to the insurer.

Revised Law

Sec. 493.052. LIMITATION ON REINSURANCE OF ENTIRE OUTSTANDING BUSINESS. (a) An insurer may not reinsure the insurer's entire outstanding business in an assuming insurer unless the assuming insurer is authorized to engage in the business of insurance in this state.

(b) Before the date of reinsurance:

(1) the reinsurance contract must be submitted to the commissioner; and

(2) the commissioner must approve the contract as fully protecting the interests of all policyholders. (V.T.I.C. Art. 5.75-1, Sec. (a) (part).)

Source Law

> (a) . . . No such company shall have the power to reinsure its entire outstanding business to an assuming insurer unless the assuming insurer is licensed in this state and until the contract therefor shall be submitted to the Commissioner and approved as protecting fully the interests of all the policyholders. . . .

Revised Law

Sec. 493.053. FILING OF REINSURANCE SCHEDULES. The commissioner shall require each insurer to file reinsurance schedules:

(1) when the insurer makes the insurer's annual report; and

(2) at other times as the commissioner directs. (V.T.I.C. Art. 5.75-1, Sec. (h).)

Source Law

> (h) The State Board of Insurance shall require schedules of reinsurance to be filed by every insurer at the time of making the annual report and at such other times as the board may direct.

Revised Law

Sec. 493.054. ACCOUNTING FOR REINSURANCE CONTRACTS. (a) An insurer shall account for reinsurance contracts and shall record the contracts in the insurer's financial statements in a manner that accurately reflects the effect of the contracts on the insurer's financial condition.

(b) A reinsurance contract may contain a provision allowing the offset of mutual debts and credits between the ceding insurer and the assuming insurer, whether arising out of one or more reinsurance contracts.

(c) The commissioner may adopt reasonable rules relating to:

(1) the accounting and financial statement requirements of this section and the treatment of reinsurance

contracts between insurers, including minimum risk transfer standards, asset debits or credits, reinsurance debits or credits, and reserve debits or credits relating to the transfer of all or any part of an insurer's risks or liabilities by reinsurance contracts; and

(2) any contingencies arising from reinsurance contracts. (V.T.I.C. Art. 5.75-1, Sec. (n).)

Source Law

(n) An insurer shall account for reinsurance agreements and shall record those agreements in the insurer's financial statements in a manner that accurately reflects the effect of the reinsurance agreements on the financial condition of the insurer. The State Board of Insurance may adopt reasonable rules relating to the accounting and financial statement requirements of this subsection and the treatment of reinsurance agreements between insurers, including minimum risk transfer standards, asset debits or credits, reinsurance debits or credits, and reserve debits or credits relating to the transfer of all or any part of an insurer's risks or liabilities by reinsurance agreements and to any contingencies arising from reinsurance agreements. Reinsurance agreements may contain a provision allowing the offset of mutual debts and credits between the ceding insurer and the assuming insurer whether arising out of one or more reinsurance agreements.

Revisor's Note

Section (n), V.T.I.C. Article 5.75-1, refers to "reinsurance agreements." For consistent use of terminology throughout this code, the revised law substitutes "contract" for "agreement." Similar changes have been made throughout this chapter.

Revised Law

Sec. 493.055. LIMITATION ON RIGHTS AGAINST REINSURER. A person does not have a right against a reinsurer that is not specifically stated in:

(1) the reinsurance contract; or

(2) a specific agreement between the reinsurer and the person. (V.T.I.C. Art. 5.75-1, Sec. (g).)

Source Law

(g) A person does not have any rights against a reinsurer that are not specifically set forth in the contract of reinsurance or in a specific agreement

between the reinsurer and the person.

[Sections 493.056-493.100 reserved for expansion]

SUBCHAPTER C. CREDIT FOR REINSURANCE

Revised Law

Sec. 493.101. EXCLUSIVE PROCEDURE FOR TAKING CREDIT FOR REINSURANCE. A ceding insurer may take a credit for reinsurance, as an asset or as a deduction from liability, only as provided by this chapter. (V.T.I.C. Art. 5.75-1, Sec. (a) (part).)

Source Law

> (a) . . . A credit for reinsurance, either as an asset or a deduction from liability, may not be taken by the ceding insurer except as provided by this article. . . .

Revised Law

Sec. 493.102. CREDIT FOR REINSURANCE GENERALLY. (a) A ceding insurer may be allowed credit for reinsurance ceded, as an asset or as a deduction from liability, only if the reinsurance is ceded to an assuming insurer that:

(1) is authorized to engage in the business of insurance or reinsurance in this state;

(2) is accredited as a reinsurer in this state, as provided by Section 493.103; or

(3) subject to Subchapter D, maintains, in a qualified United States financial institution that has been granted the authority to operate with fiduciary powers, a trust fund to pay valid claims of:

(A) the assuming insurer's United States policyholders and ceding insurers; and

(B) the policyholders' and ceding insurers' assigns and successors in interest.

(b) Notwithstanding Subsection (a), a ceding insurer may be allowed credit for reinsurance ceded to an assuming insurer that does not meet the requirements of that subsection, but only with respect to the insurance of risks located in a jurisdiction in which the reinsurance is required by the jurisdiction's law, including regulations, to be ceded to an assuming insurer that does not meet

the requirements of that subsection. (V.T.I.C. Art. 5.75-1, Secs. (b) (part), (e)(2) (part).)

Source Law

(b) Credit for reinsurance shall be allowed a ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when:

(1) the reinsurance is ceded to an assuming insurer which is licensed to transact insurance or reinsurance in this state; or

(2) the reinsurance is ceded to an assuming insurer which is accredited as a reinsurer in this state. . . .

(3) the reinsurance is ceded to an assuming insurer which maintains a trust fund in a qualified United States financial institution, as defined in Subsection (e)(2), for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns, and successors in interest. . . . or

(4) the reinsurance is ceded to an assuming insurer not meeting the requirements of Subdivision (1), (2), or (3), but only with respect to the insurance of risks located in a jurisdiction where such reinsurance is required by applicable law or regulation of that jurisdiction to be ceded to an assuming insurer that does not meet the requirements of Subdivision (1), (2), or (3) of this subsection.

[(e)]

(2) [A "qualified United States financial institution" means,] for the purposes of those provisions of this law specifying those institutions that are eligible to act as a fiduciary of a trust, [an institution that:

(A) is organized, or, in the case of a United States branch or agency office of a foreign banking organization, licensed, under the laws of the United States or any state thereof and] has been granted the authority to operate with fiduciary powers[; and

(B) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.]

Revisor's Note

Section (b)(4), V.T.I.C. Article 5.75-1, refers to reinsurance required by "applicable" law. Because reinsurance necessarily can be required only by an applicable law, the revised law omits "applicable" as unnecessary.

Revised Law

Sec. 493.103. ACCREDITED REINSURER. For purposes of Section 493.102(a)(2), an insurer is accredited as a reinsurer in this state if the insurer:

(1) submits to this state's jurisdiction;

(2) submits to this state's authority to examine the insurer's books and records;

(3) is domiciled and authorized to engage in the business of insurance or reinsurance in at least one state or, if the insurer is a United States branch of an alien assuming insurer, is entered through and authorized to engage in the business of insurance or reinsurance in at least one state;

(4) annually files with the department a copy of the annual statement the insurer files with the insurance department of the insurer's state of domicile; and

(5) maintains a surplus as regards policyholders in an amount of at least $20 million. (V.T.I.C. Art. 5.75-1, Sec. (b) (part).)

Source Law

(b) . . .

(2) . . . An accredited reinsurer is one which: submits to this state's jurisdiction; submits to this state's authority to examine its books and records; is domiciled and licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer is entered through and licensed to transact insurance or reinsurance in at least one state; files annually a copy of its annual statement, filed with the insurance department of its state of domicile, with the State Board of Insurance; and maintains a surplus as regards policyholders in an amount not less than $20 million; or

. . .

Revised Law

Sec. 493.104. CREDIT FOR FUNDS SECURING REINSURANCE OBLIGATIONS. (a) Subject to Subsection (b), any asset or deduction from liability for reinsurance ceded to an assuming insurer that does not meet the requirements of Section 493.102 shall be allowed in an amount that does not exceed the liabilities carried by the ceding insurer and in the amount of funds held by or on behalf of the ceding insurer under a reinsurance contract with the assuming insurer, including funds held in trust for the ceding insurer, as security for the payment of obligations under the contract.

(b) The funds held as security:

(1) must be held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer or, in the case of a trust, held in a qualified United States financial institution that has been granted the authority to operate with fiduciary powers; and

(2) may be in the form of:

(A) cash;

(B) securities that:

(i) are readily marketable over a national exchange;

(ii) have a maturity date of not later than one year;

(iii) are listed by the Securities Valuation Office of the National Association of Insurance Commissioners; and

(iv) qualify as admitted assets;

(C) subject to Section 493.105, a clean, irrevocable, unconditional letter of credit, issued or confirmed by a qualified United States financial institution that has been determined by the commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner; or

(D) another form of security acceptable to the commissioner. (V.T.I.C. Art. 5.75-1, Secs. (d) (part), (e)(1) (part).)

Source Law

(d) Any asset or deduction from liability for the reinsurance ceded to an assuming insurer not meeting the requirements of Subsection (b) shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer, and such asset or deduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with such assuming insurer as security for

the payment of obligations thereunder, if such security is held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer or, in the case of a trust, held in a qualified United States financial institution, as defined in Subsection (e). This security may be in the form of:

(1) cash;

(2) securities readily marketable over a national exchange with a maturity date of not more than one year listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets;

(3) clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in Subsection (e)(1). . . .

(4) any other form of security acceptable to the Commissioner.

[(e)]

(1) [For the purposes of Subsection (d)(3), a "qualified United States financial institution" means an institution that:

(A) is 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 thereof;

(B) is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies;] and

(C) has been determined by either the Commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commissioner.

[(2) A "qualified United States financial institution" means, for the purposes of those provisions of this law specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(A) . . . . has been granted the authority to operate with fiduciary powers; and . . . .]

Revised Law

Sec. 493.105. ACCEPTABILITY OF CERTAIN LETTERS OF CREDIT. A letter of credit issued or confirmed by an institution that meets the standards prescribed by Section 493.104(b)(2)(C) as of the date the letter is issued or confirmed, but later fails to meet those standards, continues to be acceptable as security under Section 493.104 until the earliest of:

(1) the letter's expiration;

(2) the letter's extension, renewal, modification, or amendment after the date the institution fails to meet those

standards; or

(3) the expiration of the three-month period after the date the institution fails to meet those standards. (V.T.I.C. Art. 5.75-1, Sec. (d) (part).)

Source Law

(d) . . .

(3) . . .

Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; provided, however, such letter of credit shall be replaced within three months after the date of the institution's failure to meet applicable standards of issuer acceptability. . . .

Revised Law

Sec. 493.106. CREDIT FOR REINSURANCE: DIRECT PAYMENT ON LIABILITY REQUIRED. (a) A ceding insurer may not be given credit for reinsurance ceded, as an asset or as a deduction from liability, in an accounting or financial statement unless the reinsurance is payable by the assuming insurer:

(1) on the liability of the ceding insurer under the contracts reinsured, without diminution because of the ceding insurer's insolvency; and

(2) directly to the ceding insurer or to the ceding insurer's domiciliary liquidator or receiver.

(b) Subsection (a)(2) does not apply if:

(1) the reinsurance contract specifically provides that, if the ceding insurer is insolvent, the reinsurance is payable to a payee other than one described by Subsection (a)(2); or

(2) the assuming insurer, with the direct insured's consent, has assumed the ceding insurer's policy obligations to the payee as the assuming insurer's direct obligations to the payee under the policy as a substitute for the ceding insurer's obligations. (V.T.I.C. Art. 5.75-1, Sec. (i).)

Source Law

(i) Credit may not be given in the accounting and financial statements, either as an asset or a deduction from liability, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contracts reinsured without diminution because of the insolvency of the ceding insurer, and is payable directly to the ceding insurer or to its domiciliary liquidator or receiver, except:

(1) where the contract of reinsurance specifically provides another payee of the reinsurance in the event of insolvency of the ceding insurer; or

(2) where the assuming insurer, with the consent of the direct insured, has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payee under the policies and in substitution for the obligations of the ceding insurer to the payee.

Revised Law

Sec. 493.107. REQUEST FOR INFORMATION FROM ASSUMING INSURER. (a) The commissioner may request that an assuming insurer not meeting the requirements of Section 493.102 file:

(1) financial statements certified and audited by an independent certified public accountant;

(2) a certified copy of the certificate or letter of authority from the domiciliary jurisdiction; and

(3) information on the principals and management of the assuming insurer.

(b) If an assuming insurer does not comply with a request under this section, the commissioner may issue a directive prohibiting all authorized insurers from taking credit for business ceded to the assuming insurer after the effective date of the directive.

(c) An unauthorized insurer that is included in the most recent quarterly listing published by the International Insurers Department of the National Association of Insurance Commissioners is considered to have complied with a request under this section. (V.T.I.C. Art. 5.75-1, Sec. (o).)

Source Law

(o) The Commissioner may request the filing of financial statements certified and audited by an independent certified public accountant, certified copies of the certificate or letter of authority from the domiciliary jurisdiction, and information on the

principals and management of any assuming insurer that does not meet the requirements of Subsection (b) of this article. The failure of an assuming insurer that does not meet the requirements of Subsection (b) of this article to comply with a request for information by the Commissioner may result in the Commissioner issuing a directive prohibiting all licensed insurers from taking credit for business ceded with any such assuming insurer after the effective date of such directive. A nonlicensed insurer that is included in the most recent quarterly listing published by the Non-admitted Insurers Information Office of the National Association of Insurance Commissioners is considered to have complied with a request for information by the Commissioner.

Revisor's Note

Section (o), V.T.I.C. Article 5.75-1, refers to the "Non-admitted Insurers Information Office" of the National Association of Insurance Commissioners. The name of that office has been changed to the International Insurers Department. The revised law is drafted accordingly.

[Sections 493.108-493.150 reserved for expansion]

SUBCHAPTER D. REQUIREMENTS FOR TRUST CREDIT ALLOWANCE

Revised Law

Sec. 493.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a trust that is used to qualify for a reinsurance credit under Section 493.102(a)(3) and to the assuming insurer that maintains the trust fund. (New.)

Revisor's Note

The revision of the requirements for a trust that is used to satisfy the conditions for taking a credit for reinsurance and the related duties of the assuming insurer have been compiled in this subchapter for clarity. This section is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the section throughout the subchapter.

Revised Law

Sec. 493.152. COMPOSITION OF TRUST. (a) If the assuming insurer is a single insurer, the trust must:

(1) consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States; and

(2) include a trusteed surplus of at least $20 million.

(b) If the assuming insurer is a group of insurers that includes an unincorporated individual insurer:

(1) the trust must:

(A) consist of a trusteed account representing the group's liabilities attributable to business written in the United States; and

(B) include a trusteed surplus of at least $100 million; and

(2) the group shall make available to the department an annual certification by the group's domiciliary regulator and its independent public accountants of each underwriter's solvency.

(c) If the assuming insurer is a group of incorporated insurers under common administration that has continuously engaged in the business of insurance for at least three years, is under the supervision of the Department of Trade and Industry of the United Kingdom, and has an aggregate policyholders' surplus of $10 billion:

(1) the trust must:

(A) consist of a trusteed account representing the group's several liabilities attributable to business written in the United States under reinsurance contracts issued in the name of the group; and

(B) include a trusteed surplus of not less than $100 million held jointly for the benefit of United States insurers that have ceded business to any member of the group; and

(2) each member of the group shall make available to the department an annual certification by the member's domiciliary regulator and its independent public accountants of each member's solvency. (V.T.I.C. Art. 5.75-1, Sec. (b) (part).)

Source Law

(b) . . .

(3) . . . In the case of a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, include a trusteed surplus of not less than $20 million. In the case of a group of insurers, which group includes unincorporated individual insurers, the trust shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, include a trusteed surplus of not less than $100 million; and the group shall make available to the State Board of Insurance an annual certification by the group's domiciliary regulator and its independent public accountants of the solvency of each underwriter. In the case of a group of incorporated insurers under common administration which has continuously transacted an insurance business for at least three years, which is under the supervision of the Department of Trade and Industry of the United Kingdom, and which has aggregate policyholder's surplus of $10 billion, the trust shall consist of a trusteed account representing the group's several liabilities attributable to business written in the United States pursuant to reinsurance contracts issued in the name of the group and, in addition, include a trusteed surplus of not less than $100 million which shall be held jointly for the benefit of United States insurers ceding business to any member of the group, and each member of the group shall make available to the State Board of Insurance an annual certification by the member's domiciliary regulator and its independent public accountants of the solvency of each member. . . .

Revised Law

Sec. 493.153. FORM OF TRUST. The trust must be established in a form approved by the commissioner. (V.T.I.C. Art. 5.75-1, Sec. (b) (part).)

Source Law

(b) . . .

(3) . . . Such trust shall be established in a form approved by the State Board of Insurance. . . .

Revised Law

Sec. 493.154. TERMS OF TRUST. (a) The trust instrument must provide that contested claims are valid and enforceable on the final order of any court in the United States.

(b) The trust must vest legal title to the trust's assets in the trustees of the trust for:

(1) the trust's United States policyholders and ceding

insurers; and

(2) the policyholders' and ceding insurers' assigns and successors in interest.

(c) The trust must remain in effect as long as the assuming insurer has outstanding obligations under a reinsurance contract subject to the trust. (V.T.I.C. Art. 5.75-1, Sec. (b) (part).)

Source Law

(b) . . .

(3) . . . The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers, their assigns, and successors in interest. . . . The trust described herein must remain in effect for as long as the assuming insurer shall have outstanding obligations due under the reinsurance agreements subject to the trust. . . .

Revisor's Note

Section (b)(3), V.T.I.C. Article 5.75-1, refers to a court "of competent jurisdiction." The revised law omits the quoted language as unnecessary because the general laws of civil jurisdiction govern which courts have jurisdiction over the matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts. Similar changes have been made throughout this chapter.

Revised Law

Sec. 493.155. REPORTS AND CERTIFICATION. (a) Not later than February 28 of each year, the trustees of the trust shall:

(1) report to the department in writing, showing the balance of the trust and listing the trust's investments at the end of the preceding year; and

(2) certify the date of termination of the trust, if termination is planned, or certify that the trust will not expire before December 31 of the year of the report.

(b) To enable the commissioner to determine the sufficiency

of the trust fund under Section 493.102(a)(3), the assuming insurer shall report to the department not later than March 1 of each year information substantially the same as the information required to be reported by an authorized insurer on the National Association of Insurance Commissioners' Annual Statement form. (V.T.I.C. Art. 5.75-1, Sec. (b) (part).)

Source Law

> (b) . . .
>
> (3) . . . The trusteed assuming insurer shall report annually not later than March 1 to the State Board of Insurance information substantially the same as that required to be reported on the NAIC Annual Statement form by licensed insurers to enable the State Board of Insurance to determine the sufficiency of the trust fund. . . . Not later than February 28 of each year the trustees of the trust shall report to the State Board of Insurance in writing setting forth the balance of the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31; . . .

Revised Law

Sec. 493.156. CERTAIN TRUSTEED ASSUMING INSURERS: REQUIREMENTS FOR REINSURANCE CONTRACT. (a) A ceding insurer may not be allowed credit under Section 493.102(a)(3) for reinsurance ceded to an assuming insurer that is not authorized or accredited to engage in the business of insurance or reinsurance in this state unless the assuming insurer agrees in the reinsurance contract:

(1) that, if the assuming insurer fails to perform the assuming insurer's obligations under the reinsurance contract, the assuming insurer, at the request of the ceding insurer, will:

(A) submit to the jurisdiction of a court in any state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of that court or, if the court's decision is appealed, of the appellate court; and

(2) to designate the commissioner or an attorney as an agent for service of process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

(b) This section is not intended to conflict with or override a provision in a reinsurance contract that requires the parties to arbitrate the parties' disputes. (V.T.I.C. Art. 5.75-1, Sec. (c).)

Source Law

> (c) If the assuming insurer is not licensed or accredited to transact insurance or reinsurance in this state, the credit permitted by Subsection (b)(3) of this article shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:
>
> (1) that in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any State of the United States, will comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or of any Appellate Court in the event of an appeal; and
>
> (2) to designate the State Board of Insurance or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding company. This provision, however, is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement.

Revisor's Note

Section (c)(2), V.T.I.C. Article 5.75-1, refers to a "true and lawful attorney" for service of "lawful" process. The revised law omits the references to "true" and "lawful" as unnecessary because those terms do not add to the clear meaning of the law. The revised law substitutes "agent" for "attorney" because agent is the term more commonly used to refer to a person designated for service of process.

Revised Law

Sec. 493.157. EXAMINATION OF TRUST AND ASSUMING INSURER. The trust and the assuming insurer are subject to examination as determined by the commissioner. (V.T.I.C. Art. 5.75-1, Sec. (b) (part).)

Source Law

> (b) . . .
>
> (3) . . . The trust and the assuming

insurer shall be subject to examination as determined by the State Board of Insurance. . . .

Revisor's Note
(End of Chapter)

Section (f), V.T.I.C. Article 5.75-1, provides that Sections (a)-(e) of that article apply to a reinsurance agreement that has "an inception, anniversary, or renewal date not less than four months after the effective date of this statute." Article 5.75-1 was substantially revised and Subsection (f) was added by Chapter 1082, Acts of the 71st Legislature, Regular Session, 1989. Those changes took effect September 1, 1989. The revised law omits Section (f) as executed because any reinsurance agreement entered into on or before January 1, 1990, has expired or been renewed or the first anniversary of the agreement has occurred. The omitted law reads:

> (f) Subsections (a) through (e) of this article shall apply to all reinsurance agreements having an inception, anniversary, or renewal date not less than four months after the effective date of this statute.

CHAPTER 494. REINSURANCE OF AIRCRAFT AND SPACE EQUIPMENT RISKS

Sec. 494.001. DEFINITIONS . . . . . 781
Sec. 494.002. AUTHORITY TO REINSURE . . . . . 782
Sec. 494.003. REQUIREMENT FOR CEDING INSURER . . . . . 783

CHAPTER 494. REINSURANCE OF AIRCRAFT AND SPACE EQUIPMENT RISKS

Revised Law

Sec. 494.001. DEFINITIONS. In this chapter:

(1) "Aircraft" means an object that is capable of:

(A) moving through the atmosphere, regardless of whether the object is powered or tethered; and

(B) lifting the weight of the object and an additional payload.

(2) "Space equipment" means a spacecraft, satellite, rocket, or other manmade object that may be:

(A) launched from earth into orbit around a

celestial body or for space travel; or

(B) placed into orbit around a celestial body. (V.T.I.C. Art. 5.75-3, Sec. (a).)

Source Law

Art. 5.75-3. (a) In this article, "aircraft" means an object capable of moving through the atmosphere, whether powered or unpowered, tethered or untethered, which is capable of lifting the weight of the object and a payload in addition thereto, and "space equipment" means spacecraft, satellites, rockets, or other manmade objects that may be launched from earth into orbit around a celestial body or for space travel or may be placed into orbit around a celestial body.

Revised Law

Sec. 494.002. AUTHORITY TO REINSURE. (a) A domestic insurance company as defined by Section 841.001, alone or together with another insurer, may reinsure any liability, property, casualty, collision, personal injury, death, or other risk relating to, arising from, or incident to the manufacture, ownership, custody, or operation of an aircraft or any space equipment, subject to any just and reasonable limitation imposed by the commissioner.

(b) A limitation imposed by the commissioner must be consistent with the purposes of this chapter. (V.T.I.C. Art. 5.75-3, Sec. (b).)

Source Law

(b) A domestic company as defined by Section 5 of Article 3.01 of this code, either by itself or together with other insurance companies, may, subject to such just and reasonable limitations as may be imposed by the State Board of Insurance, reinsure any liability, property, casualty, collision, personal injury, death, or other risks relating to, arising from, or incident to the manufacture, ownership, custody, or operation of an aircraft or any space equipment. Any limitations imposed by the State Board of Insurance shall be consistent with the purposes underlying this article.

Revisor's Note

(1) Section (b), V.T.I.C. Article 5.75-3, refers to a "domestic company as defined by Section 5 of [V.T.I.C.] Article 3.01." The relevant portion of Section 5, Article 3.01, is revised as Section

841.001(4) of this code, and that revision uses the term "domestic insurance company." The revised law is drafted accordingly.

(2) Section (b), V.T.I.C. Article 5.75-3, 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 references to the board have been changed appropriately.

Revised Law

Sec. 494.003. REQUIREMENT FOR CEDING INSURER. To enter into a reinsurance agreement under this chapter, the ceding insurer must be authorized to engage in business in this state. (V.T.I.C. Art. 5.75-3, Sec. (c).)

Source Law

(c) The ceding insurer in a reinsurance agreement entered into under Section (b) of this article must be licensed to do business in this state.

Revisor's Note

Section (c), V.T.I.C. Article 5.75-3, refers to an insurer "licensed to do business in this state." The revised law substitutes "authorized" for "licensed" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revisor's Note
(End of Chapter)

V.T.I.C. Article 5.75 provides that the "subchapter," meaning Subchapter F, V.T.I.C. Chapter 5, applies to certain kinds of insurance and insurers. The text of the article was originally enacted by Section 4, Chapter 539, Acts of the 51st Legislature, Regular Session, 1949, and was codified in 1951 as Article 5.75 in Subchapter F, V.T.I.C. Chapter 5. The

original 1949 enactment provided that the "act" applied to certain kinds of insurance and insurers and consisted only of the provisions revised as Chapter 1805. Although V.T.I.C. Article 5.75-3, which was enacted by Chapter 42, Acts of the 68th Legislature, Regular Session, 1983, is currently included in Subchapter F, that article was not included in the 1949 enactment from which Article 5.75 is derived. In addition, Article 5.75-3 includes specific applicability provisions. It is clear from the history of Subchapter F and the language of Article 5.75-3 that the legislature did not intend for the reference in Article 5.75 to "[t]his subchapter" to refer to Article 5.75-3. The revised law is drafted accordingly.

TITLE 10. PROPERTY AND CASUALTY INSURANCE

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[Chapters 2214-2250 reserved for expansion]

SUBTITLE H. RATEMAKING IN GENERAL

CHAPTER 2251. RATES

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TITLE 10. PROPERTY AND CASUALTY INSURANCE

SUBTITLE A. GENERAL PROVISIONS

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SUBCHAPTER A. GENERAL PROVISIONS

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CHAPTER 1801. PROPERTY AND CASUALTY INSURANCE LEGISLATIVE OVERSIGHT COMMITTEE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1801.001. DEFINITION. In this chapter, "committee" means the property and casualty insurance legislative oversight committee. (V.T.I.C. Art. 21.49-20, Sec. (a).)

Source Law

Art. 21.49-20. (a) In this section, "committee" means the property and casualty insurance legislative oversight committee.

Revised Law

Sec. 1801.002. SUNSET PROVISION. The committee is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the committee is abolished September 1, 2007. (V.T.I.C. Art. 21.49-20, Sec. (d).)

Source Law

(d) The committee is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the

committee is abolished September 1, 2007.

[Sections 1801.003-1801.050 reserved for expansion]

SUBCHAPTER B. LEGISLATIVE OVERSIGHT COMMITTEE

Revised Law

Sec. 1801.051. COMPOSITION OF COMMITTEE. (a) The property and casualty insurance legislative oversight committee is composed of seven members as follows:

(1) the chair of the Senate Business and Commerce Committee and the chair of the House Committee on Insurance, who shall serve as joint presiding officers of the committee;

(2) two members of the senate appointed by the lieutenant governor;

(3) two members of the house of representatives appointed by the speaker of the house of representatives; and

(4) the public insurance counsel.

(b) An appointed member of the committee serves at the pleasure of the appointing official.

(c) In making appointments to the committee, the appointing officials shall attempt to appoint persons who represent the gender composition, minority populations, and geographic regions of this state. (V.T.I.C. Art. 21.49-20, Secs. (b), (c).)

Source Law

(b) The committee is composed of seven members as follows:

(1) the chair of the Senate Business and Commerce Committee and the chair of the House Committee on Insurance, who shall serve as joint chairs of the committee;

(2) two members of the senate appointed by the lieutenant governor;

(3) two members of the house of representatives appointed by the speaker of the house of representatives; and

(4) the public insurance counsel.

(c) An appointed member of the committee serves at the pleasure of the appointing official. In making appointments to the committee, the appointing officials shall attempt to appoint persons who represent the gender composition, minority populations, and geographic regions of the state.

Revised Law

Sec. 1801.052. MEETINGS. The committee shall meet with the commissioner at least annually. (V.T.I.C. Art. 21.49-20, Sec. (e)

(part).)

Source Law

(e) The committee shall:

(1) meet at least annually with the commissioner; . . . .

Revised Law

Sec. 1801.053. POWERS AND DUTIES OF COMMITTEE. (a) The committee shall:

(1) receive information about rules proposed by the department relating to property and casualty insurance and may submit comments to the commissioner on the proposed rules;

(2) monitor the progress of property and casualty insurance regulation reform, including:

(A) the fairness of rates, underwriting guidelines, and rating manuals;

(B) the availability of coverage; and

(C) the effect of rate rollbacks, credit scoring, and regulation of homeowners and automobile insurance markets;

(3) review recommendations for legislation proposed by the department; and

(4) review the necessity of having the department periodically examine the market conduct of an insurer or group of insurers, including the insurer's or group's:

(A) business practices;

(B) performance; and

(C) operations.

(b) The committee may request reports and other information from the department as necessary to implement this chapter. (V.T.I.C. Art. 21.49-20, Secs. (e) (part), (f).)

Source Law

(e) The committee shall:

. . .

(2) receive information about rules relating to property and casualty insurance proposed by the department, and may submit comments to the commissioner on those proposed rules;

(3) monitor the progress of property and casualty insurance regulation reform, including the fairness of rates, underwriting guidelines, and rating

manuals, the availability of coverage, the effect of rate rollbacks, credit scoring, and regulation of homeowners and automobile insurance markets;

(4) review recommendations for legislation proposed by the department; and

(5) review the necessity of having the department periodically examine the market conduct of an insurer or group of insurers, including the business practices, performance, and operations of the insurer or group of insurers.

(f) The committee may request reports and other information from the department as necessary to carry out this section.

Revised Law

Sec. 1801.054. REPORT. (a) Not later than November 15 of each even-numbered year, the committee shall report on the committee's activities under Sections 1801.052 and 1801.053(a) to:

(1) the governor;

(2) the lieutenant governor; and

(3) the speaker of the house of representatives.

(b) The report must include:

(1) an analysis of any problems caused by property and casualty insurance regulation reform; and

(2) recommendations of any legislative action necessary to address those problems and to foster stability, availability, and competition within the property and casualty insurance industry. (V.T.I.C. Art. 21.49-20, Sec. (g).)

Source Law

(g) Not later than November 15 of each even-numbered year, the committee shall report to the governor, lieutenant governor, and speaker of the house of representatives on the committee's activities under Subsection (e) of this section. The report shall include:

(1) an analysis of any problems caused by property and casualty insurance regulation reform; and

(2) recommendations of any legislative action necessary to address those problems and to foster stability, availability, and competition within the property and casualty insurance industry.

CHAPTER 1802. PROPERTY AND CASUALTY INSURANCE INITIATIVES TASK FORCE

Sec. 1802.001. PROPERTY AND CASUALTY INSURANCE INITIATIVES TASK FORCE . . . . . 791

CHAPTER 1802. PROPERTY AND CASUALTY INSURANCE INITIATIVES TASK FORCE

Revised Law

Sec. 1802.001. PROPERTY AND CASUALTY INSURANCE INITIATIVES TASK FORCE. (a) The commissioner may establish a task force to study the utility and feasibility of instituting various property and casualty insurance initiatives in this state.

(b) The initiatives studied may include:

(1) possible coordination with:

(A) the Texas Economic Development Bank to make certain property and casualty insurance an enterprise zone program under Chapter 2303, Government Code; and

(B) Neighborhood Housing Service (NHS) programs to establish voluntary NHS-Insurance Industry Partnerships;

(2) possible insurance agent programs to increase minority agency access to standard insurance companies, including minority intern programs with insurance companies;

(3) possible tax incentives for insurance written in underserved areas; and

(4) a consumer education program designed to increase the ability of consumers to differentiate among different products and providers in the property and casualty insurance market. (V.T.I.C. Art. 21.49B.)

Source Law

Art. 21.49B. The commissioner may establish a task force to study the utility and feasibility of instituting various property and casualty insurance initiatives in this state. The initiatives to be studied may include, but are not limited to:

(1) possible coordination with the Texas Economic Development Bank to make certain property and casualty insurance an enterprise zone program pursuant to Chapter 2303, Government Code;

(2) possible coordination with Neighborhood Housing Service (NHS) Programs to establish voluntary NHS-Insurance Industry Partnerships;

(3) possible insurance agent programs to increase minority agency access to standard insurance companies, including minority intern programs with insurance companies;

(4) possible tax incentives for insurance written in underserved areas; and

(5) a consumer education program designed to increase the ability of consumers to differentiate among different products and providers in the property and casualty market.

Revisor's Note

(1) V.T.I.C. Article 21.49B states that the initiatives studied under that article may "include, but are not limited to" the specified initiatives. The revised law omits the phrase "but are not limited to" as unnecessary because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, 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.

(2) Subdivision (5), V.T.I.C. Article 21.49B, refers to "the property and casualty market." The revised law substitutes the phrase "the property and casualty insurance market" for "the property and casualty market" to avoid confusion and to be consistent with the first sentence of the section.

CHAPTER 1803. REPORTS OF INSURANCE COVERAGE FOR STATE AGENCIES

Sec. 1803.001. DEFINITIONS . . . . . 792
Sec. 1803.002. REPORTING REQUIREMENTS . . . . . 793
Sec. 1803.003. FAILURE TO REPORT . . . . . 794
Sec. 1803.004. RULES . . . . . 794

CHAPTER 1803. REPORTS OF INSURANCE COVERAGE FOR STATE AGENCIES

Revised Law

Sec. 1803.001. DEFINITIONS. In this chapter:

(1) "Insurer" means an insurance company or other entity that is authorized by the department to engage in the business of insurance in this state, including:

(A) a reciprocal or interinsurance exchange;

(B) a mutual insurance company;

(C) a county mutual insurance company; and

(D) a Lloyd's plan.

(2) "State agency" has the meaning assigned by Section 412.001, Labor Code. (V.T.I.C. Art. 21.49-15A, Secs. 1(1), (3).)

Source Law

Art. 21.49-15A
Sec. 1. In this article:
(1) "Insurer" means an insurance company, inter-insurance exchange, mutual or reciprocal association, county mutual insurance company, Lloyd's plan, or other entity that is authorized by the Texas Department of Insurance to engage in the business of insurance in this state.

(3) "State agency" has the meaning assigned by Section 412.001, Labor Code.

Revisor's Note

(1) Section 1(1), V.T.I.C. Article 21.49-15A, refers to an "inter-insurance exchange" and a "mutual or reciprocal association." For consistency in terminology throughout this code, the revised law substitutes "reciprocal or interinsurance exchange" for "inter-insurance exchange" and "reciprocal association" because that is the term used in Chapter 942 of this code, which governs reciprocal and interinsurance exchanges, and substitutes "mutual insurance company" for "mutual . . . association" because that is the term used in Chapter 883 of this code, which governs mutual insurance companies.

(2) Section 1(2), V.T.I.C. Article 21.49-15A, defines "office" as the State Office of Risk Management. For clarity, the revised law omits the definition and substitutes the full name of the agency for references to "office" throughout the chapter. The omitted law reads:

(2) "Office" means the State Office of Risk Management.

Revised Law

Sec. 1803.002. REPORTING REQUIREMENTS. (a) Each insurer that enters into an insurance policy or other contract or agreement

with a state agency for the purchase by the state agency of property, casualty, or liability insurance coverage, including a policy, contract, or agreement subject to competitive bidding requirements, shall report to the State Office of Risk Management the intended sale of the insurance coverage.

(b) The insurer shall report the intended sale of the insurance coverage not later than the 30th day before the date the sale is scheduled to occur in the manner prescribed by the State Office of Risk Management.

(c) The State Office of Risk Management may require an insurer to submit copies of insurance forms, policies, and other relevant information. (V.T.I.C. Art. 21.49-15A, Secs. 2(a), (b), (c).)

Source Law

> Sec. 2. (a) Each insurer that enters into an insurance policy or other contract or agreement with a state agency for the purchase of property, casualty, or liability insurance coverage by the state agency, including a policy, contract, or agreement subject to competitive bidding requirements, shall report the intended sale to the office in the manner prescribed by that office.
>
> (b) The insurer shall report the intended sale not later than the 30th day before the date the sale of the insurance coverage is scheduled to occur.
>
> (c) The office may require an insurer to submit copies of insurance forms, policies, and other relevant information.

Revised Law

Sec. 1803.003. FAILURE TO REPORT. An insurer that fails to comply with the reporting requirements of this chapter is subject to sanctions under Chapter 82. (V.T.I.C. Art. 21.49-15A, Sec. 2(e).)

Source Law

> (e) Failure by an insurer to comply with the reporting requirements adopted under this article constitutes grounds for the imposition of sanctions against that insurer under Chapter 82.

Revised Law

Sec. 1803.004. RULES. The State Office of Risk Management shall adopt rules as necessary to implement this chapter. The office shall consult with the commissioner in adopting rules.

(V.T.I.C. Art. 21.49-15A, Sec. 2(d).)

Source Law

(d) The office shall adopt rules as necessary to implement this article. In adopting those rules, the office shall consult with the commissioner.

CHAPTER 1804. RATES AND FORMS FOR NATIONAL DEFENSE PROJECTS

Sec. 1804.001. APPLICABILITY OF CHAPTER . . . . . 795

Sec. 1804.002. SPECIAL RATES AND RATING PLANS FOR CASUALTY INSURANCE . . . . . 796

Sec. 1804.003. SPECIAL RATES AND FORMS FOR MATERIAL DAMAGE INSURANCE . . . . . 797

CHAPTER 1804. RATES AND FORMS FOR NATIONAL DEFENSE PROJECTS

Revised Law

Sec. 1804.001. APPLICABILITY OF CHAPTER. This chapter applies only to insurance in relation to a national defense project in this state. (V.T.I.C. Arts. 5.69 (part), 5.70 (part), 5.71 (part).)

Source Law

Art. 5.69. . . . [to be applicable only to the construction or operation of National Defense Projects] in Texas, . . . .

Art. 5.70. . . . [required or used upon] such [National Defense Projects, and] . . . .

Art. 5.71. This subchapter shall be . . . applicable only to rates upon insurance in relation to National Defense Projects, and . . . .

Revisor's Note

V.T.I.C. Article 5.71 states that the subchapter, meaning Subchapter E, V.T.I.C. Chapter 5, revised as this chapter, is "applicable only to rates upon insurance in relation to National Defense Projects." V.T.I.C. Article 5.70, revised in relevant part in this chapter as Section 1804.003, is expressly applicable to rates and forms for this insurance. The revised law omits the reference in V.T.I.C. Article 5.71 to "rates" because the reference is inaccurate and because each provision of Subchapter E, Chapter 5, contains express language indicating the

applicability of the provision to "rates" or "rates and forms."

Revised Law

Sec. 1804.002. SPECIAL RATES AND RATING PLANS FOR CASUALTY INSURANCE. (a) The commissioner may promulgate special rates and special rating plans for workers' compensation insurance, automobile insurance, and other lines of casualty insurance, to apply only to the construction or operation of a national defense project.

(b) The commissioner may promulgate the special rates and special rating plans separately for each class of insurance or in combination for all classes of insurance.

(c) The commissioner may adopt rules as may be necessary, proper, or advisable to place in effect special rates and special rating plans promulgated under this section. (V.T.I.C. Art. 5.69 (part).)

Source Law

> Art. 5.69. The Board of Insurance Commissioners of Texas is hereby authorized and empowered to make and promulgate special rates and special rating plans for Workmen's Compensation, Motor Vehicle and other lines of Casualty insurance to be applicable only to the construction or operation of National Defense Projects . . . and to make such special rates and special rating plans separately for each class of insurance, or in combination of all such classes. The Board shall also have authority to make and promulgate such rules and regulations as may be necessary, proper or advisable in placing such rates and plans in effect.

Revisor's Note

(1) V.T.I.C. Article 5.69 refers to the "Board of Insurance Commissioners of Texas." 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. Throughout this chapter, references to the Board of Insurance Commissioners have been changed appropriately.

(2) V.T.I.C. Article 5.69 refers to "[m]otor [v]ehicle . . . insurance." The revised law substitutes "automobile insurance" for "motor vehicle insurance" for consistency of terminology in this code. "Automobile insurance" is the term more commonly used to describe the kind of insurance that provides coverage for motor vehicles.

(3) V.T.I.C. Article 5.69 authorizes the Board of Insurance Commissioners of Texas, meaning the commissioner of insurance for the reasons stated in Revisor's Note (1) to this section, to adopt certain "rules and regulations." The revised law throughout this chapter omits references to "regulations" as unnecessary in this context because a rule is defined under Section 311.005(5), Government Code (Code Construction Act), to include a regulation, and that definition applies to the revised law.

Revised Law

Sec. 1804.003. SPECIAL RATES AND FORMS FOR MATERIAL DAMAGE INSURANCE. (a) The commissioner may promulgate special rates and forms for fire insurance, windstorm insurance, and other kinds of material damage insurance required or used on a national defense project.

(b) The commissioner may adopt rules incidental to the business described by Subsection (a) and necessary to place in effect special rates and forms promulgated under this section. (V.T.I.C. Art. 5.70 (part).)

Source Law

Art. 5.70. The Board of Insurance Commissioners is hereby authorized and empowered to promulgate special rates and forms for fire and windstorm

insurance, and other types of material damage insurance required or used upon . . . National Defense Projects, and the Board may also promulgate rules and regulations incidental to said business and necessary to place its special rates and forms in effect.

Revisor's Note
(End of Chapter)

(1) The revised law omits as unnecessary the part of V.T.I.C. Article 5.71 relating to the cumulative effect of the "subchapter," meaning Subchapter E, V.T.I.C. Chapter 5, revised as this chapter. 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:

> Art. 5.71. [This subchapter shall be] cumulative of existing laws and . . . .

(2) V.T.I.C. Article 5.71 establishes that the "subchapter," meaning Subchapter E, V.T.I.C. Chapter 5, revised as this chapter, is an exception to existing laws. The revised law omits this provision as unnecessary because general rules of statutory construction provide that a more specific provision supersedes a general statement of law, and this chapter is specific to national defense projects in Texas. Furthermore, the revised law omits the provision as executed because the provision refers to existing law on the date of enactment and served its purpose on that date. The omitted law reads:

> Art. 5.71. . . . to the extent of such subject constitutes an exception to existing laws.

CHAPTER 1805. JOINT UNDERWRITING AND ADVISORY ORGANIZATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1805.001. APPLICABILITY OF CHAPTER . . . . . 799

[Sections 1805.002-1805.050 reserved for expansion]

SUBCHAPTER B. ADVISORY ORGANIZATIONS

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[Sections 1805.104-1805.150 reserved for expansion]

SUBCHAPTER D. CERTAIN PRACTICES IN JOINT UNDERWRITING OR JOINT REINSURANCE

Sec. 1805.151. AUTHORITY OF COMMISSIONER . . . . . 812

CHAPTER 1805. JOINT UNDERWRITING AND ADVISORY ORGANIZATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1805.001. APPLICABILITY OF CHAPTER. This chapter applies to the kinds of insurance and insurers subject to:

(1) Section 403.002;

(2) Section 941.003 with respect to the application of a law described by Section 941.003(b)(3) or (c);

(3) Section 942.003 with respect to the application of a law described by Section 942.003(b)(3) or (c);

(4) Subchapter A, B, C, or D, Chapter 5;

(5) Subchapter H, Chapter 544;

(6) Subchapter A, Chapter 2301;

(7) Chapter 252, 253, 254, 255, 426, 1806, 1807, 2001, 2002, 2003, 2004, 2005, 2006, 2051, 2052, 2053, 2171, 2251, or 2252;

(8) Subtitle B or C, Title 10;

(9) Chapter 406A, Labor Code; or

(10) Chapter 2154, Occupations Code. (V.T.I.C. Art. 5.75.)

Source Law

Art. 5.75. This subchapter applies to the kinds of insurance and to the insurers subject to Subchapters A, B, C, and D of Chapter 5 of this code.

Revisor's Note

(1) V.T.I.C. Article 5.75 provides that the "subchapter," meaning Subchapter F, V.T.I.C. Chapter 5, applies to certain kinds of insurance and insurers. The text of the article was originally enacted by Section 4, Chapter 539, Acts of the 51st Legislature, Regular Session, 1949, and was codified in 1951 as Article 5.75 in Subchapter F, V.T.I.C. Chapter 5. The original 1949 enactment provided that the "act" applied to certain kinds of insurance and insurers and consisted only of the provisions revised as this chapter (V.T.I.C. Articles 5.72, 5.73, 5.74, and 5.75). Although V.T.I.C. Article 5.75-1, which was enacted by Chapter 117, Acts of the 54th Legislature, Regular Session, 1955, as Article 5.76 and was later renumbered, and Article 5.75-3, which was enacted by Chapter 42, Acts of the 68th Legislature, Regular Session, 1983, are currently included in Subchapter F, those articles were not included in the 1949 enactment from which Article 5.75 is derived. In addition, Articles 5.75-1 and 5.75-3 both include specific applicability provisions. It is clear from the

history of Subchapter F and the language of Articles 5.75-1 and 5.75-3 that the legislature did not intend for the reference in Article 5.75 to "[t]his subchapter" to refer to Articles 5.75-1 and 5.75-3. The revised law is drafted accordingly.

(2) V.T.I.C. Article 5.75 refers to "the kinds of insurance and to the insurers subject to Subchapters A, B, C, and D." Section (d), V.T.I.C. Article 5.19, was included in Subchapter B, V.T.I.C. Chapter 5, and is revised as Section 36.002 of this code. The revised law does not reference Section 36.002 because that section only establishes rulemaking authority for provisions otherwise referenced in this section. V.T.I.C. Articles 5.12, 5.24, 5.49, and 5.68 were included in Subchapters A, B, C, and D, respectively, and were revised, effective April 1, 2005, in Chapters 251, 252, 253, 254, and 255 of this code. The revised law does not reference Chapter 251 because it contains only general provisions applicable in accordance with the other listed provisions. V.T.I.C. Article 5.44 was included in Subchapter C, V.T.I.C. Chapter 5, and was revised in 1987 as Section 417.008, Government Code. The revised law does not reference Section 417.008, Government Code, because that section does not apply to kinds of insurance or insurers.

[Sections 1805.002-1805.050 reserved for expansion]

SUBCHAPTER B. ADVISORY ORGANIZATIONS

Revised Law

Sec. 1805.051. LICENSE APPLICATION. (a) A corporation, unincorporated association, partnership, or individual may file with the commissioner an application for an advisory organization license for the kinds of insurance specified in the application.

(b) The applicant must:

(1) file with the commissioner:

(A) a copy of the applicant's:

(i) constitution and bylaws;

(ii) article of agreement or association or certificate of incorporation; and

(iii) rules governing the applicant's activities as an advisory organization; and

(B) a statement of qualifications to act as an advisory organization; and

(2) pay a $100 license fee. (V.T.I.C. Art. 5.73, Sec. 4A(b).)

Source Law

(b) A corporation, unincorporated association, partnership, or individual may apply to the commissioner for a license as an advisory organization for the types of insurance the applicant specifies in the application. An applicant must:

(1) file with the commissioner:

(A) a copy of the applicant's:

(i) constitution and bylaws;

(ii) article of agreement or association, or certificate of incorporation; and

(iii) rules governing the applicant's activities as an advisory organization; and

(B) a statement of qualifications to act as an advisory organization; and

(2) pay a $100 license fee.

Revised Law

Sec. 1805.052. ISSUANCE OF LICENSE; TERM. (a) The commissioner shall issue a license to an applicant the commissioner determines is qualified, without regard to:

(1) the state of domicile or residence of the applicant; or

(2) the location of the applicant's place of business.

(b) The commissioner shall grant or deny a license to an applicant not later than the 60th day after the date the commissioner receives the application.

(c) A license issued under this subchapter remains in effect until the commissioner suspends or revokes the license. (V.T.I.C. Art. 5.73, Secs. 4A(d), (e), (f).)

Source Law

(d) The commissioner shall issue a license to an applicant, without regard to the state of domicile or residence of the applicant or the location of the applicant's place of business if the commissioner determines that the applicant is qualified.

(e) The commissioner shall grant or deny a license to an applicant on or before the 60th day after the date the commissioner receives the application.

(f) A license issued under this article remains in effect until the commissioner suspends or revokes the license.

Revised Law

Sec. 1805.053. INFORMATION REPORTED BY ADVISORY ORGANIZATION. (a) An advisory organization may file with the commissioner prospective loss costs, supplementary rating information, and policy forms. A filing made by an advisory organization under this section is subject to the provisions of this code or other insurance laws of this state governing rate filings.

(b) An advisory organization at least quarterly shall file with the commissioner a list of:

(1) each subscriber company engaging in business in this state; and

(2) the products or information the subscriber company purchases.

(c) On request by the commissioner, an advisory organization shall provide to the department a summary of the actuarial assumptions, trend factors, economic factors, and other criteria used in trending data for companies engaging in business in this state. (V.T.I.C. Art. 5.73, Secs. 4A(a) (part), (g), (h).)

Source Law

Sec. 4A. (a) An advisory organization may file prospective loss costs, supplementary rating information, and policy forms with the commissioner. . . . A filing made by an advisory organization under this section is subject to the provisions of this code or the other insurance laws of this state governing rate filings.

(g) Each advisory organization shall file with the commissioner a list showing each subscriber company doing business in this state and the products or information the subscriber company purchases. The filing required by this subsection shall be made at least quarterly.

(h) On request by the commissioner, each advisory organization shall report to the department a summary of the actuarial assumptions, trend factors, economic factors, and other criteria used in trending data for companies doing business in this state.

Revised Law

Sec. 1805.054. INSURER'S AUTHORITY TO SUBSCRIBE TO ADVISORY ORGANIZATION. An insurer engaging in business in this state may subscribe to an advisory organization. (V.T.I.C. Art. 5.73, Sec. 1 (part).)

Source Law

Sec. 1. [Except as provided by Section 4A(c) of this article,] an insurer transacting business in the state may, but is not required to, subscribe to an advisory organization and . . . .

Revised Law

Sec. 1805.055. SUBMISSION, RECEIPT, AND USE OF INFORMATION BY INSURER. (a) Except as provided by Subsection (b), an insurer may submit to or receive from an advisory organization the following only if the advisory organization holds a license issued under this subchapter:

(1) statistical plans;

(2) historical data;

(3) prospective loss costs;

(4) supplementary rating information;

(5) policy forms and endorsements;

(6) research;

(7) rates of individual insurers that are effective at the time the information is submitted or received or that were previously in effect; and

(8) performance of inspections.

(b) An insurer may not:

(1) accept from an advisory organization recommendations for rates; or

(2) submit to or receive from an advisory organization recommendations for profit or expenses other than loss adjustment expenses.

(c) An insurer that subscribes to an advisory organization

may use prospective loss costs, supplementary rating information, and policy forms filed by the advisory organization under Section 1805.053(a) and may incorporate the information into the insurer's filings.

(d) Notwithstanding any other law, an insurer that reports data under this subchapter is not relieved of the responsibility of reporting that data directly to the department at the department's request. (V.T.I.C. Art. 5.73, Secs. 1 (part), 2 (part), 4(c), 4A(a) (part), (c).)

Source Law

Art. 5.73

Sec. 1. Except as provided by Section 4A(c) of this article, [an insurer transacting business in the state may, but is not required to, subscribe to an advisory organization and] is permitted to submit to and receive from any advisory organization statistical plans, historical data, prospective loss costs, supplementary rating information, policy forms and endorsements, research, rates of individual insurers that are effective at the time the information is submitted or received or that have been effective, and performance of inspections except recommendations regarding profit or expense provisions, other than loss adjustment expenses.

Sec. 2. . . . no insurer may accept from an advisory organization, recommendations for rates or for profit and expenses other than loss adjustment expenses.

[Sec. 4]

(c) Notwithstanding any provision to the contrary, reporting of data by an insurer under this article does not relieve the insurer of responsibility of reporting that data directly to the Board at the Board's request.

Sec. 4A. (a) [An advisory organization may file prospective loss costs, supplementary rating information, and policy forms with the commissioner.] An insurer that subscribes to an advisory organization may use this information and may incorporate the information into the insurer's filings. . . .

(c) An insurer may not submit information to or receive information from an advisory organization as described by Section 1 of this article unless the advisory organization holds a license issued under this article.

Revisor's Note

Section 4(c), V.T.I.C. Article 5.73, refers to the "Board," meaning 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. Throughout this chapter, references to the Board of Insurance Commissioners or the Board have been changed appropriately.

Revised Law

Sec. 1805.056. AUDIT. (a) The department shall require an annual audit of an advisory organization that provides statistics or other information to the department in a proceeding to set rates.

(b) The audit must:

(1) be conducted at the expense of the advisory organization under rules adopted by the commissioner; and

(2) examine the advisory organization's method of collecting, analyzing, and reporting data to ensure the accuracy of data.

(c) The audit may examine source documents within individual companies.

(d) Except for individual company information, an audit is public information. (V.T.I.C. Art. 5.73, Sec. 4(a).)

Source Law

Sec. 4. (a) The Board shall annually require an audit of any advisory organization that provides statistics or other information to the Board in a proceeding to set rates. The audit shall be conducted under rules adopted by the Board, at the expense of the advisory organization. The audit must examine the advisory organization's method of collecting, analyzing, and reporting data to assure the accuracy of data. The audit may examine source documents within individual companies. Except for individual company information, an audit is public information.

Revised Law

Sec. 1805.057. RATE FILING REVIEW. The commissioner may:

(1) review the rate filing of an insurer that relies on the prospective loss costs provided by an advisory organization; and

(2) require the insurer to provide the insurer's actual data and loss experience in addition to the information provided by the advisory organization. (V.T.I.C. Art. 5.73, Sec. 4B.)

Source Law

> Sec. 4B. The commissioner may review the rate filing of an insurer that relies on the prospective loss costs provided by an advisory organization and may require the insurer to provide the insurer's actual data and loss experience in addition to the information provided by the advisory organization.

Revised Law

Sec. 1805.058. PROHIBITED ACTS. (a) An advisory organization may not compile or distribute recommendations for:

(1) rates; or

(2) profit or expenses other than loss adjustment expenses.

(b) An insurer or advisory organization may not:

(1) attempt to monopolize, combine, or conspire with another person to monopolize an insurance market;

(2) engage in a boycott, on a concerted basis, of an insurance market; or

(3) make an agreement with another insurer, advisory organization, or person if the agreement has the purpose or effect of restraining trade unreasonably or substantially lessening competition in the business of insurance. (V.T.I.C. Art. 5.73, Secs. 2 (part), 3(a), (b).)

Source Law

> Sec. 2. No advisory organization shall compile or distribute, and . . . recommendations for rates or for profit and expenses other than loss adjustment expenses.
>
> Sec. 3. (a) An insurer or advisory organization may not:
>
> (1) attempt to monopolize, combine, or conspire with any other person to monopolize an insurance market; or
>
> (2) engage in a boycott, on a concerted

basis, of an insurance market.

(b) An insurer or advisory organization may not make an agreement with any other insurer, advisory organization, or other person if the agreement has the purpose or effect of restraining trade unreasonably or of substantially lessening competition in the business of insurance.

Revised Law

Sec. 1805.059. DISCIPLINARY ACTION. (a) If, after a hearing, the commissioner determines that the furnishing of specified services by an advisory organization involves an act or practice that is unfair, unreasonable, or otherwise inconsistent with this chapter or other applicable laws of this state, the commissioner may issue a written order:

(1) specifying the manner in which the act or practice is unfair, unreasonable, or inconsistent with the applicable law; and

(2) requiring the advisory organization to discontinue the act or practice.

(b) In addition to any other remedies available at law, the commissioner may impose a sanction authorized under Chapter 82. (V.T.I.C. Art. 5.73, Sec. 3(c).)

Source Law

(c) If, after a hearing, the Board finds that the furnishing of specified services by an advisory organization involves any act or practice which is unfair or unreasonable or otherwise inconsistent with the provisions of this subchapter or with the applicable laws of this State, it may issue a written order specifying in what respects such act or practice is unfair or unreasonable or otherwise inconsistent with the provisions of law and requiring the discontinuance of such act or practice. In addition to any other remedies available at law, the Board may impose any sanction authorized under Article 1.10 of this code.

Revisor's Note

Section 3(c), V.T.I.C. Article 5.73, authorizes the Board of Insurance Commissioners to take certain action against an advisory organization that provides services involving an act or practice that is unfair, unreasonable, or otherwise inconsistent with the provisions of "this subchapter," meaning Subchapter F,

V.T.I.C. Chapter 5. The revised law substitutes a reference to "this chapter" for the reference to "this subchapter" and does not include a reference to V.T.I.C. Articles 5.75-1 and 5.75-3, which are also included in Subchapter F, V.T.I.C. Chapter 5, for the reasons stated in Revisor's Note (1) to Section 1805.001.

Revised Law

Sec. 1805.060. SUNSET REVIEW. During the period in which the Sunset Advisory Commission performs its review of the department under Chapter 325, Government Code, the commission shall review the authority granted under this subchapter. (V.T.I.C. Art. 5.73, Sec. 5.)

Source Law

Sec. 5. The authority granted under this article shall be reviewed during the normal Sunset cycle of the Texas Department of Insurance.

Revisor's Note

Section 5, V.T.I.C. Article 5.73, provides that the authority granted under the article is to be reviewed during "the normal Sunset cycle" of the Texas Department of Insurance. For the convenience of the reader, the revised law adds a reference to the Sunset Advisory Commission performing the review under Chapter 325, Government Code.

Revised Law

Sec. 1805.061. CONFLICT WITH OTHER LAW. To the extent this subchapter conflicts with Section 2053.052(c), 2053.055, 2053.151, 2053.152, or 2053.153, or Subchapter A or C, Chapter 2053, with respect to the setting of rates for workers' compensation insurance, the referenced provision of Chapter 2053 controls. (V.T.I.C. Art. 5.73, Sec. 6.)

Source Law

Sec. 6. To the extent that this article conflicts with the provisions of Articles 5.55, 5.58, and 5.58A of this code with respect to the setting of

rates for workers' compensation insurance, the provisions of those articles control.

Revisor's Note

Section 6, V.T.I.C. Article 5.73, refers to conflicts between Article 5.73 and V.T.I.C. Article 5.58A. The revised law omits the reference to Article 5.58A because that article was repealed by Section 8.13, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993.

Revisor's Note
(End of Subchapter)

Section 4D, V.T.I.C. Article 5.73, requires the select committee on rate and form regulation to appoint an independent consulting firm to evaluate the activities of advisory organizations in this state. The revised law omits Section 4D because that select committee was abolished by Section 13.01, Chapter 876, Acts of the 74th Legislature, Regular Session, 1995. The omitted law reads:

> Sec. 4D. The select committee on rate and form regulation created under Article 1.50 of this code shall appoint an independent consulting firm to evaluate the activities of advisory organizations in this state, including their impact on competition in the insurance market, their use by insurers, and their impact on availability and affordability of coverage, and any other matters relevant to determining their continued authorization. The committee shall include in its report to the legislature a recommendation for the future role of advisory organizations in this state.

[Sections 1805.062-1805.100 reserved for expansion]

SUBCHAPTER C. EXAMINATIONS

Revised Law

Sec. 1805.101. EXAMINATION AUTHORIZED. (a) As often as the department determines expedient, the department may examine a group, association, or other organization referred to in this chapter, including an advisory organization described by Subchapter B.

(b) An officer, manager, agent, or employee of the group, association, or organization may be examined at any time under oath and shall make available any book, record, account, document, or agreement governing the method of operation of the group, association, or organization. (V.T.I.C. Art. 5.73, Sec. 4(b); Art. 5.74 (part).)

Source Law

> [Art. 5.73, Sec. 4]
>
> (b) An advisory organization is subject to examination under Article 5.74 of this code.
>
> Art. 5.74. The said Board may, as often as it may deem it expedient, make or cause to be made an examination of each group, association, or other organization referred to in Articles 5.72 and 5.73 of this subchapter. . . . The officer, manager, agents and employees of such group, association or other organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation. . . .

Revisor's Note

V.T.I.C. Article 5.74 refers to each group, association, or other organization referred to in "Articles 5.72 and 5.73 of this subchapter." V.T.I.C. Articles 5.72 and 5.73 are revised in this chapter as Subchapters B, C, and D. The revised law substitutes for the quoted language a reference to "this chapter" because the groups, associations, and other organizations referred to in Articles 5.72 and 5.73 are the only organizations regulated under this chapter.

Revised Law

Sec. 1805.102. EXAMINATION COSTS. The group, association, or other organization shall pay the reasonable costs of an examination under this subchapter on presentation of a detailed account of the costs. (V.T.I.C. Art. 5.74 (part).)

Source Law

> Art. 5.74. . . . The reasonable costs of any such examination shall be paid by the group, association or other organization examined upon presentation to it of a detailed account of such costs. . . .

Revised Law

Sec. 1805.103. OUT-OF-STATE EXAMINATION. In lieu of an examination under this subchapter, the department may accept the report of an examination made by the insurance supervisory official of another state in accordance with the laws of that state. (V.T.I.C. Art. 5.74 (part).)

Source Law

> Art. 5.74. . . . In lieu of any such examination the Board may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of such state.

[Sections 1805.104-1805.150 reserved for expansion]

SUBCHAPTER D. CERTAIN PRACTICES IN JOINT UNDERWRITING OR JOINT REINSURANCE

Revised Law

Sec. 1805.151. AUTHORITY OF COMMISSIONER. If, after a hearing, the commissioner determines that an activity or practice of a group, association, or other organization of insurers engaging in joint underwriting or joint reinsurance is unfair, unreasonable, or otherwise inconsistent with this chapter or other applicable law, the commissioner may issue a written order:

(1) specifying the manner in which the activity or practice is unfair, unreasonable, or inconsistent with the applicable law; and

(2) requiring the group, association, or organization to discontinue the activity or practice. (V.T.I.C. Art. 5.72.)

Source Law

> Art. 5.72. (a) Every group, association or other organization of insurers which engages in joint underwriting or joint reinsurance, shall be subject to regulation with respect thereto as herein provided.
>
> (b) If, after a hearing, the Board of Insurance Commissioners finds that any activity or practice of any such group, association or other organization is unfair or unreasonable or otherwise inconsistent with the provisions of this subchapter or with the laws applicable thereto, it may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of the applicable laws, and requiring the discontinuance of such activity or practice.

Revisor's Note

V.T.I.C. Article 5.72 authorizes the Board of Insurance Commissioners to take certain action against a group, association, or other organization of insurers that engages in joint underwriting or joint reinsurance if an act or practice of the group, association, or organization is unfair, unreasonable, or otherwise inconsistent with "this subchapter," meaning Subchapter F, V.T.I.C. Chapter 5. The revised law substitutes a reference to "this chapter" for the reference to "this subchapter" and does not include a reference to V.T.I.C. Articles 5.75-1 and 5.75-3, which are also included in Subchapter F, V.T.I.C. Chapter 5, for the reasons stated in Revisor's Note (1) to Section 1805.001.

CHAPTER 1806. PROHIBITED PRACTICES AND REBATES RELATED TO POLICIES

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CHAPTER 1806. PROHIBITED PRACTICES AND REBATES RELATED TO POLICIES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1806.001. DEFINITION. In this chapter, "nonprofit business association" means a business association that is a nonprofit corporation exempt from federal income taxation under Section 501(a), Internal Revenue Code of 1986, and its subsequent amendments by being described as an exempt organization by Section 501(c)(6) of that code. (V.T.I.C. Art. 5.08, Sec. (d) (part); Art. 5.20, Sec. (c) (part).)

Source Law

[Art. 5.08]

(d) . . . For purposes of this subsection, "nonprofit business association" means a business association that is a nonprofit corporation exempt from federal income tax under Section 501(a) of the

Internal Revenue Code of 1986, and its subsequent amendments, by being listed as an exempt organization under Section 501(c)(6) of that code.

[Art. 5.20]

(c) . . . For purposes of this subsection, "nonprofit business association" means a business association that is a nonprofit corporation exempt from federal income tax under Section 501(a) of the Internal Revenue Code of 1986, and its subsequent amendments, by being listed as an exempt organization under Section 501(c)(6) of that code.

[Sections 1806.002-1806.050 reserved for expansion]

SUBCHAPTER B. PROVISIONS APPLICABLE TO AUTOMOBILE INSURANCE

Revised Law

Sec. 1806.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies to an insurer writing automobile insurance in this state, including an insurance company, corporation, reciprocal or interinsurance exchange, mutual insurance company, association, Lloyd's plan, or other insurer. (V.T.I.C. Art. 5.01, Sec. (a) (part); Art. 5.08, Sec. (a) (part); Art. 5.09, Sec. (a) (part).)

Source Law

Art. 5.01. (a) Every insurance company, corporation, interinsurance exchange, mutual, reciprocal, association, Lloyd's or other insurer, hereinafter called insurer, writing any form of motor vehicle insurance in this State, [shall annually file] . . . .

Art. 5.08. (a) . . . [it shall be unlawful for any insurer,] as defined in this subchapter, . . . [to grant to or contract with insured] . . . .

Art. 5.09. (a) . . . [no insurer] coming within the terms of this subchapter [shall . . . make or permit any distinction] . . . .

Revisor's Note

(1) Section (a), V.T.I.C. Article 5.01, refers to an "interinsurance exchange," a "mutual," a "reciprocal," and a "Lloyd's." For consistent use of terminology throughout this code, the revised law substitutes for the quoted language references to a "reciprocal or interinsurance exchange," a "mutual insurance company," and a "Lloyd's plan." Similar changes have been made throughout this chapter.

(2) Section (a), V.T.I.C. Article 5.01, refers to "motor vehicle insurance." The revised law substitutes "automobile insurance" for "motor vehicle insurance" in this section and throughout this chapter for consistency with terminology used in this code and because "automobile insurance" is the term more commonly used to describe the kind of insurance that provides coverage for motor vehicles.

Revised Law

Sec. 1806.052. CONSTRUCTION OF SUBCHAPTER. This subchapter may not be construed to prohibit the modification of rates by a rating plan that is filed in accordance with the requirements of Chapter 2251 or Article 5.13-2, as applicable, that has not been disapproved by the commissioner, and that is designed to encourage the prevention of accidents, and to account for all relevant factors inside and outside this state, including the peculiar hazards and experience of past and prospective individual risks. (V.T.I.C. Art. 5.09, Sec. (a) (part).)

Source Law

(a) . . . provided that nothing in this subchapter shall be construed to prohibit the modification of rates by rating plans designed to encourage the prevention of accidents, and to take account of the peculiar hazards and experience of individual risks, past and prospective, within and outside the State, and of all other relevant factors, within and outside the State, provided such plan shall have been approved by the Board.

Revisor's Note

(1) Section (a), V.T.I.C. Article 5.09, states that "this subchapter," meaning Subchapter A, V.T.I.C. Chapter 5, may not be construed to prohibit certain modifications of rates. Subchapter A, Chapter 5, is revised in various chapters in this code. The only provisions of Subchapter A that could be interpreted to prohibit the modification of rates are revised in this subchapter. The revised law is drafted accordingly.

(2) Section (a), V.T.I.C. Article 5.09, requires that certain rating plans be approved by the State Board of Insurance, formerly 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 board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. For that reason, references to the Board of Insurance Commissioners and State Board of Insurance have been changed appropriately throughout this chapter.

In addition, under Chapter 206, Acts of the 78th Legislature, Regular Session, 2003, the legislature amended V.T.I.C. Article 5.13-2 to apply on and after June 11, 2003, to commercial automobile insurance, and on and after December 1, 2004, to both personal and commercial automobile insurance. As a result, all rates applicable to automobile insurance are now governed by Article 5.13-2, the relevant portions of which that are revised are contained in Chapter 2251 of this code.

Under the rate regulation system established by Article 5.13-2, most insurers to which the article applies are required to file rates and supplementary rating information, including rating plans, with the commissioner and are authorized to use a rate unless the rate filing or the rate is disapproved by the commissioner. However, under certain circumstances, the commissioner is authorized to require an insurer

to file rates and supplementary rating information and obtain approval before using the rate or to require use of a different regulatory system. Because the rate regulation system established by Article 5.13-2 requires the absence of the commissioner's disapproval of a rate or rate filing under certain circumstances, but has different requirements under other circumstances, the revised law substitutes a reference to a rating plan "that is filed in accordance with the requirements of Chapter 2251 or Article 5.13-2" and "that has not been disapproved by the commissioner" for the requirement that the rating plan be approved by the commissioner to accurately reflect the regulatory system established under Article 5.13-2. In addition, although Chapter 2251 contains provisions that are derived from V.T.I.C. Article 5.13-2C, the revised law appropriately refers to the chapter in its entirety because the provisions that are derived from Article 5.13-2C do not relate to rating plans for automobile insurance.

(3) Section (c), V.T.I.C. Article 5.09, specifies the provisions of this code under which rates for automobile insurance are determined. The revised law omits the provisions of Section (c), Article 5.09, relating to rate regulation before December 1, 2004, as executed, and omits the provisions of that section relating to rate regulation on and after December 1, 2004, as unnecessary because V.T.I.C. Article 5.13-2, the relevant portions of which that are revised are contained in Chapter 2251 of this code, applies by its own terms to personal and commercial automobile insurance. The omitted law reads:

(c) Notwithstanding Subsection (a)

of this article, on and after the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003, rates for personal automobile insurance in this state are determined as provided by Article 5.101 of this code, and rates for commercial motor vehicle insurance in this state are determined as provided by Article 5.13-2 of this code. On and after December 1, 2004, rates for personal automobile insurance and commercial automobile insurance in this state are determined as provided by Article 5.13-2 of this code.

Revised Law

Sec. 1806.053. DISCRIMINATIONS OR DISTINCTIONS. Except as provided by Section 1806.056, with respect to business written in this state:

(1) an insurer may not discriminate or make a distinction, or permit discrimination or a distinction to be made, among insureds having like hazards with respect to premiums charged for, or dividends or other benefits payable under, an insurance policy;

(2) an insurer or an insurer's agent may not make an insurance contract or an agreement relating to that insurance, other than as expressed in the policy; and

(3) an insurer or an insurer's agent or other representative may not directly or indirectly pay, allow, or give, or offer to pay, allow, or give, as an inducement to the insured, a rebate payable on the policy or a special favor or advantage in the dividends or other benefits to accrue, or anything of value, not specified in the policy. (V.T.I.C. Art. 5.09, Sec. (a) (part).)

Source Law

Art. 5.09. (a) Except as provided by Subsection (b) of this article, no insurer . . . shall, in its business in this State, make or permit any distinction or discrimination in favor of the insured having a like hazard, in the matter of the charge of premiums for insurance, or in dividends or other benefits payable under any policy, nor shall any such insurer or agent make any contract of insurance, or agreement as to such insurance, other than expressed in the policy, nor shall any such insurer or its agents or representatives pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to insured, any rebate payable upon the policy or any special favor or advantage in dividends or other benefits to accrue, or anything of value whatsoever, not specified in the policy; . . . .

Revised Law

Sec. 1806.054. OTHER PROHIBITED INDUCEMENTS. Except as provided by Section 1806.055, 1806.056, or 1806.057, an insurer or an insurer's officer, director, agent, or other representative may not, for the purpose of writing the insurance of an insured, grant to the insured or contract with the insured for a special favor or advantage in dividends or other profits, or commissions or dividends of commissions or profits to accrue on the policy, or compensation or other valuable consideration not specified in the policy, or an inducement not specified in the policy. (V.T.I.C. Art. 5.08, Sec. (a) (part).)

Source Law

> Art. 5.08. (a) Except as provided by this article, it shall be unlawful for any insurer, . . . or its officers, directors, general agent, state agents, special agents, local agents or other representatives, to grant to or contract with insured for any special favor or advantage in dividends or other profits, or any commissions or dividends of commissions or profits to accrue thereon, or any compensation or any valuable consideration not specified in the policy contract, or any inducement not specified in the policy contract, for the purpose of writing the insurance of any insured.

Revisor's Note

(1) Section (a), V.T.I.C. Article 5.08, refers to the "general agent, state agents, special agents, [and] local agents" of an automobile insurer. The terms are obsolete terms that describe the types of agents that may represent an automobile insurer. Therefore, the revised law omits "general agent," "state agents," "special agents," and "local agents" as obsolete terms that are included within the meaning of "agent or other representative." Similar changes have been made throughout this chapter.

(2) Section (a), V.T.I.C. Article 5.08, refers to an insurance "policy contract." The revised law substitutes the term "policy" for "policy contract" because a contract between an insurer and an insured is

more commonly referred to as a policy. Similar changes have been made throughout this chapter.

Revised Law

Sec. 1806.055. PROFIT SHARING AUTHORIZED; CERTAIN PROHIBITIONS. (a) Section 1806.054 does not prohibit an insurer from sharing earned profits with the insurer's policyholders under a profit sharing agreement contained in the policy if:

(1) the insurer shares profits uniformly among those insured under the policy; and

(2) the insurer distributes earnings equitably among those insureds under the terms of the policy.

(b) An insurer may not:

(1) discriminate in the distribution of profits among insureds of the same class;

(2) distribute the profit to an insured before the expiration of the policy; or

(3) establish a class of insureds for the distribution of profits, except on the commissioner's approval.

(c) A violation of this section is unjust discrimination and rebating.

(d) The commissioner may revoke the certificate of authority of an insurer that violates this section or the license of an agent who violates this section. (V.T.I.C. Art. 5.08, Sec. (b).)

Source Law

(b) Nothing in this article, however, shall be construed to prohibit an insurer from sharing its profits after the same have been earned with its policyholders under and in accordance with an agreement as to such profit sharing contained in its policy contract. Any profit sharing under any policy with insured shall be uniform as between such insured, and shall consist only and solely of an equitable distribution under and in accordance with the terms of the policy of earnings between such insured, and no such insurer shall discriminate in any distribution of profits between insured of a class, and no classes for such distribution shall be made or established except on the approval of the commissioner. No part of any profit shall be distributed to any insured under any such policy until the expiration of the policy contract. Any violation of the terms of this subsection shall constitute unjust discrimination and shall constitute rebating, and shall be sufficient

grounds for the revocation of the permit of the insurer or of the license of the agent being guilty of such unjust discrimination and rebating.

Revisor's Note

(1) Section (b), V.T.I.C. Article 5.08, refers to insurers sharing earned profits with policyholders "under and in accordance with" a profit sharing agreement and the policy. The revised law omits "in accordance with" as included within the meaning of "under."

(2) Section (b), V.T.I.C. Article 5.08, refers to classes of insureds "made or established" by an insurer. The reference to "made" is omitted from the revised law because the terms are synonymous and the latter is more commonly used.

(3) Section (b), V.T.I.C. Article 5.08, refers to an insurer's "permit." Throughout this chapter, the revised law substitutes "certificate of authority" for "permit" because, in this context, "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 1806.056. PROFIT SHARING BASED ON COMBAT DUTY AUTHORIZED. (a) This subchapter does not prohibit an insurer, on approval by the commissioner, from distributing to policyholders who are on active duty in the United States Armed Forces any estimated profits resulting from service by those policyholders in a foreign country in a combat theater of operations after January 1, 1990.

(b) An insurer that elects to make distributions under this section must:

(1) file a written description of the insurer's distribution program with the commissioner for approval; and

(2) notify the commissioner in writing of each

distribution made under the program.

(c) If the commissioner does not act on the insurer's distribution program on or before the fifth business day after the date the commissioner receives the insurer's description of the program, the distribution program is considered approved.

(d) An insurer may distribute estimated profits among policyholders under this section based on:

(1) the time served by a policyholder in a combat theater of operations;

(2) the location of the policyholder's military service;

(3) the duration of the applicable insurance policy; or

(4) any other reasonable basis. (V.T.I.C. Art. 5.08, Sec. (c); Art. 5.09, Sec. (b).)

Source Law

[Art. 5.08]

(c) This article does not prohibit an insurer, on approval by the commissioner, from distributing to policyholders who are on active duty in the United States Armed Forces any estimated profits resulting from service by those policyholders in any foreign country in a combat theater of operations at any time after January 1, 1990. An insurer that elects to make such distributions shall file a written description of its distribution program with the commissioner for approval by the commissioner and shall notify the commissioner in writing of each distribution made under the program. The insurer may distribute the estimated profits among those policyholders based on the length of time served by a policyholder in a combat theater of operations, the location of the military service, the duration of the applicable insurance policy, or any other reasonable basis. The commissioner shall act on the insurer's distribution program within five business days of receipt of the insurer's distribution program, otherwise the distribution program shall be deemed approved.

[Art. 5.09]

(b) This article does not prohibit an insurer, on approval by the Board, from distributing to policyholders who are on active duty in the United States Armed Forces any estimated profits resulting from service by those policyholders in any foreign country in a combat theater of operations at any time after January 1, 1990. An insurer that elects to make such distributions shall file a written description of its distribution program with the Board for approval by the Board and shall notify the Board in writing of each distribution made under the program. The insurer

may distribute the estimated profits among those policyholders based on the length of time served by a policyholder in a combat theater of operations, the location of the military service, the duration of the applicable insurance policy, or any other reasonable basis. The Board shall act on the insurer's distribution program within five business days of receipt of the insurer's distribution program, otherwise the distribution program shall be deemed approved.

Revised Law

Sec. 1806.057. PROFIT SHARING WITH MEMBERS OF CERTAIN ASSOCIATIONS AUTHORIZED. (a) Section 1806.054 does not prohibit an insurer, on approval by the commissioner, from sharing profits with policyholders who are part of a group program established by a nonprofit business association and who participate in the group program because of membership in the association.

(b) An insurer that elects to make distributions under this section must:

(1) file a written description of the insurer's distribution program with the commissioner for approval; and

(2) notify the commissioner in writing of each distribution made under the program.

(c) If the commissioner does not act on the insurer's distribution program on or before the fifth business day after the date the commissioner receives the insurer's description of the program, the distribution program is considered approved. (V.T.I.C. Art. 5.08, Sec. (d) (part).)

Source Law

(d) This article does not prohibit an insurer, on approval by the commissioner, from sharing profits with policyholders who are part of a group program established by a nonprofit business association and who participate in the group program because of membership in the association. An insurer that elects to make distributions under this subsection shall file a written description of its distribution program with the commissioner for approval by the commissioner and shall notify the commissioner in writing of each distribution made under the program. The commissioner shall act on the insurer's distribution program within five business days of receipt of the insurer's distribution program, otherwise the distribution program shall be deemed approved. . . .

Revised Law

Sec. 1806.058. PARTICIPATING POLICIES. (a) This

subchapter, Subtitle C, and Subchapter A, Chapter 5, may not be construed to prohibit:

(1) a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan from operating under this subchapter, Subchapter A, Chapter 5, and Subtitle C; or

(2) a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan from issuing participating policies.

(b) A distribution of profits or dividends to insureds may not take effect or be paid until the commissioner approves the distribution. The commissioner may not approve a distribution of profits or dividends until the insurer has provided adequate reserves. The reserves must be computed on the same basis for all classes of insurers operating under this subchapter, Subtitle C, and Subchapter A, Chapter 5. (V.T.I.C. Art. 5.07.)

Source Law

Art. 5.07. Nothing in this subchapter shall be construed to prohibit the operation hereunder of any stock company, mutual company, reciprocal or interinsurance exchange or Lloyd's association or to prohibit any stock company, mutual company, reciprocal or interinsurance exchange or Lloyd's association issuing participating policies; provided no distribution of profit or dividends to insured shall take effect or be paid until the same shall have been approved by the Board; and provided further that no such distribution shall be approved until adequate reserves shall have been provided, such reserves to be computed on the same basis for all classes of insurers operating under this subchapter.

Revisor's Note

V.T.I.C. Article 5.07 refers to "this subchapter," meaning Subchapter A, V.T.I.C. Chapter 5. Parts of that subchapter are revised in various chapters in this code, and of those parts, the relevant provisions are revised in this subchapter and Subtitle C, Title 10, of this code. For that reason, the revised law substitutes a reference to "[t]his subchapter, Subtitle C, and Subchapter A, Chapter 5"

for the reference to "this subchapter."

[Sections 1806.059-1806.100 reserved for expansion]

SUBCHAPTER C. PROVISIONS APPLICABLE TO CASUALTY INSURANCE AND FIDELITY, GUARANTY, AND SURETY BONDS

Revised Law

Sec. 1806.101. DEFINITIONS. In this subchapter:

(1) "Insurance" includes a suretyship.

(2) "Policy" includes a bond. (V.T.I.C. Art. 5.20, Sec. (d).)

Source Law

(d) As used in this article the word "insurance" includes suretyship, and the word "policy" includes bond.

Revised Law

Sec. 1806.102. APPLICABILITY OF SUBCHAPTER. (a) Except as provided by Subsections (b) and (c), this subchapter applies to an insurer, including a corporation, reciprocal or interinsurance exchange, mutual insurance company, association, Lloyd's plan, or other organization, writing casualty insurance or writing fidelity, surety, or guaranty bonds, on risks or operations in this state.

(b) This subchapter does not apply to:

(1) a farm mutual insurance company or association regulated under Chapter 911; or

(2) a county mutual insurance company regulated under Chapter 912.

(c) This subchapter does not apply to the writing of:

(1) automobile insurance;

(2) life, health, or accident insurance;

(3) professional liability insurance;

(4) reinsurance;

(5) aircraft insurance;

(6) fraternal benefit insurance;

(7) fire insurance;

(8) workers' compensation insurance;

(9) marine insurance, including noncommercial inland marine insurance and ocean marine insurance;

(10) title insurance;

(11) explosion insurance, except insurance against loss from personal injury or property damage resulting accidentally from:

(A) a steam boiler;

(B) a heater or pressure vessel;

(C) an electrical device;

(D) an engine; or

(E) all machinery and appliances used in connection with or in the operation of a boiler, heater, vessel, electrical device, or engine described by Paragraphs (A)-(D); or

(12) insurance coverage for any of the following conditions or risks:

(A) weather or climatic conditions, including lightning, tornado, windstorm, hail, cyclone, rain, or frost and freeze;

(B) earthquake or volcanic eruption;

(C) smoke or smudge;

(D) excess or deficiency of moisture;

(E) flood;

(F) the rising water of an ocean or an ocean's tributary;

(G) bombardment, invasion, insurrection, riot, civil war or commotion, military or usurped power, or any order of a civil authority made to prevent the spread of a conflagration, epidemic or catastrophe;

(H) vandalism or malicious mischief;

(I) strike or lockout;

(J) water or other fluid or substance resulting from:

(i) the breakage or leakage of a sprinkler, pump, or other apparatus erected for extinguishing fire, or a water

pipe or other conduit or container; or

(ii) casual water entering a building through a leak or opening in the building or by seepage through building walls; or

(K) accidental damage to a sprinkler, pump, fire apparatus, pipe, or other conduit or container described by Paragraph (J)(i). (V.T.I.C. Art. 5.13, Secs. (a) (part), (b), (c).)

Source Law

> Art. 5.13. (a) This subchapter applies to every insurance company, corporation, interinsurance exchange, mutual, reciprocal, association, Lloyd's plan, or other organization or insurer writing any of the characters of insurance business herein set forth, hereinafter called "Insurer"; provided that nothing in this entire subchapter shall be construed to apply to any county or farm mutual insurance company or association, as regulated under Chapters 911 and 912 of this code, . . . .
>
> (b) This subchapter applies to the writing of casualty insurance and the writing of fidelity, surety, and guaranty bonds, on risks or operations in this State except as herein stated.
>
> (c) Except as otherwise provided by this subchapter, this subchapter does not apply to the writing of motor vehicle, life, health, accident, professional liability, reinsurance, aircraft, fraternal benefit, 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, 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, or resulting from casual water entering through leaks or opening in buildings or by seepage through building walls, including insurance against accidental injury of such sprinklers, pumps, fire apparatus, conduits or container, workers' compensation, noncommercial inland marine, ocean marine, marine, or title insurance; nor does this subchapter apply to the writing of explosion insurance, except insurance against loss from injury to person or property which results accidentally from steam boilers, heaters or pressure vessels, electrical devices, engines and all machinery and appliances used in connection therewith or operation thereby.

Revisor's Note

(1) V.T.I.C. Article 5.13 refers to "this

subchapter," meaning Subchapter B, V.T.I.C. Chapter 5. Subchapter B, Chapter 5, is revised in various chapters in this title. The revised law substitutes a reference to "this subchapter" of the revised law for the reference to "this subchapter" because the substance of Article 5.13 is repeated in each of the chapters of this title in which other articles from Subchapter B, V.T.I.C. Chapter 5, are revised.

(2) Section (a), V.T.I.C. Article 5.13, states that the law revised in this subchapter does not apply to a "county or farm mutual insurance company or association, as regulated under Chapters 911 and 912 of this code." The only applicable references to an "association" are in Chapter 911 of this code, which regulates farm mutual insurance companies. The revised law is drafted accordingly.

(3) Section (c), V.T.I.C. Article 5.13, states that "[e]xcept as otherwise provided by this subchapter," meaning Subchapter B, V.T.I.C. Chapter 5, "this subchapter" does not apply to the writing of certain insurance, including "motor vehicle" insurance. The revised law omits the reference to "[e]xcept as otherwise provided by this subchapter" as unnecessary because the portions of Subchapter B, Chapter 5, that are revised in this subchapter do not contain any exception to the general statement of inapplicability.

Revised Law

Sec. 1806.103. CONSTRUCTION OF SUBCHAPTER. (a) This subchapter does not limit in any manner the kinds or classes of insurance that an insurer may write under an appropriate statute or the insurer's charter or certificate of authority.

(b) This subchapter may not be construed to prohibit the modification of rates by a rating plan that complies with Chapter

2251 or Article 5.13-2, as applicable. (V.T.I.C. Art. 5.13, Sec. (d); Art. 5.20, Sec. (b) (part).)

Source Law

[Art. 5.13]

(d) This subchapter shall not be construed as limiting in any manner the types or classes of insurance which may be written by the several types of insurers under appropriate statutes or their charters or permits.

[Art. 5.20]

(b) . . . provided further, that nothing in this subchapter shall be construed to prohibit the modification of rates by any rating plan authorized under this subchapter.

Revisor's Note

(1) Section (d), V.T.I.C. Article 5.13, refers to "[t]his subchapter," meaning Subchapter B, V.T.I.C. Chapter 5. The revised law substitutes a reference to "this subchapter" of the revised law for "[t]his subchapter" for the reason stated in Revisor's Note (1) to Section 1806.102.

(2) Section (b), V.T.I.C. Article 5.20, states that "this subchapter," meaning Subchapter B, V.T.I.C. Chapter 5, may not be construed to prohibit the modification of rates by a "rating plan authorized under this subchapter." The revised law substitutes a reference to "this subchapter" of the revised law for the first reference to "this subchapter" because the only provisions of Subchapter B, Chapter 5, that could be construed to prohibit the modification of rates by a rating plan are revised in this subchapter.

In addition, the revised law substitutes a reference to a "rating plan that complies with Chapter 2251 or Article 5.13-2, as applicable," for the reference to a "rating plan authorized under this subchapter" for accuracy. In 2003, under Chapter 206, Acts of the 78th Legislature, Regular Session, the legislature amended Section 2(a), V.T.I.C. Article

5.13-2, revised in this code in Section 2251.003, to expand the application of Article 5.13-2 to the kinds of casualty insurance and fidelity, surety, or guaranty bonds to which this subchapter applies, and that article governs rates for that insurance and those bonds, including the authority to use a rating plan. Therefore, a rating plan authorized under Subchapter B, Chapter 5, means a rating plan authorized under Article 5.13-2. The relevant provisions of that article that are revised are contained in Chapter 2251 of this code. Although that chapter contains other provisions that are derived from V.T.I.C. Article 5.13-2C, the revised law appropriately refers to the chapter in its entirety because the provisions that are derived from Article 5.13-2C do not relate to rating plans for casualty insurance and fidelity, guaranty, or surety bonds. In addition, the revised law substitutes "complies with" for "authorized under" to accurately reflect the regulatory system established under Article 5.13-2 as explained in Revisor's Note (2) to Section 1806.052.

Revised Law

Sec. 1806.104. PROHIBITED ACTS. (a) Except as otherwise provided by this subchapter, an insurer, an insurer's employee, or a broker or agent may not knowingly:

(1) issue an insurance policy that is not in accordance with an applicable filing that is filed and in effect under Chapter 2251 or 2301 or Article 5.13-2; or

(2) charge, demand, or receive a premium on an insurance policy that is not in accordance with an applicable filing that is filed and in effect under Chapter 2251 or 2301 or Article 5.13-2.

(b) Except as provided in an applicable filing that is filed and in effect under Chapter 2251 or 2301 or Article 5.13-2, an

insurer, an insurer's employee, or a broker or agent may not directly or indirectly pay, allow, or give, or offer to pay, allow, or give, as an inducement to insurance, or after insurance has been written, a rebate, discount, abatement, credit or reduction of the premium stated in an insurance policy, or a special favor or advantage in the dividends or other benefits to accrue on the policy, or any valuable consideration or inducement, not specified in the policy.

(c) An insured named in an insurance policy or an employee of an insured may not knowingly receive or accept, directly or indirectly, a rebate, discount, abatement, credit, or reduction of the premium stated in an insurance policy, or a special favor or advantage or valuable consideration or inducement. (V.T.I.C. Art. 5.20, Sec. (a).)

Source Law

> Art. 5.20. (a) Except as provided by this article, no insurer or employee thereof, and no broker or agent shall knowingly issue any policy of insurance nor charge, demand or receive a premium thereon except in accordance with the applicable filing which has been approved by the commissioner. No insurer or employee thereof, and no broker or agent shall pay, allow or give, or offer to pay, allow, or give, directly or indirectly, as an inducement to insurance, or after insurance has been effected, any rebate, discount, abatement, credit or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement whatever, not specified in the policy of insurance, except to the extent provided for in such applicable filing. No insured named in a policy of insurance, nor any employee of such insured shall knowingly receive or accept, directly or indirectly, any such rebate, discount, abatements, or reduction of premium, or any special favor or advantage or valuable consideration or inducement.

Revisor's Note

(1) Section (a), V.T.I.C. Article 5.20, prohibits issuing an insurance policy or charging, demanding, or receiving a premium on an insurance policy "except in accordance with the applicable filing which has been approved by the commissioner" and prohibits any inducement to insurance "except to

the extent provided for in such applicable filing." As explained in Revisor's Note (2) to Section 1806.103, V.T.I.C. Article 5.13-2, the portions of which that are revised are contained in Chapters 2251 and 2301 of this code, governs rates and forms for the kinds of casualty insurance and surety, fidelity, and guaranty bonds to which this subchapter applies. Under the provisions of that article revised in Chapters 2251 and 2301, rates and forms are filed with the commissioner of insurance and, under most circumstances, may be used unless disapproved by the commissioner. For accuracy, the revised law substitutes references to a filing "that is filed and in effect under Chapter 2251 or 2301 or Article 5.13-2" for the references to the "filing which has been approved by the commissioner" and "such . . . filing." Although Chapter 2251 contains provisions that are derived from V.T.I.C. Article 5.13-2C, and Chapter 2301 contains provisions that are derived from V.T.I.C. Article 5.145, the revised law appropriately refers to those chapters in their entirety because the provisions that are derived from Articles 5.13-2C and 5.145 do not relate to casualty insurance or fidelity, surety, or guaranty bonds.

(2) Section (a), V.T.I.C. Article 5.20, refers to a "rebate, discount, abatement, credit or reduction" of premiums and subsequently refers to "any such rebate, discount, abatements, or reduction" of premiums. The revised law substitutes the former phrase for the latter phrase for consistency and because it is clear from the context that the two phrases are intended to have the same meaning.

Revised Law

Sec. 1806.105. PROFIT SHARING AUTHORIZED; CERTAIN

PROHIBITIONS. (a) This subchapter does not prohibit an insurer from sharing earned profits with the insurer's policyholders in accordance with a profit sharing agreement contained in the policy, provided that any profit sharing under the policy with those insureds must be uniform among the insureds and may consist only of the equitable distribution of earnings among the insureds in accordance with the terms of the policy.

(b) An insurer may not:

(1) discriminate in the distribution of profits among insureds of the same class;

(2) distribute the profit to an insured before the expiration of the policy; or

(3) establish a class of insureds for the distribution of profits, except on the commissioner's approval.

(c) A distribution of profits or dividends to an insured may not take effect or be distributed until:

(1) adequate reserves are provided, as computed on the same basis for all classes of insurers to which this subchapter applies; and

(2) the commissioner approves the distribution. (V.T.I.C. Art. 5.20, Sec. (b) (part).)

Source Law

(b) Nothing in this article, however, shall be construed to prohibit an insurer from sharing its profits after the same have been earned with its policyholders under and in accordance with an agreement as to such profit sharing contained in its policy contract. Any profit sharing under any policy with insured shall be uniform as between such insured, and shall consist only and solely of the equitable distribution under and in accordance with the terms of the policy of earnings between such insured, and no such insurer shall discriminate in any distribution of profits between insured of a class, and no classes for such distribution shall be made or established except on the approval of the commissioner. No part of any profit shall be distributed to any insured under any such policy until the expiration of the policy contract, provided no distribution of profits or dividends to insured shall take effect or be paid until the same shall have been approved by the commissioner; and provided further, that no such distribution shall be approved until adequate reserves shall have been provided, such reserves to be computed on the same basis for all classes of insurers operating under this

subchapter. . . .

Revisor's Note

(1) Section (b), V.T.I.C. Article 5.20, refers to insurers sharing earned profits with policyholders "under and in accordance with" a profit sharing agreement and the policy. The revised law omits "in accordance with" for the reason stated in Revisor's Note (1) to Section 1806.055.

(2) Section (b), V.T.I.C. Article 5.20, refers to profits being "paid." The revised law substitutes "distributed" for "paid" for consistency of terminology throughout this chapter and because the terms are synonymous and the former is more commonly used.

Revised Law

Sec. 1806.106. PROFIT SHARING WITH CERTAIN ASSOCIATIONS AUTHORIZED. (a) This subchapter does not prohibit an insurer, on approval by the commissioner, from sharing profits with policyholders who are part of a group program established by a nonprofit business association and who participate in the group program because of membership in the association.

(b) An insurer that elects to make distributions under this section must:

(1) file a written description of the insurer's distribution program with the commissioner for approval; and

(2) notify the commissioner in writing of each distribution made under the program.

(c) If the commissioner does not act on the insurer's distribution program on or before the fifth business day after the date the commissioner receives the insurer's description of the program, the distribution program is considered approved. (V.T.I.C. Art. 5.20, Sec. (c) (part).)

Source Law

(c) This article does not prohibit an insurer, on approval by the commissioner, from sharing profits

with policyholders who are part of a group program established by a nonprofit business association and who participate in the group program because of membership in the association. An insurer that elects to make distributions under this subsection shall file a written description of its distribution program with the commissioner for approval by the commissioner and shall notify the commissioner in writing of each distribution made under the program. If the commissioner does not act on the insurer's distribution program within five business days of receipt of the insurer's distribution program, the distribution program is considered approved. . . .

Revised Law

Sec. 1806.107. ENFORCEMENT. (a) A violation of this subchapter is unjust discrimination and rebating.

(b) The commissioner may revoke the certificate of authority of an insurer that violates this subchapter or the license of an agent who violates this subchapter. (V.T.I.C. Art. 5.20, Sec. (b) (part).)

Source Law

(b) . . . Any violation of the terms of this article shall constitute unjust discrimination and shall constitute rebating, and shall be sufficient grounds for the revocation of the permit of the insurer or of the license of the agent being guilty of such unjust discrimination and rebating; . . . .

Revisor's Note
(End of Subchapter)

Section (e), V.T.I.C. Article 5.13, states that the regulatory power conferred in this subchapter is vested in the commissioner of insurance. The revised law omits this statement as unnecessary. Section 31.021 of this code provides that the commissioner "is the department's chief executive and administrative officer" and "has the powers and duties vested in the department by this code." The omitted law reads:

(e) The regulatory power herein conferred is vested in the commissioner.

[Sections 1806.108-1806.150 reserved for expansion]

SUBCHAPTER D. PROVISIONS APPLICABLE TO FIRE INSURANCE AND ALLIED LINES

Revised Law

Sec. 1806.151. APPLICABILITY OF SUBCHAPTER. (a) Each

insurance policy or contract insuring property in this state against loss by fire, including a policy or contract or portion of a policy or contract that insures the shore end of a marine risk against loss by fire, must be issued in accordance with:

(1) this subchapter;

(2) Section 403.002;

(3) Subchapter C, Chapter 5;

(4) Subchapter H, Chapter 544; and

(5) Chapters 252, 2001, 2002, 2003, 2004, 2005, 2006, and 2171.

(b) An insurer issuing an insurance policy or contract described by Subsection (a), including a fire insurance company, marine insurance company, fire and marine insurance company, and fire and tornado insurance company, is governed by the laws described by Subsection (a).

(c) This section applies to an insurer or to an insurance policy or contract regardless of:

(1) the kind and character of property insured;

(2) whether the property is:

(A) fixed or movable;

(B) stationary or in transit; or

(C) consigned or billed for shipment inside or outside the boundaries of this state or to a foreign country;

(3) whether the insurer is organized:

(A) under the laws of this state, another state, territory, or possession of the United States, or a foreign country; or

(B) by authority of the federal government; or

(4) the kind of insurer or the name of the insurer issuing the policy or contract. (V.T.I.C. Art. 5.27 (part).)

Source Law

Art. 5.27. Every fire insurance company, every marine insurance company, every fire and marine insurance company, every fire and tornado insurance company, and each and every insurance company of every kind and name issuing a contract or policy of

insurance, or contracts or policies of insurance against loss by fire on property within this State, whether such property be fixed or movable, stationary or in transit, or whether such property is consigned or billed for shipment within or beyond the boundary of this State or to some foreign county, whether such company is organized under the laws of this State or under the laws of any other state, territory or possession of the United States, or foreign country, or by authority of the Federal Government, [now holding certificate of authority to transact business in this State, shall be deemed to have accepted such certificate and to transact business thereunder, upon condition that it consents to the terms and provisions of this subchapter and that it agrees to transact business in this State, subject thereto;] it being intended that every contract or policy of insurance against the hazard of fire shall be issued in accordance with the terms and provisions of this subchapter, and the company issuing the same governed thereby, regardless of the kind and character of such property and whether the same is fixed or movable, stationary or in transit, including the shore end of all marine risks insured against loss by fire.

Revisor's Note

(1) V.T.I.C. Article 5.27 refers to a foreign "county." It is clear from the context that "county" is a typographical error and that the legislature intended to refer to a foreign "country." The revised law is drafted accordingly.

(2) V.T.I.C. Article 5.27 requires a fire insurance policy and an insurer that issues a fire insurance policy to comply with "this subchapter," meaning Subchapter C, V.T.I.C. Chapter 5. Included in Subchapter C, Chapter 5, were V.T.I.C. Articles 5.43-4, 5.44, 5.49, 5.53, and 5.54. Article 5.43-4 was revised in 1999 as Chapter 2154, Occupations Code, Article 5.44 was revised in 1987 as Section 417.008, Government Code, and Article 5.49 was revised, effective April 1, 2005, in part in Chapter 251 of this code. In addition, Articles 5.53 and 5.54 are revised in part as Chapter 1807 of this code. The revised law does not reference the statutes revising those articles because those provisions do not regulate fire insurance policies or insurers with respect to issuing those policies.

Revised Law

Sec. 1806.152. CONSTRUCTION OF SUBCHAPTER. (a) This subchapter, Subtitle D, and Subchapter C, Chapter 5, may not be construed to deal with the collection of premiums, but each insurer may make rules and regulations the insurer considers just between the insurer and the insurer's agents and policyholders.

(b) A bona fide extension of credit may not be construed as discrimination or as a violation of this subchapter. (V.T.I.C. Art. 5.42 (part).)

Source Law

> Art. 5.42. The provisions of this subchapter shall not deal with the collection of premiums, but each company shall be permitted to make such rules and regulations as it may deem just between the company, its agents, and its policyholders; and no bona fide extension of credit shall be construed as a discrimination, or in violation of the provisions of this subchapter. . . .

Revisor's Note

V.T.I.C. Article 5.42 states that a bona fide extension of credit may not be construed as discrimination or as a violation of "this subchapter," meaning Subchapter C, V.T.I.C. Chapter 5. Subchapter C, Chapter 5, is revised in various chapters in this code. The only provisions of Subchapter C that could be interpreted to prohibit a bona fide extension of credit are revised in this subchapter. The revised law is drafted accordingly.

Revised Law

Sec. 1806.153. UNJUST DISCRIMINATION; REBATES. (a) An insurer or an insurer's officer, director, agent, or other representative may not grant or contract for a special favor or advantage in:

(1) dividends or other profits to accrue on an insurance policy;

(2) commissions in the dividends or other profits to accrue on an insurance policy;

(3) commissions or division of commission; or

(4) a position, valuable consideration, or inducement not specified in an insurance policy.

(b) An insurer may not directly or indirectly give, sell, or purchase or offer to give, sell, or purchase as an inducement to insurance or in connection with insurance:

(1) stocks, bonds, or other securities of an insurer or other corporation, partnership, or individual;

(2) dividends or profits that have accrued or will accrue on stocks, bonds, or other securities of an insurer or other corporation, partnership, or individual; or

(3) anything of value not specified in the policy.

(c) An insurer or an insurer's officer, director, agent, or other representative that violates this section has engaged in unjust discrimination. (V.T.I.C. Art. 5.41, Sec. (a) (part).)

Source Law

> (a) . . . [nor shall any such company knowingly write insurance . . .] it shall be unlawful for any company, or its officers, directors, general agents, state agents, special agents, local agents, or its representatives, to grant or contract for any special favor or advantages in the dividends or other profits to come thereon, or in commissions in the dividends or other profits to accrue thereon, or in commissions or division of commission, or any position or any valuable consideration or any inducement not specified in the policy contract of insurance; nor shall such company give, sell or purchase, offer to give, sell or purchase, directly or indirectly, as an inducement to insure or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, partnership or individual, or any dividends or profits accrued or to accrue thereon, or anything of value whatsoever, not specified in the policy. . . . Any company, or any of its officers, directors, general agents, state agents, special agents, local agents or its representatives, doing any of the acts in this article prohibited, shall be deemed guilty of unjust discrimination. . . .

Revisor's Note

Section (a), V.T.I.C. Article 5.41, refers to the "general agents, state agents, special agents, [and] local agents" of an insurer. The revised law omits the references to those agents for the reason stated in Revisor's Note (1) to Section 1806.054.

Revised Law

Sec. 1806.154. PROFIT SHARING AUTHORIZED. (a) Section 1806.153 does not prohibit an insurer from sharing profits with the insurer's policyholders if:

(1) a profit sharing agreement is placed on or in the face of the policy;

(2) the profit sharing is uniform and does not discriminate among individuals or among classes; and

(3) the profit is not distributed to an insured before the expiration of the insurance policy.

(b) An insurer or an insurer's officer, director, agent, or other representative that violates this section has engaged in unjust discrimination. (V.T.I.C. Art. 5.41, Sec. (a) (part).)

Source Law

> (a) . . . Nothing in this law shall be construed to prohibit a company from sharing its profits with its policyholders, if such agreement as to profit sharing shall be placed on or in the face of the policy, and such profit sharing shall be uniform and shall not discriminate between individuals or between classes. No part of the profit shall be paid until the expiration of the policy. . . .

Revisor's Note

(1) Section (a), V.T.I.C. Article 5.41, states that "this law" may not be construed to prohibit an insurer from sharing profits with policyholders if certain requirements are satisfied. The only provision of this code that could be interpreted to prohibit an insurer from sharing profits with policyholders in this context is revised in this subchapter as Section 1806.153. The revised law is drafted accordingly.

(2) Section (a), V.T.I.C. Article 5.41, refers to profits being "paid." The revised law substitutes "distributed" for "paid" for the reason stated in Revisor's Note (2) to Section 1806.105.

Revised Law

Sec. 1806.155. INSURER LIABILITY ON POLICY ISSUED WITHOUT AUTHORITY. (a) If an insurer or an insurer's agent issues an insurance policy without authority and the policyholder sustains a loss or damage covered under the policy, the insurer is liable to the policyholder under the policy in the same manner and to the same extent as if the insurer had been authorized to issue the policy, although the policy was issued in violation of this code.

(b) This section may not be construed to give an insurer the authority to issue an insurance policy or contract other than as provided by this code. (V.T.I.C. Art. 5.41, Sec. (a) (part).)

Source Law

> (a) . . . If any agent or company shall issue a policy without authority, and any policyholder holding such policy shall sustain a loss or damage thereunder, said company or companies shall be liable to the policyholder thereunder, in the same manner and to the same extent as if said company had been authorized to issue said policies, although the company issued said policy in violation of the provisions of this subchapter. But this shall not be construed to give any company the right to issue any contract or policy of insurance other than as provided in this subchapter.

Revisor's Note

Section (a), V.T.I.C. Article 5.41, states that the provision, which provides consequences if an insurer or agent issues an insurance policy "without authority," may not be construed to give an insurer the authority to issue an insurance policy other than as provided in "this subchapter," meaning Subchapter C, V.T.I.C. Chapter 5. V.T.I.C. Article 5.41 was derived from Section 22, Chapter 106, Acts of the 33rd Legislature, Regular Session, 1913. As originally enacted, the provision referred to the issuance of a policy other than as provided in "this Act," meaning Chapter 106, which, at the time, was the entirety of insurance laws for this state. In that context, the reference intended to prevent Section 22 from being

construed to allow an insurer to issue a policy without authority under the insurance laws. The reference was changed from "this Act" to "this subchapter" in the codification of Section 22 as V.T.I.C. Article 5.41 by Chapter 491, Acts of the 52nd Legislature, Regular Session, 1951. That Act was a nonsubstantive revision of the insurance laws of this state. The revised law substitutes "this code" for "this subchapter" to preserve the intent of the original enactment by referring to the entirety of the insurance laws for this state.

Revised Law

Sec. 1806.156. ACCEPTANCE OF REBATE OR OTHER INDUCEMENT; CRIMINAL PENALTY. (a) A person commits an offense if the person knowingly receives or accepts from an insurer, an insurer's agent, broker, or other representative, or any other person a rebate of premium payable on an insurance policy, or a special favor or advantage in dividends or other financial profits accrued or to accrue on the policy, or any valuable consideration, position or inducement not specified in the policy.

(b) An offense under this section is punishable by:

(1) a fine of not more than $100;

(2) confinement in jail for not more than 90 days; or

(3) both a fine and confinement under this subsection.

(V.T.I.C. Art. 5.41-1.)

Source Law

Art. 5.41-1. Whoever shall knowingly receive or accept from any insurance company or from any of its agents, sub-agents, brokers, solicitors, employés, intermediaries or representatives, or any other person, any rebate of premium payable on policy, or any special favor or advantage in the dividends or other financial profits accrued or to accrue thereon, or any valuable consideration, position or inducement not specified in the policy of insurance, shall be fined not exceeding one hundred dollars or be imprisoned in jail not exceeding ninety days, or both.

Revisor's Note

(1) V.T.I.C. Article 5.41-1 refers to the

"agents, sub-agents, brokers, solicitors, employés, intermediaries or representatives" of an insurer. The revised law omits the reference to "sub-agents," because the meaning of that term is included within the meaning of "agent" and omits the references to "solicitors," "employés," and "intermediaries" because, in context, the meaning of those terms is included within the meaning of "representative."

(2) V.T.I.C. Article 5.41-1 refers to a punishment of being "imprisoned" in jail. The revised law refers to "confinement" in jail rather than imprisonment to conform to the terminology of the Penal Code.

Revisor's Note
(End of Subchapter)

A portion of Section (a), V.T.I.C. Article 5.41, requires a company insuring property against loss or damage by fire to comply with the requirements of state law regulating that type of insurer. Each provision of this chapter, by its own terms, requires compliance by an insurer. V.T.I.C. Article 5.27, revised in relevant part in this chapter, specifies to which companies this chapter applies. Therefore, the revised law omits the portion of Article 5.41 as unnecessary. The omitted law reads:

> Art. 5.41. (a) [No company shall engage or participate in the insuring or reinsuring of any property in this State against loss or damage by fire] except in compliance with the terms and provisions of this law; . . . .

CHAPTER 1807. APPLICABILITY TO MARINE INSURANCE

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CHAPTER 1807. APPLICABILITY TO MARINE INSURANCE

Revised Law

Sec. 1807.001. DEFINITIONS. In this chapter:

(1) "Insurable property and interests" includes:

(A) goods, freights, and cargoes;

(B) merchandise;

(C) effects;

(D) disbursements;

(E) profits;

(F) money, bullion, and precious stones;

(G) securities;

(H) choses in action;

(I) evidences of debt;

(J) valuable papers; and

(K) bottomry and respondentia interests.

(2) "Marine insurance" means:

(A) insurance and reinsurance that covers:

(i) loss or damage to:

(a) a hull, vessel, or craft of any kind, an aid to navigation, a dry dock, or a marine railway, whether complete, under construction, or awaiting construction; or

(b) insurable property and interests in respect to, appertaining to, or in connection with a risk or peril of navigation, transit, or transportation:

(1) on or under a sea, lake, or river or other water, in the air, or on land in connection with or incident to export, import, or waterborne risks;

(2) while being assembled, packed, crated, baled, compressed, or similarly prepared for shipment;

(3) while awaiting shipment; or

(4) during any delay, storage, or transshipment or reshipment incident to the initial shipment;

(ii) a marine builder or repairer risk;

(iii) a marine protection or indemnity risk; or

(iv) a war risk regarding any insurable property or interest described by this section; and

(B) insurance defined as marine insurance by another statute, lawful custom, or rule adopted by the commissioner. (V.T.I.C. Art. 5.53 (part).)

Source Law

> Art. 5.53. The provisions of this article shall apply to all insurance which is now or hereafter defined by statute, by rules of the commissioner, or by lawful custom, as marine insurance. . . .
>
> The term "Marine Insurance" shall mean and include insurance and reinsurance against any and all kinds of loss or damage to the following subject matters of insurance interest therein:
>
> Marine Insurance. Hulls, vessels and craft of every kind, aids to navigation, dry docks and marine railways, including marine builders' and repairers' risks, and whether complete or in process of or awaiting construction; also all marine protection and indemnity risks; also all goods, freights, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests, and all other kinds of property and interests therein, in respect to, appertaining to or in connection with any and all risks or perils of navigation, transit or transportation on or under any seas, lakes, rivers, or other waters or in the air, or on land in connection with or incident to export, import or waterborne risks, or while being assembled, packed, crated, baled, compressed or similarly prepared for such shipment or while awaiting the same, or during any delays, storage, transshipment or reshipment incident thereto, including the insurance of war risks in respect to any or all of the aforesaid subject matters of insurance.
>
> . . .

Revised Law

Sec. 1807.002. INAPPLICABILITY OF CERTAIN LAWS TO MARINE INSURANCE; EXCEPTION. (a) The following provisions do not apply to marine insurance:

(1) Sections 36.002, 37.051, 403.002, 492.051, and 501.159;

(2) Subchapter H, Chapter 544;

(3) Chapters 5, 252, 253, 493, 494, 1804, 1805, 1806, and 2171; and

(4) Subtitles B, C, D, E, F, H, and I.

(b) Subsection (a) does not apply to:

(1) a farm mutual insurance company operating under Chapter 911;

(2) a mutual insurance company engaged in business under Chapter 12, Title 78, Revised Statutes, before that chapter's repeal by Section 18, Chapter 40, Acts of the 41st Legislature, 1st Called Session, 1929, as amended by Section 1, Chapter 60, General Laws, Acts of the 41st Legislature, 2nd Called Session, 1929, that retains the rights and privileges under the repealed law to the extent provided by those sections; or

(3) a county mutual insurance company operating under Chapter 912. (V.T.I.C. Arts. 5.53 (part), 5.54 (part).)

Source Law

> Art. 5.53. . . .
> The provisions of Chapter 5 of this code, other than this article, shall not apply to marine insurance as defined by this article.
> Art. 5.54. Nothing in Articles . . . 5.53 of this subchapter shall ever be construed to apply to any farm mutual insurance company operating under Chapter 16 of this Code or to any company now operating under Chapter 12, of Title 78, which has heretofore been repealed. Nothing in Articles . . . 5.53 of this subchapter shall ever be construed to apply to any county mutual insurance company operating under Chapter 17 of this Code.

Revisor's Note

(1) V.T.I.C. Article 5.53 states in part that the provisions of V.T.I.C. Chapter 5 do not apply to marine insurance. Many provisions of Chapter 5, now revised in various parts of this code, could not be interpreted to apply to marine insurance by their own terms; others are simply inapplicable, as a practical matter, to marine insurance. The revised law, however, continues the references to all of the provisions previously contained in Chapter 5 unless the references are clearly inapplicable to marine insurance.

V.T.I.C. Articles 5.12, 5.24, 5.49, 5.68, and 5.91 were included in Chapter 5 and were revised,

effective April 1, 2005, in Chapters 251, 252, 253, 254, 255, and 256. The revised law does not reference Chapter 251 because it contains only general provisions that have no effect except in relation to the other listed laws. The revised law does not reference Chapter 254, 255, or 256 because those laws apply by their own terms to motor vehicle insurance, workers' compensation insurance, and aircraft insurance, respectively, and could not be interpreted to apply to marine insurance.

Chapter 5 included V.T.I.C. Article 5.43-4, which was revised in 1999 as Chapter 2154, Occupations Code, and V.T.I.C. Article 5.44, which was revised in 1987 as Section 417.008, Government Code. Chapter 5 also includes V.T.I.C. Article 5.57A, revised as Chapter 406A, Labor Code. The revised law does not reference Section 417.008, Government Code, Chapter 2154, Occupations Code, or Chapter 406A, Labor Code, because those provisions could not be construed to apply to marine insurance.

V.T.I.C. Article 5.61, contained in Chapter 5, is revised as Chapter 426. The revised law does not reference Chapter 426 because that law applies to reserves for workers' compensation insurance companies and could not be interpreted to apply to marine insurance.

V.T.I.C. Article 5.54, contained in Chapter 5, provides that certain laws, including Subsection (a) of the revised law, do not apply to certain companies. Article 5.54 is revised in part in this section as Subsection (b). The revised law does not reference Subsection (b) because the reference would be nonsensical.

V.T.I.C. Article 5.75-1, contained in Chapter 5,

is revised as part of Section 492.051. The revised law refers to that section in its entirety because the other provisions of Section 492.051 apply to life insurance companies and do not apply to marine insurance.

(2) V.T.I.C. Article 5.54 refers to a farm mutual insurance company operating under "Chapter 16 of this Code" and a county mutual insurance company operating under "Chapter 17 of this Code." Chapters 16 and 17 were codified in 2001 as Chapters 911 and 912, respectively. The revised law is drafted accordingly.

[Chapters 1808-1900 reserved for expansion]

SUBTITLE B. LIABILITY INSURANCE FOR PHYSICIANS AND HEALTH CARE PROVIDERS

CHAPTER 1901. PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AND HEALTH CARE PROVIDERS

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CHAPTER 1901. PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AND HEALTH CARE PROVIDERS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1901.001. DEFINITIONS. In this chapter:

(1) "Health care provider" means:

(A) a person, partnership, professional association, corporation, facility, or institution, or an officer, employee, or agent of the person or entity acting in the course and scope of authority, employment, or agency, as applicable, if the person or entity is licensed or chartered by this state to provide health care as:

(i) a registered nurse;

(ii) a hospital;

(iii) a dentist;

(iv) a podiatrist;

(v) a chiropractor;

(vi) an optometrist or therapeutic optometrist;

(vii) a pharmacist;

(viii) a veterinarian;

(ix) a not-for-profit kidney dialysis center;

(x) a blood bank that is a nonprofit corporation chartered to operate a blood bank and is accredited by the American Association of Blood Banks;

(xi) a for-profit or not-for-profit nursing home; or

(xii) a for-profit or not-for-profit assisted living facility; or

(B) a health care practitioner or facility that the commissioner, in accordance with Section 2203.103(b), determines is eligible for coverage under this chapter.

(2) "Hospital" means a public or private institution licensed under Chapter 241 or 577, Health and Safety Code.

(3) "Physician" means a person licensed to practice medicine in this state. (V.T.I.C. Art. 5.15-1, Sec. 2.)

Source Law

Sec. 2. In this article:

(1) "Physician" means a person licensed to practice medicine in this state.

(2) "Health care provider" means any person, partnership, professional association, corporation, facility, or institution licensed or chartered by the State of Texas to provide health care as a registered nurse, hospital, dentist, podiatrist, chiropractor, optometrist, pharmacist, veterinarian, not-for-profit kidney dialysis center, blood bank that is a nonprofit corporation chartered to operate a blood bank and which is accredited by the American Association of Blood Banks, for-profit nursing home or not-for-profit nursing home, for-profit assisted living facility or not-for-profit assisted living facility, or an officer, employee, or agent of any of them acting in the course and scope of his employment, or a health care practitioner or facility that the commissioner, in accordance with Section 3B(b), Article 21.49-3, of this code, determines is eligible for coverage under this article.

(3) "Hospital" means a licensed public or private institution as defined in Chapter 241, Health

and Safety Code, or in Section 88, Chapter 243, Acts of the 55th Legislature, Regular Session, 1957 (Article 5547-88, Vernon's Texas Civil Statutes).

Revisor's Note

(1) Section 2, V.T.I.C. Article 5.15-1, provides definitions applicable to "this article," meaning V.T.I.C. Article 5.15-1, which is revised in this chapter. Although other provisions of this chapter are derived from V.T.I.C. Article 5.15-4, the revised law substitutes "this chapter" for "this article" in this context because the terms defined in Section 2 are not used in Article 5.15-4.

In addition, subsequent provisions of Article 5.15-1, including Section 2(2), revised in this section, refer to "this article." Article 5.15-1 applies to professional liability insurance for physicians and health care providers, including the setting of rates for that kind of insurance. Section 2(2) defines "health care provider" to include a nursing home. Article 5.15-4, revised in this chapter as Subchapter D, in part governs the consideration of best practices for nursing homes in setting rates for professional liability insurance for nursing homes. Because both Articles 5.15-1 and 5.15-4 apply to the setting of rates for professional liability insurance for nursing homes and the articles must, therefore, be read in conjunction with respect to that kind of insurance, it is appropriate throughout this chapter to substitute references to "this chapter" for references to "this article" in Article 5.15-1. The revised law is drafted accordingly.

(2) Section 2(2), V.T.I.C. Article 5.15-1, defines "health care provider" to include an "optometrist." The revised law adds "therapeutic optometrist" for consistency with the terminology used

in Chapter 351, Occupations Code, which governs the practice of optometry, and because Section 351.003, Occupations Code, provides that a reference in a law of this state to an optometrist means an optometrist or therapeutic optometrist, unless the context clearly indicates otherwise.

(3) Section 2(3), V.T.I.C. Article 5.15-1, refers to Section 88, Chapter 243, Acts of the 55th Legislature, Regular Session, 1957 (Article 5547-88, Vernon's Texas Civil Statutes). Article 5547-88 was codified in 1991 in Chapter 577, Health and Safety Code, which governs the licensing of certain mental health facilities. The revised law is drafted accordingly.

Revised Law

Sec. 1901.002. APPLICABILITY OF CHAPTER. This chapter applies to:

(1) an insurer authorized to write or engaged in writing professional liability insurance for a physician or health care provider; and

(2) a rating organization acting on behalf of an insurer described by Subdivision (1). (V.T.I.C. Art. 5.15-1, Sec. 1.)

Source Law

Art. 5.15-1

Sec. 1. This article shall apply to the making and use of insurance rates by every insurer licensed to write or engaged in writing professional liability insurance for any physician or any health care provider including rating organizations, acting on behalf of insurers.

Revisor's Note

(1) Section 1, V.T.I.C. Article 5.15-1, states that V.T.I.C. Article 5.15-1, which is revised in this chapter, applies to "the making and use of insurance rates" by an insurer authorized to write professional liability insurance for physicians or health care

providers. The revised law omits the quoted language because the article applies by its own terms to the making and use of insurance rates by an insurer to whom this chapter applies, and an additional statement to that effect is unnecessary. In addition, the revised law omits the quoted language as misleading because the article applies to the making and use of insurance forms as well as insurance rates. See, for example, Section 4(c), V.T.I.C. Article 5.15-1, revised in this chapter as Section 1901.201.

(2) Section 1, V.T.I.C. Article 5.15-1, refers to an insurer "licensed to write" professional liability insurance for physicians or health care providers. The revised law substitutes "authorized" for "licensed" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 1901.003. APPLICABILITY OF OTHER LAW. Chapters 2251 and 2301 and Article 5.13-2 apply to rates and forms for professional liability insurance for physicians and health care providers under this chapter. (V.T.I.C. Art. 5.15-1, Sec. 4(a).)

Source Law

Sec. 4. (a) The provisions of Article 5.13-2 of this code shall apply to the filing of rates and rating information required under this article.

Revisor's Note

Section 4(a), V.T.I.C. Article 5.15-1, states that V.T.I.C. Article 5.13-2, revised in part in Chapters 2251 and 2301 of this code, applies to the filing of rates and rating information required under V.T.I.C. Article 5.15-1, which is revised in this chapter. Article 5.13-2 applies by its own terms to both insurance rates and insurance forms for certain specified kinds of insurance, including the kinds of

insurance regulated under this chapter. The revised law is drafted to accurately reflect that applicability.

In addition, although Chapter 2251 is also derived in part from V.T.I.C. Article 5.13-2C and Chapter 2301 is also derived in part from V.T.I.C. Article 5.145, the revised law appropriately refers to both chapters in their entirety because Article 5.13-2C relates only to certain insurers writing residential property insurance and Article 5.145 relates only to personal automobile and residential property insurance; therefore, the provisions of Chapters 2251 and 2301 derived from Articles 5.13-2C and 5.145 are inapplicable by their own terms to rates and forms for the kinds of insurance regulated under this chapter.

Revised Law

Sec. 1901.004. ANNUAL REPORTS. (a) An insurer that issues professional liability insurance policies covering physicians and health care providers shall file annually with the commissioner a report of:

(1) all claims and the amounts of those claims;

(2) amounts of claims reserves;

(3) investment income of the insurer derived from medical professional liability premiums;

(4) information relating to amounts of judgments and settlements paid on claims; and

(5) other information required by the commissioner.

(b) The commissioner may promulgate a form on which the information under Subsection (a) must be reported. The form must require that the information be reported in an accurate manner and be reasonably calculated to:

(1) facilitate interpretation; and

(2) protect the confidentiality of the physician or

health care provider. (V.T.I.C. Art. 5.15-1, Sec. 5.)

Source Law

Sec. 5. Each insurer who issues policies of professional liability insurance covering physicians and health care providers shall file annually with the State Board of Insurance a report of all claims and amount of claims, amounts of claims reserves, investment income of the company derived from medical professional liability premiums, information relating to amounts of judgments and settlements paid on claims, and other information required by the board. The board may formulate and promulgate a form on which this information shall be reported. The form shall be so devised as to require the information to be reported in an accurate manner, reasonably calculated to facilitate interpretation and to protect the confidentiality of the health care provider or physician.

Revisor's Note

(1) Section 5, V.T.I.C. Article 5.15-1, 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. Throughout this chapter, references to the board have been changed appropriately.

(2) Section 5, V.T.I.C. Article 5.15-1, authorizes the State Board of Insurance, meaning the commissioner of insurance for the reason stated in Revisor's Note (1) to this section, to "formulate and promulgate" a form. The revised law omits "formulate" because "formulate" is included within the meaning of "promulgate."

Revised Law

Sec. 1901.005. RULES. The commissioner shall establish by rule:

(1) criteria that insurers must follow in establishing reconsideration procedures under Section 1901.101; and

(2) standards and procedures to be followed in the review of rates and premiums by the commissioner. (V.T.I.C. Art. 5.15-1, Sec. 4B(c).)

Source Law

(c) The State Board of Insurance by rule shall establish criteria to be followed by insurers in establishing reconsideration procedures under Subsection (a) of this section and standards and procedures to be followed in review of rates and premiums by the board.

[Sections 1901.006-1901.050 reserved for expansion]

SUBCHAPTER B. RATE STANDARDS

Revised Law

Sec. 1901.051. CONSIDERATIONS IN SETTING RATES. (a) In setting rates, an insurer shall consider:

(1) past and prospective loss and expense experience for all professional liability insurance for physicians and health care providers written in this state, subject to Subsection (b);

(2) a reasonable margin for underwriting profit and contingencies;

(3) investment income; and

(4) dividends or savings allowed or returned by the insurer to the insurer's policyholders or members.

(b) If the department finds that the group or risk to be insured is not of sufficient size to be credible, an insurer must also consider in setting rates past and prospective loss and expense experience for all professional liability insurance for physicians and health care providers written outside this state. (V.T.I.C. Art. 5.15-1, Sec. 3 (part).)

Source Law

Sec. 3. Rates shall be made in accordance with the following provisions:

(a) Consideration shall be given to past and prospective loss and expense experience for all professional liability insurance for physicians and health care providers written in this state, unless the State Board of Insurance shall find that the group or risk to be insured is not of sufficient size to be deemed credible, in which event, past and prospective loss and expense experience for all professional liability insurance for physicians and health care providers written outside this state shall also be considered, to a reasonable margin for underwriting profit and contingencies, to investment income, to dividends or savings allowed or returned by insurers to their policyholders or members.

. . .

Revised Law

Sec. 1901.052. GROUPING OF RISKS. In setting rates, an insurer may group risks by classification, rating schedule, or any other reasonable method. (V.T.I.C. Art. 5.15-1, Sec. 3 (part).)

Source Law

> Sec. 3. Rates shall be made in accordance with the following provisions:
>
> . . .
>
> (c) For the establishment of rates, risks may be grouped by classifications, by rating schedules, or by any other reasonable methods. . . .

Revised Law

Sec. 1901.053. MODIFICATION OF CLASSIFICATION RATES. (a) An insurer may modify classification rates to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions.

(b) The standards may measure any difference among risks that can be demonstrated to have a probable effect on losses or expenses. (V.T.I.C. Art. 5.15-1, Sec. 3 (part).)

Source Law

> Sec. 3. Rates shall be made in accordance with the following provisions:
>
> . . .
>
> (c) . . . Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Those standards may measure any difference among risks that can be demonstrated to have a probable effect upon losses or expenses.
>
> . . .

Revised Law

Sec. 1901.054. LIMITATIONS ON RATES. (a) Rates set under this chapter may not be excessive or inadequate, as described by this section, or unreasonable or unfairly discriminatory.

(b) A rate is not excessive unless:

(1) the rate is unreasonably high for the insurance coverage provided; and

(2) a reasonable degree of competition does not exist in the area with respect to the classification to which the rate

applies.

(c) A rate is not inadequate unless the rate is unreasonably low for the insurance coverage provided and:

(1) is insufficient to sustain projected losses and expenses; or

(2) the use of the rate has or, if continued, will have the effect of destroying competition or creating a monopoly. (V.T.I.C. Art. 5.15-1, Sec. 3 (part).)

Source Law

> Sec. 3. Rates shall be made in accordance with the following provisions:
>
> . . .
>
> (d) Rates shall be reasonable and shall not be excessive or inadequate, as defined in this subsection, nor shall they be unfairly discriminatory. No rate shall be held to be excessive unless the rate is unreasonably high for the insurance coverage provided and a reasonable degree of competition does not exist in the area with respect to the classification to which the rate is applicable. No rate shall be held to be inadequate unless the rate is unreasonably low for the insurance coverage provided and is insufficient to sustain projected losses and expenses; or unless the rate is unreasonably low for the insurance coverage provided and the use of the rate has or, if continued, will have the effect of destroying competition or creating a monopoly.

Revised Law

Sec. 1901.055. CLAIM SURCHARGE. A claim surcharge assessed by an insurer against a physician or health care provider under a professional liability insurance policy may be based only on claims actually paid by an insurer as a result of:

(1) a settlement; or

(2) an adverse judgment or decision of a court. (V.T.I.C. Art. 5.15-1, Sec. 9.)

Source Law

> Sec. 9. A claim surcharge assessed by an insurer against a health care provider or physician under a professional liability insurance policy may be based only on claims actually paid by an insurer as a result of a settlement or an adverse judgment or an adverse decision of a court.

Revised Law

Sec. 1901.056. ABSOLUTE RATES PROHIBITED. (a) In this section, "absolute rates" means rates, rating plans, or rating

classifications that are filed under Chapter 2251 or Article 5.13-2 by an insurer or authorized rating organization and that are required to be used, to the exclusion of all others, by each insurer authorized to write policies.

(b) A provision of this chapter, Chapter 2251, or Article 5.13-2 relating to the regulation of rates, rating plans, and rating classifications for professional liability insurance for physicians and health care providers does not:

(1) give the commissioner the power to promulgate uniform or absolute rates; or

(2) prevent different insurers or organizations authorized to file rates from filing different rates for risks in a given classification or modified rates for individual risks made in accordance with rating plans. (V.T.I.C. Art. 5.15-1, Sec. 4(b).)

Source Law

(b) Nothing contained in this article or other provisions of this subchapter concerning the regulation of rates, rating plans, and rating classifications shall, as applies to the writing of professional liability insurance for health care providers and physicians, give the board the power to prescribe uniform or absolute rates; nor shall anything therein be construed as preventing the filing of different rates for risks in a given classification or modified rates for individual risks made in accordance with rating plans, as filed by different insurers or organizations authorized to file such rates. As used in this subsection, "absolute rates" means rates, rating classifications, or rating plans filed by an insurer or authorized rating organization in accordance with this subchapter and the rates, rating classifications, or rating plans so filed are required to be used, to the exclusion of all others, by each insurer lawfully engaged in writing policies.

Revisor's Note

Section 4(b), V.T.I.C. Article 5.15-1, refers to the filing and regulation of rates, rating plans, and rating classifications under "this subchapter," meaning Subchapter B, V.T.I.C. Chapter 5. The pertinent provisions of Subchapter B, Chapter 5, are contained in V.T.I.C. Article 5.13-2, revised in part in Chapter 2251 of this code, and the revised law is drafted accordingly. Although Chapter 2251 is also

derived in part from V.T.I.C. Article 5.13-2C, the revised law refers to that chapter in its entirety for the reason stated in the revisor's note to Section 1901.003.

Revised Law

Sec. 1901.057. CONSIDERATIONS IN APPROVING RATES. In approving rates under this chapter, the commissioner shall consider the impact of risk management courses taken by physicians and health care providers in this state. (V.T.I.C. Art. 5.15-1, Sec. 3 (part).)

Source Law

> Sec. 3. Rates shall be made in accordance with the following provisions:
>
> . . .
>
> (b) The State Board of Insurance shall consider the impact of risk management courses taken by physicians and health care providers in this state in approving rates under this article.
>
> . . .

[Sections 1901.058-1901.100 reserved for expansion]

SUBCHAPTER C. REVIEW OF RATES

Revised Law

Sec. 1901.101. RECONSIDERATION OF RATES AND PREMIUMS. (a) Each insurer to which this chapter applies shall adopt a procedure for reconsideration of a rate or premium charged a physician or health care provider for professional liability insurance coverage.

(b) The procedure must include:

(1) an opportunity for a hearing before officers or employees who have responsibility for determining rates and premiums to be charged for professional liability insurance; and

(2) a requirement that the insurer reconsider the rate or premium and provide the physician or health care provider a written explanation of the rate or premium being charged. (V.T.I.C. Art. 5.15-1, Sec. 4B(a).)

Source Law

> Sec. 4B. (a) Each insurer covered by this article shall adopt a procedure for reconsideration of

a rate or premium charged a physician or health care provider for professional liability insurance coverage. The procedure shall include an opportunity for a hearing before officers or employees who have responsibility for determining rates and premiums to be charged for professional liability insurance and a requirement that the insurer reconsider the rate or premium and provide the physician or health care provider a written explanation of the rate or premium being charged.

Revised Law

Sec. 1901.102. APPEAL. A physician or health care provider that is not satisfied with a decision under procedures established under Section 1901.101 may appeal to the commissioner for:

(1) a review of the rate or premium; and

(2) a determination of whether the rate or premium being charged complies with criteria under Sections 1901.051-1901.054 and 1901.057. (V.T.I.C. Art. 5.15-1, Sec. 4B(b).)

Source Law

(b) If a physician or health care provider is not satisfied with a decision under procedures established under Subsection (a) of this section, the physician or health care provider may appeal to the State Board of Insurance for a review of the rate or premium and a determination if the rate or premium being charged complies with criteria under Section 3 of this article.

[Sections 1901.103-1901.150 reserved for expansion]

SUBCHAPTER D. BEST PRACTICES FOR NURSING HOMES

Revised Law

Sec. 1901.151. BEST PRACTICES. (a) The commissioner shall adopt best practices for risk management and loss control that may be used by for-profit and not-for-profit nursing homes.

(b) In developing or amending the best practices, the commissioner shall consult with the Health and Human Services Commission and a task force appointed by the commissioner.

(c) The task force must be composed of representatives of:

(1) insurers that write professional liability insurance for nursing homes;

(2) the Texas Medical Liability Insurance Underwriting Association;

(3) nursing homes; and

(4) consumers. (V.T.I.C. Art. 5.15-4, Secs. (a), (c).)

Source Law

Art. 5.15-4. (a) The commissioner shall adopt best practices for risk management and loss control that may be used by for-profit and not-for-profit nursing homes.

(c) In developing or amending best practices for for-profit and not-for-profit nursing homes, the commissioner shall consult with the Health and Human Services Commission and a task force appointed by the commissioner. The task force must be composed of representatives of:

(1) insurance companies that write professional liability insurance for nursing homes;

(2) the Texas Medical Liability Insurance Underwriting Association;

(3) nursing homes; and

(4) consumers.

Revised Law

Sec. 1901.152. CONSIDERATION OF BEST PRACTICES IN SETTING RATES. In setting rates for professional liability insurance applicable to a for-profit or not-for-profit nursing home, an insurer or the Texas Medical Liability Insurance Underwriting Association may consider whether the nursing home adopts and implements the best practices adopted under this subchapter. (V.T.I.C. Art. 5.15-4, Sec. (b).)

Source Law

(b) In determining rates for professional liability insurance applicable to a for-profit or not-for-profit nursing home, an insurance company or the Texas Medical Liability Insurance Underwriting Association may consider whether the nursing home adopts and implements the best practices adopted by the commissioner under Subsection (a) of this article.

Revised Law

Sec. 1901.153. STANDARD OF CARE FOR CIVIL ACTIONS NOT ESTABLISHED. The best practices for risk management and loss control adopted under this subchapter do not establish standards of care for nursing homes applicable in a civil action against a nursing home. (V.T.I.C. Art. 5.15-4, Sec. (d).)

Source Law

(d) The best practices for risk management and

loss control adopted under this article do not establish standards of care for nursing homes applicable in a civil action against a nursing home.

[Sections 1901.154-1901.200 reserved for expansion]

SUBCHAPTER E. POLICY FORMS

Revised Law

Sec. 1901.201. STANDARDIZED POLICY FORMS; APPROVAL OF OTHER FORMS. (a) The commissioner shall prescribe standardized policy forms for occurrence, claims-made, and claims-paid professional liability insurance policies for physicians and health care providers.

(b) An insurer may not use a form other than a standardized policy form in writing professional liability insurance for physicians and health care providers unless the form has been approved by the commissioner.

(c) An insurer writing professional liability insurance for physicians and health care providers may use an endorsement if the endorsement has been filed with and approved by the commissioner. (V.T.I.C. Art. 5.15-1, Sec. 4(c).)

Source Law

(c) The State Board of Insurance shall prescribe standardized policy forms for occurrence, claims-made and claims-paid policies of professional liability insurance covering health care providers and physicians, and no insurer may use any other forms in writing professional liability insurance for health care providers and physicians without the prior approval of the State Board of Insurance. However, an insurer writing professional liability insurance for health care providers and physicians may use any form of endorsement if the endorsement is first submitted to and approved by the board.

[Sections 1901.202-1901.250 reserved for expansion]

SUBCHAPTER F. COVERAGE

Revised Law

Sec. 1901.251. PREMIUM BASIS. An insurer may not write a professional liability insurance policy under this chapter on less than an annual premium basis. (V.T.I.C. Art. 5.15-1, Sec. 6.)

Source Law

Sec. 6. Policies of professional liability insurance under this article shall be written on not less than an annual premium basis.

Revised Law

Sec. 1901.252. COVERAGE FOR EXEMPLARY DAMAGES. (a) Except as provided by Subsection (b), a medical professional liability insurance policy issued to or renewed for a physician or health care provider in this state may not include coverage for exemplary damages that may be assessed against the physician or health care provider.

(b) The commissioner may approve an endorsement form that provides for coverage for exemplary damages for use on a medical professional liability insurance policy issued to:

(1) a hospital; or

(2) a for-profit or not-for-profit nursing home or assisted living facility. (V.T.I.C. Art. 5.15-1, Sec. 8.)

Source Law

> Sec. 8. No policy of medical professional liability insurance issued to or renewed for a health care provider or physician in this state may include coverage for exemplary damages that may be assessed against the health care provider or physician; provided, however, that the commissioner may approve an endorsement form that provides for coverage for exemplary damages to be used on a policy of medical professional liability insurance issued to a hospital, as the term "hospital" is defined in this article, or to a for-profit or not-for-profit nursing home or assisted living facility.

Revised Law

Sec. 1901.253. NOTICE OF PREMIUM INCREASE, CANCELLATION, OR NONRENEWAL. (a) An insurer that issues a professional liability insurance policy for a physician or health care provider must provide to the insured written notice of at least 90 days if the insurer intends to:

(1) increase the premiums on the policy; or

(2) cancel or not renew the policy for a reason other than for nonpayment of premiums or because the insured is no longer licensed.

(b) If the insurer intends to increase the premiums, the insurer shall state in the notice the amount of the increase.

(c) If the insurer intends to cancel or not renew the

policy, the insurer shall state in the notice the reason for cancellation or nonrenewal.

(d) An insurer may provide notice of cancellation under this section only within the first 90 days from the effective date of the policy. (V.T.I.C. Art. 5.15-1, Sec. 7.)

Source Law

> Sec. 7. An insurer who issues a policy of professional liability insurance covered by this article shall give at least 90 days' written notice to an insured if premiums on the insurance are to be increased or the policy is to be cancelled or is not to be renewed other than for nonpayment of premiums or because the insured is no longer licensed. If the premiums are to be increased, the notice shall state the amount of the increase, and if the policy is to be cancelled or is not to be renewed, the insurer shall state in the notice the reason for cancellation or nonrenewal. Notice of cancellation under this section may only be given within the first 90 days from the effective date of the policy.

CHAPTER 1902. CERTAIN LIABILITY COVERAGE FOR PHYSICIANS AND HEALTH CARE PROVIDERS

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CHAPTER 1902. CERTAIN LIABILITY COVERAGE FOR PHYSICIANS AND HEALTH CARE PROVIDERS

Revised Law

Sec. 1902.001. DEFINITIONS. In this chapter:

(1) "Health care provider" has the meaning assigned by Section 1901.001.

(2) "Manufacturer" has the meaning assigned by Section 82.001, Civil Practice and Remedies Code.

(3) "Physician" has the meaning assigned by Section 1901.001. (New; V.T.I.C. Art. 5.15-1, Sec. 11 (part).)

Source Law

> Sec. 11. [An insurer may not exclude or otherwise limit coverage . . . under a vendor's

endorsement issued to a manufacturer,] as that term is defined by Section 82.001, Civil Practice and Remedies Code. . . .

Revisor's Note

Section 2, V.T.I.C. Article 5.15-1, provides definitions applicable to terms used in Section 11 of that article, revised as this chapter. The revised law adds a cross-reference to the applicable definitions as revised in Section 1901.001 of this code.

Revised Law

Sec. 1902.002. COVERAGE FOR PHYSICIANS OR HEALTH CARE PROVIDERS UNDER VENDOR ENDORSEMENTS OR CERTAIN POLICIES. A physician or health care provider is considered a vendor for purposes of coverage under a vendor's endorsement or a manufacturer's general liability or products liability policy. (V.T.I.C. Art. 5.15-1, Sec. 11 (part).)

Source Law

Sec. 11. . . . A physician or health care provider shall be considered a vendor for purposes of coverage under a vendor's endorsement or a manufacturer's general liability or products liability policy.

Revised Law

Sec. 1902.003. EXCLUSIONS AND LIMITATIONS ON COVERAGE UNDER VENDOR ENDORSEMENTS PROHIBITED. An insurer may not exclude or otherwise limit coverage for physicians or health care providers under a vendor's endorsement issued to a manufacturer. (V.T.I.C. Art. 5.15-1, Sec. 11 (part).)

Source Law

Sec. 11. An insurer may not exclude or otherwise limit coverage for physicians or health care providers under a vendor's endorsement issued to a manufacturer, . . . .

CHAPTER 1903. LOSS CONTROL INFORMATION AND SERVICES

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CHAPTER 1903. LOSS CONTROL INFORMATION AND SERVICES

SUBCHAPTER A. LOSS CONTROL SERVICES FOR PROFESSIONAL LIABILITY INSURANCE FOR HOSPITALS

Revised Law

Sec. 1903.001. DEFINITION. In this subchapter, "hospital" means a public or private institution licensed under Chapter 241 or 577, Health and Safety Code. (V.T.I.C. Art. 5.15-2, Sec. (e).)

Source Law

(e) In this article, "hospital" means a licensed public or private institution as defined in Chapter 241, Health and Safety Code, or in Section 88, Chapter 243, Acts of the 55th Legislature, Regular Session, 1957 (Article 5547-88, Vernon's Texas Civil Statutes).

Revisor's Note

Section (e), V.T.I.C. Article 5.15-2, refers to Section 88, Chapter 243, Acts of the 55th Legislature, Regular Session, 1957 (Article 5547-88, Vernon's Texas Civil Statutes). Article 5547-88 was codified in 1991 in Chapter 577, Health and Safety Code, which governs the licensing of certain mental health facilities. The revised law is drafted accordingly.

Revised Law

Sec. 1903.002. INAPPLICABILITY OF SUBCHAPTER. This

subchapter and Subchapter C do not apply to insurance policies that provide excess coverage issued by the Texas Medical Liability Insurance Underwriting Association under Chapter 2203, or to those policies if the policies are serviced by an insurer acting as a servicing carrier under an agreement entered into between the association and the insurer and approved by the commissioner. (V.T.I.C. Art. 5.15-2, Sec. (f).)

Source Law

(f) This article does not apply to insurance policies that provide excess coverage issued by the Texas Medical Liability Insurance Underwriting Association under Article 21.49-3 of this code, and does not apply to those policies if serviced by an insurer acting as a servicing carrier under an agreement entered into between the Texas Medical Liability Insurance Underwriting Association and the insurer and approved by the State Board of Insurance.

Revisor's Note

(1) Section (f), V.T.I.C. Article 5.15-2, refers to insurance policies that provide excess coverage issued by the Texas Medical Liability Insurance Underwriting Association under V.T.I.C. Article 21.49-3. The relevant provisions of Article 21.49-3 are revised in Chapter 2203 of this code. That chapter also contains provisions derived from V.T.I.C. Article 21.49-3d, which relates to the issuance of bonds on behalf of the association to provide certain professional liability insurance. The revised law refers to Chapter 2203 in its entirety because the provisions of that chapter that are derived from Article 21.49-3d do not relate to the issuance of policies by the association.

(2) Section (f), V.T.I.C. Article 5.15-2, 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. 1903.003. LOSS CONTROL SERVICES REQUIRED. (a) Before writing professional liability insurance for a hospital in this state, an insurer must maintain or provide loss control facilities that:

(1) provide loss control services reasonably commensurate with the risks, exposures, and experience of the insured's business;

(2) are adequate to provide loss control services required by the nature of the policyholder's operations; and

(3) include surveys, recommendations, training programs, consultations, and analyses of accident causes.

(b) To provide the facilities required by this section, the insurer may:

(1) employ qualified personnel;

(2) retain qualified independent contractors;

(3) contract with the policyholder to provide qualified loss control personnel and services; or

(4) use a combination of methods described by this subsection.

(c) Independent contractors and other personnel described by Subsection (b) must have the qualifications of a field safety representative. A field safety representative must be an individual who:

(1) holds a:

(A) bachelor's degree in science or engineering;

(B) bachelor of arts degree in nursing;

(C) bachelor of science degree in nursing, pharmacy, or physical therapy; or

(D) master's degree in hospital administration;

(2) is a licensed engineer;

(3) is a certified safety professional;

(4) is a certified industrial hygienist;

(5) has at least 10 years' experience in occupational safety and health; or

(6) has completed a course of training in loss control services approved by the department. (V.T.I.C. Art. 5.15-2, Secs. (a), (b).)

Source Law

Art. 5.15-2. (a) Any insurer desiring to write professional liability insurance for hospitals in Texas shall maintain or provide loss control facilities as a prerequisite for writing such insurance. Such facilities shall be adequate to furnish loss control services required by the nature of its policyholder's operations and shall include surveys, recommendations, training programs, consultations, and analyses of accident causes. Each field safety representative shall be either a college graduate who shall have a bachelor's degree in science or engineering, a bachelor of arts degree in nursing, a bachelor of science degree in nursing, pharmacy, or physical therapy, or a master's degree in hospital administration, or shall be a registered professional engineer, a certified safety professional, a certified industrial hygienist, an individual with 10 years' experience in occupational safety and health, or an individual who shall have completed a course of training in loss control services approved by the State Board of Insurance.

(b) The insurer shall render loss control services to its policyholders reasonably commensurate with the risks and exposures and experience of the insured's business. To provide such facilities, the insurer may employ qualified personnel, retain qualified independent contractors, contract with the policyholder to provide qualified loss control personnel and services, or use a combination of the methods enumerated in this subsection. Such personnel shall have the qualification required for field safety representatives as provided in Subsection (a) of this article.

Revisor's Note

Section (a), V.T.I.C. Article 5.15-2, refers to a "registered professional engineer." The revised law substitutes "engineer" for "professional engineer" because "engineer" is the term used by Chapter 1001, Occupations Code, which regulates engineers. The revised law also substitutes "licensed" for "registered" because that chapter requires that a person hold a license to engage in the practice of engineering.

Revised Law

Sec. 1903.004. SANCTIONS. (a) If there is evidence that reasonable loss control services are not being maintained or provided by an insurer as required by this subchapter or are not being used by the insurer in a reasonable manner to prevent injury to patients of the insurer's policyholders, the commissioner shall order a hearing to determine whether the insurer is not in compliance with this subchapter.

(b) If it is determined that the insurer is not in compliance, the commissioner may impose any sanction authorized by Chapter 82. (V.T.I.C. Art. 5.15-2, Sec. (c).)

Source Law

> (c) If the Commissioner of Insurance shall determine that reasonable loss control services are not being maintained or provided by the insurer or are not being used by the insurer in a reasonable manner to prevent injury to patients of its policyholders, the fact shall be reported to the State Board of Insurance, and the board shall order a hearing to determine if the insurer is not in compliance with this article. If it is determined that the insurer is not in compliance, the board may impose any sanctions authorized by Section 7, Article 1.10, of this code.

Revisor's Note

(1) Section (c), V.T.I.C. Article 5.15-2, refers to the "Commissioner of Insurance." The revised law substitutes "commissioner" for "Commissioner of Insurance" because Section 31.001 of this code defines "commissioner" to mean the commissioner of insurance for purposes of this code.

(2) Section (c), V.T.I.C. Article 5.15-2, requires the commissioner of insurance to report certain facts to the State Board of Insurance. The revised law omits the requirement as unnecessary because, as explained in Revisor's Note (2) to Section 1903.002, the State Board of Insurance was abolished and its functions were transferred to the commissioner and Texas Department of Insurance. In this context, the function of receiving the report has been

transferred to the commissioner, and it is unnecessary to require the commissioner to both make and receive the report.

Revised Law

Sec. 1903.005. RULES. The commissioner may adopt reasonable rules for the enforcement of this subchapter after holding a public hearing on the proposed rules. (V.T.I.C. Art. 5.15-2, Sec. (d).)

Source Law

(d) The State Board of Insurance may promulgate reasonable rules and regulations for the enforcement of this article after holding a public hearing on the proposed rules and regulations.

Revisor's Note

Section (d), V.T.I.C. Article 5.15-2, 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.

[Sections 1903.006-1903.050 reserved for expansion]

SUBCHAPTER B. LOSS CONTROL INFORMATION FOR GENERAL AND CERTAIN PROFESSIONAL LIABILITY INSURANCE

Revised Law

Sec. 1903.051. LOSS CONTROL INFORMATION REQUIRED. (a) Before writing professional liability insurance, including medical professional liability insurance, for insureds other than hospitals or general liability insurance in this state, an insurer must provide to the insurer's policyholders loss control information reasonably commensurate with the risks, exposures, and experience of the insured's business.

(b) To provide the information described by Subsection (a) or services, the insurer may:

(1) employ qualified personnel;

(2) retain qualified independent contractors;

(3) contract with the policyholder to provide qualified loss control personnel and services; or

(4) use a combination of methods described by this subsection. (V.T.I.C. Art. 5.15-3, Secs. (a), (b).)

Source Law

Art. 5.15-3. (a) Any insurer desiring to write professional liability insurance for insureds other than hospitals, general liability insurance, or medical professional liability insurance for insureds other than hospitals in this state must provide loss control information as a prerequisite for writing that insurance.

(b) The insurer shall provide loss control information to its policyholders reasonably commensurate with the risks and exposures and experience of the insured's business. To provide this information or services, the insurer may employ qualified personnel, retain qualified independent contractors, contract with the policyholder to provide qualified accident prevention personnel and services, or use a combination of the methods provided by this article.

Revisor's Note

Section (b), V.T.I.C. Article 5.15-3, refers to "qualified accident prevention personnel and services." Section (b), V.T.I.C. Article 5.15-2, revised in this chapter in Section 1903.003, refers to "qualified loss control personnel and services." The revised law substitutes "qualified loss control personnel and services" for "qualified accident prevention personnel and services" for consistency of terminology throughout this chapter and because "qualified loss control personnel and services" more accurately describes the type of personnel and services provided with respect to liability insurance.

Revised Law

Sec. 1903.052. SANCTIONS. (a) If there is evidence that reasonable loss control information is not being provided by an insurer as required by this subchapter or is not being used by the insurer in a reasonable manner to reduce losses, the commissioner shall order a hearing to determine whether the insurer is not in

compliance with this subchapter.

(b) If it is determined that the insurer is not in compliance, the commissioner may impose any sanction authorized by Chapter 82. (V.T.I.C. Art. 5.15-3, Sec. (c).)

Source Law

> (c) If there is evidence that reasonable loss control information is not being provided by the insurer or is not being used by the insurer in a reasonable manner to reduce losses, the State Board of Insurance shall order a hearing to determine if the insurer is not in compliance with this article. If it is determined that the insurer is not in compliance, the board may impose any of the sanctions authorized by Section 7, Article 1.10, of this code.

Revised Law

Sec. 1903.053. RULES. After opportunity for a hearing, the commissioner may adopt reasonable rules for the enforcement of this subchapter. (V.T.I.C. Art. 5.15-3, Sec. (d).)

Source Law

> (d) After opportunity for a hearing, the State Board of Insurance may promulgate reasonable rules and regulations for the enforcement of this article.

Revisor's Note

Section (d), V.T.I.C. Article 5.15-3, refers to "rules and regulations." The reference to "regulations" is omitted from the revised law for the reason stated in the revisor's note to Section 1903.005.

[Sections 1903.054-1903.100 reserved for expansion]

SUBCHAPTER C. CIVIL PROCEEDINGS

Revised Law

Sec. 1903.101. IMMUNITY FROM LIABILITY. (a) An insurer or an agent or employee of the insurer is not liable, and a cause of action does not arise against the insurer, agent, or employee, for an accident based on an allegation that the accident was caused or could have been prevented by a program, information, inspection, or other activity or service undertaken by the insurer to prevent accidents or to control losses, as applicable, in connection with the operations of the insured.

(b) The immunity from liability provided by this section does not affect the liability of an insurer as otherwise provided in an insurance policy. (V.T.I.C. Art. 5.15-2, Sec. (g); Art. 5.15-3, Sec. (e).)

Source Law

[Art. 5.15-2]

(g) An insurer, its agents, servants, or employees are not liable for and no cause of action arises with respect to any accident based on the allegation that the accident was caused or could have been prevented by a program, inspection, or other activity or service undertaken by the insurer for the prevention of accidents in connection with operations of its insured. However, this immunity does not affect the liability of an insurer as otherwise provided in a policy of insurance.

[Art. 5.15-3]

(e) An insurer, its agents, servants, or employees are not liable and no cause of action arises with respect to any accident based on the allegation that the accident was caused or could have been prevented by a program, information, inspection, or other activity or service undertaken by the insurer for the prevention of accidents or control of losses in connection with operations of its insured. However, this immunity does not affect the liability of an insurer otherwise provided by a policy of insurance.

Revisor's Note

Section (g), V.T.I.C. Article 5.15-2, and Section (e), V.T.I.C. Article 5.15-3, refer to an insurer's "agents, servants, or employees." The revised law omits "servants" because the term is included within the meaning of "agents . . . or employees."

Revised Law

Sec. 1903.102. LOSS CONTROL INFORMATION NOT DISCOVERABLE OR ADMISSIBLE. Loss control information provided by an insurer to an insured is not discoverable or admissible as evidence in a civil proceeding. (V.T.I.C. Art. 5.15-2, Sec. (h); Art. 5.15-3, Sec. (f).)

Source Law

[Art. 5.15-2]

(h) Loss control information provided by an insurer to an insured is not discoverable or admissible in any civil proceeding as evidence.

[Art. 5.15-3]

(f) Any loss control information provided by an

insurer to an insured is not subject to discovery or admissible in any civil proceeding as evidence.

[Chapters 1904-1950 reserved for expansion]

SUBTITLE C. AUTOMOBILE INSURANCE

CHAPTER 1951. GENERAL PROVISIONS: AUTOMOBILE INSURANCE

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Sec. 1951.003. FORMER MILITARY VEHICLES . . . . . 879

Sec. 1951.004. CRIMINAL PENALTY . . . . . 879

CHAPTER 1951. GENERAL PROVISIONS: AUTOMOBILE INSURANCE

Revised Law

Sec. 1951.001. RATES FOR AUTOMOBILE INSURANCE. Rates for personal and commercial automobile insurance in this state are determined as provided by Chapter 2251 and Article 5.13-2. (V.T.I.C. Art. 5.11, Sec. (c) (part).)

Source Law

(c) . . . On and after December 1, 2004, rates for personal automobile insurance and commercial automobile insurance in this state are determined as provided by Article 5.13-2 of this code.

Revisor's Note

Section (c), V.T.I.C. Article 5.11, provides that rates for commercial and personal automobile insurance are determined as provided by V.T.I.C. Article 5.13-2. The relevant provisions of that article that are revised are contained in Chapter 2251 of this code. Although that chapter contains other provisions that are derived from V.T.I.C. Article 5.13-2C, the revised law appropriately refers to the chapter in its entirety because the provisions that are derived from Article 5.13-2C do not apply by their own terms to automobile insurance.

Revised Law

Sec. 1951.002. RULES. The commissioner may adopt and enforce reasonable rules necessary to carry out the provisions of this subtitle. (V.T.I.C. Art. 5.10.)

Source Law

Art. 5.10. The Board is hereby empowered to make and enforce all such reasonable rules and regulations not inconsistent with the provisions of this subchapter as are necessary to carry out its provisions.

Revisor's Note

(1) V.T.I.C. Article 5.10 refers to the "Board," meaning 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. For that reason, the revised law substitutes a reference to the commissioner for the reference to the Board of Insurance Commissioners.

(2) V.T.I.C. Article 5.10 authorizes the Board of Insurance Commissioners, meaning the commissioner of insurance for the reasons stated in Revisor's Note (1) to this section, to adopt "rules and regulations not inconsistent with the provisions of this subchapter." The revised law omits as unnecessary the reference to "regulations" because a rule is defined under Section 311.005(5), Government Code (Code Construction Act), to include a regulation, and that definition applies to the revised law. In addition, the revised law omits the reference to "not inconsistent with the provisions of this subchapter" as unnecessary because the commissioner of insurance does not have authority to adopt rules that are inconsistent with a statute.

Revised Law

Sec. 1951.003. FORMER MILITARY VEHICLES. (a) In this section, "former military vehicle" has the meaning assigned by Section 504.502, Transportation Code.

(b) A rating plan that includes a classification applicable to antique, privately owned passenger vehicles that are maintained primarily for use in exhibitions, club activities, parades, or other functions of public interest and that may be used occasionally for other purposes must include in that classification former military vehicles maintained for those uses. (V.T.I.C. Art. 5.01-3.)

Source Law

> Art. 5.01-3. (a) A rating plan that includes a classification applicable to antique, private passenger vehicles maintained primarily for use in exhibitions, club activities, parades, and other functions of public interest and occasionally used for other purposes must include in the classification former military vehicles maintained for those uses.
>
> (b) In this article, "former military vehicle" has the meaning assigned by Section 502.275, Transportation Code.

Revisor's Note

> Section (b), V.T.I.C. Article 5.01-3, provides that "'former military vehicle' has the meaning assigned by Section 502.275, Transportation Code." Section 502.275, Transportation Code, was repealed by Chapter 1320, Acts of the 78th Legislature, Regular Session, 2003, which enacted Chapter 504, Transportation Code, relating to specialty license plates. "Former military vehicle" is now defined by Section 504.502, Transportation Code, and the revised law is drafted accordingly.

Revised Law

Sec. 1951.004. CRIMINAL PENALTY. (a) An insurer, or an officer or representative of an insurer, commits an offense if the insurer, officer, or representative violates:

(1) Section 1951.001, 1951.002, 1952.051, 1952.052,

1952.053, 1952.054, or 1952.055;

(2) Subchapter B, Chapter 1806;

(3) Chapter 254; or

(4) Article 5.01, 5.02, 5.03, 5.05, 5.06, 5.10, or 5.11.

(b) An offense under this section is a misdemeanor punishable by a fine of not less than $100 or more than $500. (V.T.I.C. Art. 5.12-1 (part).)

Source Law

> Art. 5.12-1. Any insurer or officer or representative thereof which shall violate any provision of this Act . . . shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than One Hundred ($100.00) Dollars nor more than Five Hundred ($500.00) Dollars for each such offense.

Revisor's Note

(1) V.T.I.C. Article 5.12-1 refers to certain sanctions imposed on an insurer or an officer or representative of an insurer for a violation of "this Act." Article 5.12-1 was transferred from Article 571a, Vernon's Annotated Penal Code, by authority of Section 5, Chapter 399, Acts of the 63rd Legislature, Regular Session, 1973, enacting the current Texas Penal Code. Former Article 571a was originally enacted as Section 12, Chapter 253, Acts of the 40th Legislature, Regular Session, 1927. Sections 1-11 of that chapter were originally published as Article 4682b, Vernon's Texas Civil Statutes. Article 4682b was codified as Subchapter A, V.T.I.C. Chapter 5, which consisted of V.T.I.C. Articles 5.01, 5.02, 5.03, 5.04, 5.05, 5.06, 5.07, 5.08, 5.09, 5.10, 5.11, and 5.12, by Chapter 491, Acts of the 52nd Legislature, Regular Session, 1951. The revised law omits the references to Article 5.04 and to the portion of Article 5.12 that is revised in Chapter 251 of this code, because those laws relate to powers and duties of

the commissioner of insurance and do not contain provisions that an insurer or an officer or representative of an insurer could violate.

(2) V.T.I.C. Article 5.12-1 in part provides that an insurer or an officer or representative of an insurer is subject to revocation of the insurer's, officer's, or representative's license by the Board of Insurance Commissioners for a violation of "this Act," meaning V.T.I.C. Articles 5.01, 5.02, 5.03, 5.04, 5.05, 5.06, 5.07, 5.08, 5.09, 5.10, 5.11, and 5.12, for the reason stated in Revisor's Note (1) to this section. For the reasons stated in Revisor's Note (1) to Section 1951.002, the commissioner of insurance now has the authority to revoke a license under Article 5.12-1 that was formerly granted to the board. The revised law omits the referenced provision of Article 5.12-1 as unnecessary. Section 82.051 of this code authorizes the commissioner to revoke a certificate of authority, which includes a license, after notice and an opportunity for hearing if the holder of the authorization violates this code. That revocation procedure applies to an insurer, officer, or representative that violates one of the listed provisions without an additional statement to that effect. The omitted law reads:

> Art. 5.12-1. [Any insurer or officer or representative thereof which shall violate any provision of this Act] shall be subject to a revocation of his or its license by the Board of Insurance Commissioners and in addition . . . .

CHAPTER 1952. POLICY PROVISIONS AND FORMS FOR AUTOMOBILE INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

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CHAPTER 1952. POLICY PROVISIONS AND FORMS FOR AUTOMOBILE INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1952.001. APPLICABILITY OF CHAPTER. Except as provided by Section 1952.201, this chapter applies to an insurer writing automobile insurance in this state, including an insurance company, corporation, reciprocal or interinsurance exchange, mutual insurance company, association, Lloyd's plan, or other insurer. (V.T.I.C. Art. 5.01, Sec. (a) (part).)

Source Law

> Art. 5.01. (a) Every insurance company, corporation, interinsurance exchange, mutual, reciprocal, association, Lloyd's or other insurer, hereinafter called insurer, writing any form of motor vehicle insurance in this State, . . . .

Revisor's Note

(1) Section (a), V.T.I.C. Article 5.01, in part states the general applicability of Subchapter A, V.T.I.C. Chapter 5. The provisions revised in this chapter are derived from that subchapter. V.T.I.C. Article 5.01C, revised in this chapter as Subchapter

E, is included in Subchapter A, Chapter 5. Section 1(1), Article 5.01C, revised in this chapter as Section 1952.201, states the applicability of Article 5.01C, which is different from the general applicability of Subchapter A, Chapter 5. For that reason, the revised law adds a cross-reference to Section 1952.201 for the convenience of the reader.

(2) Section (a), V.T.I.C. Article 5.01, refers to an "interinsurance exchange," a "mutual," a "reciprocal," and a "Lloyd's." For consistent use of terminology throughout this code, the revised law substitutes for the quoted language references to a "reciprocal or interinsurance exchange," a "mutual insurance company," and a "Lloyd's plan." Similar changes have been made throughout this chapter.

(3) Section (a), V.T.I.C. Article 5.01, refers to "motor vehicle insurance." Throughout this chapter, the revised law substitutes "automobile insurance" for "motor vehicle insurance" for consistency of terminology in this code. "Automobile insurance" is the term more commonly used to describe the kind of insurance that provides coverage for motor vehicles.

[Sections 1952.002-1952.050 reserved for expansion]

SUBCHAPTER B. POLICY FORMS AND PROVISIONS IN GENERAL

Revised Law

Sec. 1952.051. POLICY FORMS FOR AUTOMOBILE INSURANCE. Notwithstanding Subsections (1)-(4) and (7), Article 5.06, policy forms and endorsements for automobile insurance in this state are regulated under Chapter 2301 and Article 5.13-2. (V.T.I.C. Art. 5.06, Sec. (12)(a).)

Source Law

(12)(a) Notwithstanding Subsections (1)-(10) of this article, policy forms and endorsements for automobile insurance in this state are regulated under

Article 5.13-2 of this code.

Revisor's Note

Section (12)(a), V.T.I.C. Article 5.06, provides that "[n]otwithstanding Subsections (1)-(10) of this article," policy forms and endorsements for automobile insurance in this state are regulated under V.T.I.C. Article 5.13-2. The relevant provisions of Article 5.13-2 that are revised are contained in Chapter 2301. That chapter also contains provisions that are derived from V.T.I.C. Article 5.145. The revised law appropriately refers to Chapter 2301 in its entirety because the provisions of that chapter that are derived from Article 5.145 are necessary to construe the provisions of Article 5.13-2 that are revised in that chapter.

In addition, the revised law substitutes a reference to "Subsections (1)-(4) and (7), Article 5.06," for the reference to Subsections (1)-(10) of that article because Subsections (5) and (6), revised in this chapter as Section 1952.055, Subsection (8), revised in this chapter as Section 1952.053, and Subsections (9) and (10), revised in this chapter as Section 1952.054, apply on their own terms and do not conflict with Article 5.13-2.

Revised Law

Sec. 1952.052. USE OF PREVIOUSLY APPROVED OR ADOPTED POLICY FORMS AUTHORIZED. An insurer may continue to use a policy form or endorsement approved or adopted by the commissioner under Article 5.06 before June 11, 2003, on notification in writing to the commissioner that the insurer will continue to use the policy form or endorsement. (V.T.I.C. Art. 5.06, Sec. (12)(b).)

Source Law

(b) An insurer may continue to use the policy forms and endorsements promulgated, approved, or adopted by the commissioner under this article before the effective date of S.B. No. 14, Acts of the

78th Legislature, Regular Session, 2003, on notification in writing to the commissioner that the insurer will continue to use the policy forms and endorsements promulgated, approved, or adopted by the commissioner under this article.

Revisor's Note

(1) Section (12)(b), V.T.I.C. Article 5.06, refers to forms and endorsements "promulgated, approved, or adopted" by the commissioner of insurance under V.T.I.C. Article 5.06, revised in this subchapter. The revised law omits "promulgated" as unnecessary. Article 5.06 authorizes the commissioner to adopt or approve forms and endorsements, but does not authorize the commissioner to promulgate forms or endorsements.

(2) Section (12)(b), V.T.I.C. Article 5.06, refers to "the effective date of S.B. No. 14, [Chapter 206,] Acts of the 78th Legislature, Regular Session, 2003." That act had various effective dates. The revised law substitutes a reference to "June 11, 2003," for the quoted language because the general effective date of Chapter 206 was June 11, 2003. Furthermore, Article 5.06 was amended by Article 21 of Chapter 206, and the effective date of that article was also June 11, 2003.

Revised Law

Sec. 1952.053. WITHDRAWAL OF APPROVAL. The commissioner may, after notice and hearing, withdraw the commissioner's approval of a policy or endorsement form that was approved by the commissioner under Article 5.06. (V.T.I.C. Art. 5.06, Sec. (8).)

Source Law

(8) The Board may withdraw its approval of a policy or endorsement form at any time, after notice and hearing.

Revisor's Note

(1) Section (8), V.T.I.C. Article 5.06, refers to the "Board," meaning 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. Throughout this chapter, references to the "Board" have been changed appropriately.

(2) Section (8), V.T.I.C. Article 5.06, provides that the "Board," meaning the commissioner of insurance for the reason stated in Revisor's Note (1) to this section, may withdraw the board's approval of a policy or endorsement form "at any time, after notice and hearing." The revised law omits "at any time" as unnecessary and misleading. A grant of power to the commissioner, absent any language limiting the exercise of the power, implies that the commissioner may exercise the power at appropriate times. "At any time" is misleading because it contradicts the source law's requirement of notice and hearing, which acts as a restriction on the time at which the commissioner can act.

Revised Law

Sec. 1952.054. REQUIRED DISCLOSURES REGARDING SHORT-TERM POLICIES. (a) An insurance policy or other document evidencing proof of purchase of a personal automobile insurance policy written for a term of less than 30 days may not be used to obtain an original or renewal driver's license, an automobile registration or license plates, or a motor vehicle inspection certificate. An insurance policy or other document described by this subsection must contain the following statement:

TEXAS LAW PROHIBITS USE OF THIS DOCUMENT TO OBTAIN A MOTOR VEHICLE INSPECTION CERTIFICATE, AN ORIGINAL OR RENEWAL DRIVER'S LICENSE, OR AN AUTOMOBILE REGISTRATION OR LICENSE PLATES.

(b) Before accepting any premium or fee for a personal automobile insurance policy or binder for a term of less than 30 days, an agent or insurer must make the following written disclosure to the applicant or insured:

TEXAS LAW PROHIBITS USE OF THIS POLICY OR BINDER TO OBTAIN A MOTOR VEHICLE INSPECTION CERTIFICATE, AN ORIGINAL OR RENEWAL DRIVER'S LICENSE, OR AN AUTOMOBILE REGISTRATION OR LICENSE PLATES.

(V.T.I.C. Art. 5.06, Secs. (9) (part), (10) (part).)

Source Law

(9) An insurance policy or other document evidencing proof of purchase of a personal automobile insurance policy written for a term of less than 30 days . . . may not be used to obtain an original or renewal driver's license, an automobile registration or license plates, or a motor vehicle inspection certificate and must contain a statement as follows:
"TEXAS LAW PROHIBITS USE OF THIS DOCUMENT TO OBTAIN A MOTOR VEHICLE INSPECTION CERTIFICATE, AN ORIGINAL OR RENEWAL DRIVER'S LICENSE, OR AN AUTOMOBILE REGISTRATION OR LICENSE PLATES."

(10) Before accepting any premium or fee for a personal automobile insurance policy or binder for a term of less than 30 days . . . an agent or insurer must make the following written disclosure to the applicant or insured:
"TEXAS LAW PROHIBITS USE OF THIS POLICY OR BINDER TO OBTAIN A MOTOR VEHICLE INSPECTION CERTIFICATE, AN ORIGINAL OR RENEWAL DRIVER'S LICENSE, OR AN AUTOMOBILE REGISTRATION OR LICENSE PLATES."

Revisor's Note

Section (11), V.T.I.C. Article 5.06, defines "time-based rating plan" and "mile-based rating plan" to have the meanings assigned by V.T.I.C. Article 5.01-4. Sections (9) and (10), Article 5.06, refer to policy premiums computed on a time-based rating plan and a mile-based rating plan. The revised law omits Section (11) and the provisions of Sections (9) and (10) relating to both types of rating plans because the

plans no longer exist. V.T.I.C. Article 5.01-4, which created time-based rating plans and mile-based rating plans and authorized the use of those rating plans, expired on September 1, 2005. The omitted law reads:

> (9) [An insurance policy or other document evidencing proof of purchase of a personal automobile insurance policy written for a term of less than 30 days] if the policy premium is computed using a time-based rating plan, or written for less than 1,000 miles if the policy premium is computed using a mile-based rating plan, . . . .
>
> (10) [Before accepting any premium or fee for a personal automobile insurance policy or binder for a term of less than 30 days] if the policy premium is computed using a time-based rating plan, or written for less than 1,000 miles if the policy premium is computed using a mile-based rating plan, . . . .
>
> (11) In this article, the terms "time-based rating plan" and "mile-based rating plan" have the meanings assigned by Article 5.01-4 of this code.

<u>Revised Law</u>

Sec. 1952.055. CERTIFICATE OF INSURANCE AS SUBSTITUTE FOR INSURANCE POLICY. (a) An insurer that complies with applicable requirements may issue and deliver a certificate of insurance as a substitute for issuing and delivering an insurance policy adopted or approved by the commissioner. The certificate must:

(1) be in the form prescribed by the commissioner; and

(2) refer to and identify the policy form for which the certificate is substituted.

(b) A certificate under this section represents the insurance policy and, when issued, is evidence that the certificate holder is insured under the identified policy form. The certificate is subject to the same limitations, conditions, coverages, selection of options, and other provisions provided in the policy, and the certificate must show and adequately reference that policy information. The certificate or subsequent attachments to the certificate must refer to all endorsements to the policy.

(c) A certificate under this section must be executed in the same manner as though an insurance policy were issued. If an

insurer substitutes a certificate for a policy, the insurer shall simultaneously provide the insured receiving the certificate with an outline of coverages in the form and content approved by the commissioner. At the insured's request, the insurer shall provide the insured with a copy of the policy.

(d) The commissioner may adopt rules necessary to implement this section, including a rule limiting the application of this section to private passenger automobile insurance policies. (V.T.I.C. Art. 5.06, Secs. (5), (6).)

Source Law

> (5) An insurer, if in compliance with applicable requirements and conditions, may issue and deliver a certificate of insurance as a substitute for the entire policy of insurance. The certificate of insurance shall make reference to and identify the policy form adopted or approved by the Board for which the substitution of certificate is made. The certificate shall be in such form as is prescribed by the Board. The certificate will represent the policy of insurance, and when issued, shall be evidence that the certificate holder is insured under the identified policy form. The certificate is subject to the same limitations, conditions, coverages, selection of options, and other provisions of the policy as are provided in the policy, and that insurance policy information is to be shown on and adequately referenced by the certificate of insurance issued by the insurer to the insured. Reference shall be made in the certificate, or in subsequent attachments, to all endorsements to the policy of insurance. The certificate shall be executed in the same manner as though a policy were issued. When the certificate is substituted for the policy of insurance by an insurer, the insurer shall simultaneously furnish to the insured receiving the certificate an "outline of coverages", the form and content of which has been approved by the Board. At the request of an insured at any time, an insurer which has substituted a certificate for a policy of insurance shall provide a copy of the policy.
>
> (6) The Board may promulgate such rules as are necessary to implement the certificate in lieu of policy provision herein, including a rule limiting the application thereof to private passenger automobile policies.

Revisor's Note

(1) Section (5), V.T.I.C. Article 5.06, refers to "requirements and conditions" applicable to an insurer. The revised law omits "conditions" because, in this context, "conditions" is included within the meaning of "requirements."

(2) Section (5), V.T.I.C. Article 5.06, requires an insurer that has substituted a certificate of insurance for an insurance policy to provide the insured with a copy of the policy "[a]t the request of [the] insured at any time." The revised law omits "at any time" as unnecessary. The grant of a right to an insured, absent any language limiting the exercise of the right, implies that the insured may exercise the right at any time.

Revised Law

Sec. 1952.056. REQUIRED PROVISION: COVERAGE FOR CERTAIN SPOUSES. A personal automobile insurance policy or any similar policy form adopted or approved by the commissioner under Article 5.06 or filed under Subchapter B, Chapter 2301, that covers liability arising out of ownership, maintenance, or use of a motor vehicle of a spouse who is otherwise insured by the policy must contain a provision to continue coverage for the spouse during a period of separation in contemplation of divorce. (V.T.I.C. Art. 5.06-6.)

Source Law

Art. 5.06-6. A personal automobile policy or any similar policy form adopted or approved by the commissioner under Article 5.06 of this code or filed under Article 5.145 of this code that covers liability arising out of ownership, maintenance, or use of a motor vehicle of a spouse, who is otherwise insured by the policy, shall contain a provision to continue coverage for the spouse during a period of separation in contemplation of divorce.

Revisor's Note

V.T.I.C. Article 5.06-6 refers to a policy form filed under V.T.I.C. Article 5.145. The relevant provisions of that article are revised as Subchapter B, Chapter 2301, of this code. The revised law is drafted accordingly.

Revised Law

Sec. 1952.057. PROHIBITED PROVISION: PAYMENT ON CONVICTION FOR DRUG OFFENSE. (a) An insurer may not deliver or issue for

delivery in this state an automobile insurance policy that provides payment on final conviction of the named insured for loss for a covered motor vehicle seized by federal or state law enforcement officers as evidence in a case against the named insured under Chapter 481, Health and Safety Code, or under the federal Controlled Substances Act (21 U.S.C. Section 801 et seq.).

(b) For purposes of this section, a named insured for:

(1) an individual automobile insurance policy is the person named on the declaration page of the policy and the person's spouse; and

(2) an automobile insurance policy other than an individual policy is the company or corporation named on the declaration page of the policy and any officer, director, or shareholder of that company or corporation. (V.T.I.C. Art. 5.06-5.)

Source Law

> Art. 5.06-5. (a) A motor vehicle insurance policy delivered or issued for delivery in this state may not provide payment on final conviction of the named insured for loss for a covered motor vehicle that is seized by federal or state law enforcement officers as evidence in a case against the named insured under Chapter 481, Health and Safety Code or the federal Controlled Substances Act, 21 U.S.C. Section 801 et seq. For the purpose of this section a named insured shall be the person named on the declaration page of an automobile insurance policy and his or her spouse if the policy is written on an individual. If a policy is other than an individual policy, a named insured shall be the company or corporation named on the declaration page of an automobile insurance policy and any officer, director, or stockholder of that company or corporation.
>
> (b) An insurer may not deliver or issue for delivery in this state a motor vehicle insurance policy that provides payment on final conviction of the named insured for loss for a covered motor vehicle that is seized by federal or state law enforcement officers as evidence in a case against the named insured under Chapter 481, Health and Safety Code or the federal Controlled Substances Act, 21 U.S.C. Section 801 et seq.

Revised Law

Sec. 1952.058. LOSS CONTROL INFORMATION AND SERVICES REQUIRED. (a) An insurer must provide loss control information as a prerequisite to writing commercial automobile liability

insurance in this state.

(b) The insurer shall provide to the insurer's policyholders loss control information reasonably commensurate with the risks, exposures, and experience of the insured's business. To provide loss control information or services, the insurer may:

(1) employ qualified personnel;

(2) retain qualified independent contractors;

(3) contract with the policyholder to provide qualified loss control personnel and services; or

(4) use a combination of methods described by this subsection.

(c) If there is evidence that an insurer is not providing reasonable loss control information or is not using that information in a reasonable manner to reduce losses, the commissioner shall order a hearing to determine whether the insurer is in compliance with this section. If the commissioner determines that the insurer is not in compliance, the commissioner may impose any sanction authorized by Chapter 82.

(d) An insurer or an agent or employee of the insurer is not liable, and a cause of action does not arise against the insurer, agent, or employee, for any accident based on the allegation that the accident was caused or could have been prevented by a program, information, inspection, or other activity or service undertaken by the insurer for the prevention of accidents in connection with operations of the insured. The immunity provided by this subsection does not affect the liability of an insurer for compensation or as otherwise provided in an insurance policy.

(e) Loss control information an insurer provides to an insured under this section is not subject to discovery and is not admissible as evidence in any civil proceeding.

(f) The commissioner, after holding a public hearing on the proposed rules, may adopt reasonable rules for the enforcement of this section. (V.T.I.C. Art. 5.06-4.)

Source Law

Art. 5.06-4. (a) Any insurer desiring to write commercial automobile liability insurance in this state must provide loss control information as a prerequisite for writing that insurance.

(b) The insurer shall provide loss control information to its policyholders reasonably commensurate with the risks and exposures and experience of the insured's business. To provide this information or services, the insurer may employ qualified personnel, retain qualified independent contractors, contract with the policyholder to provide qualified accident prevention personnel and services, or use a combination of the methods provided by this section.

(c) If there is evidence that reasonable loss control information is not being provided by the insurer or is not being used by the insurer in a reasonable manner to reduce losses, the State Board of Insurance shall order a hearing to determine if the insurer is not in compliance with this article. If it is determined that the insurer is not in compliance, the board may impose any of the sanctions authorized by Section 7, Article 1.10, of this code.

(d) The State Board of Insurance may promulgate reasonable rules and regulations for the enforcement of this article after holding a public hearing on the proposed rules and regulations.

(e) An insurer or its agents, servants, or employees are not liable for, and no cause of action arises with respect to, any accident based on the allegation that the accident was caused or could have been prevented by a program, information, inspection, or other activity or service undertaken by the insurer for the prevention of accidents in connection with operations of its insured. However, this immunity does not affect the liability of an insurer for compensation or as otherwise provided in a policy of insurance.

(f) Loss control information provided by an insurer to an insured pursuant to this article is not subject to discovery or admissible in any civil proceeding as evidence.

Revisor's Note

(1) Section (b), V.T.I.C. Article 5.06-4, refers to "qualified accident prevention personnel and services." The revised law substitutes "qualified loss control personnel and services" for "qualified accident prevention personnel and services" because "qualified loss control personnel and services" more accurately describes the type of personnel and services provided with respect to automobile insurance.

(2) Section (d), V.T.I.C. Article 5.06-4,

authorizes the State Board of Insurance to adopt certain "rules and regulations" after holding a public hearing on the proposed "rules and regulations." For the reason stated in Revisor's Note (1) to Section 1952.053, the commissioner of insurance has the authority formerly granted to the board. The revised law omits as unnecessary the references to "regulations" because a rule is defined under Section 311.005(5), Government Code (Code Construction Act), to include a regulation, and that definition applies to the revised law.

[Sections 1952.059-1952.100 reserved for expansion]

SUBCHAPTER C. UNINSURED OR UNDERINSURED MOTORIST COVERAGE

Revised Law

Sec. 1952.101. UNINSURED OR UNDERINSURED MOTORIST COVERAGE REQUIRED. (a) In this section, "uninsured or underinsured motorist coverage" means the provisions of an automobile liability insurance policy that provide for coverage in at least the limits prescribed by Chapter 601, Transportation Code, that protects insureds who are legally entitled to recover from owners or operators of uninsured or underinsured motor vehicles damages for bodily injury, sickness, disease, or death, or property damage resulting from the ownership, maintenance, or use of any motor vehicle.

(b) An insurer may not deliver or issue for delivery in this state an automobile liability insurance policy, including a policy provided through the Texas Automobile Insurance Plan Association under Chapter 2151, that covers liability arising out of the ownership, maintenance, or use of any motor vehicle unless the insurer provides uninsured or underinsured motorist coverage in the policy or supplemental to the policy.

(c) The coverage required by this subchapter does not apply if any insured named in the insurance policy rejects the coverage in writing. Unless the named insured requests in writing the coverage

required by this subchapter, the insurer is not required to provide that coverage in or supplemental to a renewal insurance policy if the named insured rejected the coverage in connection with an insurance policy previously issued to the insured by the same insurer or by an affiliated insurer. (V.T.I.C. Art. 5.06-1, Sec. (1).)

Source Law

> Art. 5.06-1. (1) No automobile liability insurance (including insurance issued pursuant to an Assigned Risk Plan established under authority of Section 35 of the Texas Motor Vehicle Safety-Responsibility Act), covering liability arising out of the ownership, maintenance, or use of any motor vehicle shall be delivered or issued for delivery in this state unless coverage is provided therein or supplemental thereto, in at least the limits described in the Texas Motor Vehicle Safety-Responsibility Act, under provisions prescribed by the Board, for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured or underinsured motor vehicles because of bodily injury, sickness, or disease, including death, or property damage resulting therefrom. The coverages required under this Article shall not be applicable where any insured named in the policy shall reject the coverage in writing; provided that unless the named insured thereafter requests such coverage in writing, such coverage need not be provided in or supplemental to a renewal policy where the named insured has rejected the coverage in connection with a policy previously issued to him by the same insurer or by an affiliated insurer.

Revisor's Note

(1) Section (1), V.T.I.C. Article 5.06-1, refers to "the Texas Motor Vehicle Safety-Responsibility Act" and to an "Assigned Risk Plan established under authority of Section 35 of the Texas Motor Vehicle Safety-Responsibility Act." That act, formerly Article 6701h, Vernon's Texas Civil Statutes, was codified in 1995 as Chapter 601, Transportation Code. Section 35, Article 6701h, provided for insurers to establish an "administrative agency" to administer an assigned risk plan to provide motor vehicle liability insurance to persons "unable to secure it through ordinary methods." Section 35 was

repealed by Section 14.08, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993. Section 14.03 of that act added V.T.I.C. Article 21.81, which created the Texas Automobile Insurance Plan Association. The association's primary duty is to provide eligible persons with insurance required under the Texas Motor Vehicle Safety-Responsibility Act. Section 14.09(b) of that act required the administrative agency created under Section 35, Article 6701h, to transfer its assets and obligations to the Texas Automobile Insurance Plan Association. Throughout this chapter, the revised law is drafted accordingly.

(2) Section (1), V.T.I.C. Article 5.06-1, prohibits an insurer from delivering or issuing for delivery an automobile insurance policy unless the insurer provides coverage "under provisions prescribed by the Board," meaning the commissioner of insurance for the reasons stated in Revisor's Note (1) to Section 1952.053. The revised law omits the quoted phrase as unnecessary and misleading for the reasons that follow. Before June 11, 2003, the commissioner adopted and approved policy forms for automobile insurance under V.T.I.C. Article 5.06. In 2003, the legislature enacted Chapter 206, Acts of the 78th Legislature, Regular Session, which provides that policy forms for various kinds of insurance, including automobile insurance, are now governed by V.T.I.C. Article 5.13-2. However, under Section 2(b), V.T.I.C. Article 5.145, an insurer is authorized to continue using policy forms previously approved or adopted under Article 5.06. Therefore, under the current regulatory system for policy forms for automobile insurance, an insurer is authorized to use policy

forms that are subject to Article 5.13-2 or to Article 5.06. Those articles by their terms prescribe the requirements for the policy forms that are subject to them, and those requirements apply to the provisions for uninsured or underinsured motorist coverage under Article 5.06-1 contained in the forms without a statement to that effect.

Revised Law

Sec. 1952.102. UNINSURED MOTOR VEHICLE. (a) For purposes of the coverage required by this subchapter, "uninsured motor vehicle," subject to the terms of the coverage, is considered to include an insured motor vehicle as to which the insurer providing liability insurance is unable because of insolvency to make payment with respect to the legal liability of the insured within the limits specified in the insurance.

(b) The commissioner may, in the policy forms filed under Subchapter B, Chapter 2301, allow "uninsured motor vehicle" to be defined or, in policy forms adopted under Article 5.06, define "uninsured motor vehicle," to exclude certain motor vehicles whose operators are in fact uninsured. (V.T.I.C. Art. 5.06-1, Secs. (2)(a), (c).)

Source Law

(2) For the purpose of these coverages: (a) the term "uninsured motor vehicle" shall, subject to the terms and conditions of such coverage, be deemed to include an insured motor vehicle where the liability insurer thereof is unable to make payment with respect to the legal liability of its insured within the limits specified therein because of insolvency.

(c) The commissioner may, in the policy forms adopted under Article 5.06 of this code, define "uninsured motor vehicle" to exclude certain motor vehicles whose operators are in fact uninsured. The commissioner may in the policy forms filed under Article 5.145 of this code allow the term "uninsured motor vehicle" to be defined to exclude certain motor vehicles whose operators are in fact uninsured.

Revisor's Note

Section (2)(a), V.T.I.C. Article 5.06-1, refers to "terms and conditions" of uninsured motor vehicle

coverage. Throughout this chapter, the revised law omits "conditions" as unnecessary because "conditions" is included within the meaning of "terms."

Revised Law

Sec. 1952.103. UNDERINSURED MOTOR VEHICLE. For purposes of the coverage required by this subchapter, "underinsured motor vehicle" means an insured motor vehicle on which there is collectible liability insurance coverage with limits of liability for the owner or operator that were originally lower than, or have been reduced by payment of claims arising from the same accident to, an amount less than the limit of liability stated in the underinsured coverage of the insured's policy. (V.T.I.C. Art. 5.06-1, Sec. (2)(b).)

Source Law

(2) For the purpose of these coverages:

(b) The term "underinsured motor vehicle" means an insured motor vehicle on which there is valid and collectible liability insurance coverage with limits of liability for the owner or operator which were originally lower than, or have been reduced by payment of claims arising from the same accident to, an amount less than the limit of liability stated in the underinsured coverage of the insured's policy.

Revisor's Note

Section (2)(b), V.T.I.C. Article 5.06-1, refers to "valid and collectible" liability insurance coverage. The revised law omits the reference to "valid" as unnecessary because a policy that is not valid is not collectible.

Revised Law

Sec. 1952.104. REQUIRED PROVISIONS RELATING TO UNINSURED OR UNDERINSURED MOTORIST COVERAGE. The portion of a policy form adopted under Article 5.06 or filed as provided by Subchapter B, Chapter 2301, to provide coverage under this subchapter must:

(1) provide that, regardless of the number of persons insured, policies or bonds applicable, vehicles involved, or claims

made, the total aggregate limit of liability to any one person who sustains bodily injury or property damage as the result of a single occurrence may not exceed the limit of liability for those coverages as stated in the insurance policy and that the total aggregate limit of liability to all claimants, if more than one, may not exceed the total limit of liability per occurrence as stated in the policy;

(2) provide for the exclusion of the recovery of damages for bodily injury or property damage, or both, resulting from the intentional acts of the insured; and

(3) require that, for the insured to recover under the uninsured motorist coverage if the owner or operator of any motor vehicle that causes bodily injury or property damage to the insured is unknown, actual physical contact must have occurred between the motor vehicle owned or operated by the unknown person and the person or property of the insured. (V.T.I.C. Art. 5.06-1, Sec. (2)(d).)

Source Law

> (d) The portion of a policy form adopted under Article 5.06 of this code or filed under Article 5.145 of this code to provide coverage under this article shall include provisions that, regardless of the number of persons insured, policies or bonds applicable, vehicles involved, or claims made, the total aggregate limit of liability to any one person who sustains bodily injury or property damage as the result of any one occurrence shall not exceed the limit of liability for these coverages as stated in the policy and the total aggregate limit of liability to all claimants, if more than one, shall not exceed the total limit of liability per occurrence as stated in the policy; and shall provide for the exclusion of the recovery of damages for bodily injury or property damage or both resulting from the intentional acts of the insured. The portion of a policy form adopted under Article 5.06 of this code or filed under Article 5.145 of this code to provide coverage under this article shall require that in order for the insured to recover under the uninsured motorist coverages where the owner or operator of any motor vehicle which causes bodily injury or property damage to the insured is unknown, actual physical contact must have occurred between the motor vehicle owned or operated by such unknown person and the person or property of the insured.

Revised Law

Sec. 1952.105. LIABILITY LIMITS. (a) The limits of liability for bodily injury, sickness, disease, or death must be

offered to an insured in the amounts desired by the insured, but not in amounts greater than the limits of liability specified in the bodily injury liability provisions of the insured's policy.

(b) Subject to a deductible amount of $250, coverage for property damage must be offered to an insured in the amounts desired by the insured, but not in amounts greater than the limits of liability specified in the property damage liability provisions of the insured's policy.

(c) Notwithstanding Subsections (a) and (b), amounts of liability limits for bodily injury, sickness, disease, or death and amounts for coverage for property damage may not be offered in amounts less than those prescribed by Chapter 601, Transportation Code. (V.T.I.C. Art. 5.06-1, Secs. (3), (4)(a).)

Source Law

> (3) The limits of liability for bodily injury, sickness, or disease, including death, shall be offered to the insured in amounts not less than those prescribed in the Texas Motor Vehicle Safety-Responsibility Act and such higher available limits as may be desired by the insured, but not greater than the limits of liability specified in the bodily injury liability provisions of the insured's policy.
>
> (4)(a) Coverage for property damage shall be offered to the insured in amounts not less than those prescribed in the Texas Motor Vehicle Safety-Responsibility Act and such higher available limits as may be desired by the insured, but not greater than limits of liability specified in the property damage liability provisions of the insured's policy, subject to a deductible amount of $250.

Revised Law

Sec. 1952.106. RECOVERY UNDER UNDERINSURED MOTORIST COVERAGE. Underinsured motorist coverage must provide for payment to the insured of all amounts that the insured is legally entitled to recover as damages from owners or operators of underinsured motor vehicles because of bodily injury or property damage, not to exceed the limit specified in the insurance policy, and reduced by the amount recovered or recoverable from the insurer of the underinsured motor vehicle. (V.T.I.C. Art. 5.06-1, Sec. (5).)

Source Law

> (5) The underinsured motorist coverage shall

provide for payment to the insured of all sums which he shall be legally entitled to recover as damages from owners or operators of underinsured motor vehicles because of bodily injury or property damage in an amount up to the limit specified in the policy, reduced by the amount recovered or recoverable from the insurer of the underinsured motor vehicle.

Revised Law

Sec. 1952.107. RECOVERY UNDER COLLISION OR COMBINED COVERAGE. (a) An insured who has collision coverage and uninsured or underinsured property damage liability coverage may recover under the coverage the insured chooses.

(b) If neither the collision coverage or the uninsured or underinsured property damage liability coverage is sufficient alone to cover all damage resulting from a single occurrence, the insured may recover under both coverages. If recovering under both coverages, the insured shall designate one coverage as the primary coverage and pay the deductible applicable to that coverage. The primary coverage must be exhausted before any recovery is made under the secondary coverage.

(c) If both the primary and secondary coverages are used to pay damages from a single occurrence, the insured may not be required to pay the deductible applicable to the secondary coverage when the amount of the deductible otherwise applicable to the secondary coverage is the same as or less than the amount of the deductible applicable to the primary coverage. If both coverages are used to pay damages from a single occurrence and the amount of the deductible otherwise applicable to the secondary coverage is greater than the amount of the deductible applicable to the primary coverage, the insured shall pay the difference between the amount of the two deductibles with respect to the secondary coverage.

(d) The insured may not recover under both the primary and secondary coverages more than the actual damages suffered. (V.T.I.C. Art. 5.06-1, Sec. (4)(b).)

Source Law

(b) If the insured has collision coverage and uninsured or underinsured property damage liability coverage, the insured may recover under the policy coverage chosen by the insured. In the event

neither coverage is sufficient alone to cover all damage resulting from a single occurrence, the insured may recover under both coverages. When recovering under both coverages, the insured shall designate one coverage as the primary coverage and pay the deductible applicable to that coverage. The primary coverage must be exhausted before any recovery is made under the secondary coverage. If both coverages are utilized in the payment of damages from a single occurrence, the insured shall not be required to pay the deductible applicable to the secondary coverage when the amount of the deductible otherwise applicable to the secondary coverage is the same as or less than the amount of the deductible applicable to the primary coverage. If both coverages are utilized in the payment of damages from a single occurrence and the amount of the deductible otherwise applicable to the secondary coverage is greater than the amount of the deductible applicable to the primary coverage, the insured shall be required to pay in respect of the secondary coverage only the difference between the amount of the two deductibles. In no event shall the insured recover under both coverages more than the actual damages suffered.

Revised Law

Sec. 1952.108. INSURER'S RIGHT OF RECOVERY. (a) An insurer that makes a payment to any person under any coverage required by this subchapter is subject to the terms of that coverage and, to the extent of the payment, is entitled to the proceeds of any settlement or judgment resulting from the exercise of any right of recovery of the person to whom the payment is made against any person or organization legally responsible for the bodily injury, sickness, disease, or death for which the payment is made, including the proceeds recoverable from the assets of an insolvent insurer.

(b) If, under an insurance policy issued under this subchapter, an insurer makes a payment as a result of the insolvency of another insurer:

(1) the insolvent insurer's insured shall be given credit to the extent of the paying insurer's payment in any judgment obtained against the insured with respect to the insured's legal liability for damages described by Subsection (a); and

(2) subject to Subchapter F, Chapter 462, the paying insurer has the right to proceed directly against the insolvent insurer or that insurer's receiver, and in pursuing that right the paying insurer has any rights that the insolvent insurer's insured might otherwise have had if the insured had made the payment.

(V.T.I.C. Art. 5.06-1, Sec. (6).)

Source Law

(6) In the event of payment to any person under any coverage required by this Section and subject to the terms and conditions of such coverage, the insurer making such payment shall, to the extent thereof, be entitled to the proceeds of any settlement or judgment resulting from the exercise of any rights of recovery of such person against any person or organization legally responsible for the bodily injury, sickness or disease, or death for which such payment is made, including the proceeds recoverable from the assets of the insolvent insurer; provided, however, whenever an insurer shall make payment under a policy of insurance issued pursuant to this Act, which payment is occasioned by the insolvency of an insurer, the insured of said insolvent insurer shall be given credit in any judgment obtained against him, with respect to his legal liability for such damages, to the extent of such payment, but, subject to Section 12 of Article 21.28-C of this code, such paying insurer shall have the right to proceed directly against the insolvent insurer or its receiver, and in pursuance of such right such paying insurer shall possess any rights which the insured of the insolvent company might otherwise have had if the insured of the insolvent insurer had made the payment.

Revised Law

Sec. 1952.109. BURDEN OF PROOF IN DISPUTE. The insurer has the burden of proof in a dispute as to whether a motor vehicle is uninsured. (V.T.I.C. Art. 5.06-1, Sec. (7).)

Source Law

(7) If a dispute exists as to whether a motor vehicle is uninsured, the burden of proof as to that issue shall be upon the insurer.

Revised Law

Sec. 1952.110. VENUE. Notwithstanding Section 15.032, Civil Practice and Remedies Code, an action against an insurer in relation to the coverage provided under this subchapter, including an action to enforce that coverage, may be brought only in the county in which:

(1) the policyholder or beneficiary instituting the action resided at the time of the accident involving the uninsured or underinsured motor vehicle; or

(2) the accident occurred. (V.T.I.C. Art. 5.06-1, Sec. (8).)

Source Law

(8) Notwithstanding Section 15.032, Civil Practice and Remedies Code, an action against an insurer in relation to the coverage provided under this article, including an action to enforce that coverage, may be brought only:

(a) in the county in which the policyholder or beneficiary instituting the suit resided at the time of the accident; or

(b) in the county in which the accident involving the uninsured or underinsured motor vehicle occurred.

[Sections 1952.111-1952.150 reserved for expansion]

SUBCHAPTER D. PERSONAL INJURY PROTECTION COVERAGE

Revised Law

Sec. 1952.151. PERSONAL INJURY PROTECTION. "Personal injury protection" consists of provisions of an automobile liability insurance policy that provide for payment to the named insured in the policy, members of the insured's household, and any authorized operator or passenger of the named insured's motor vehicle, including a guest occupant, of all reasonable expenses that:

(1) arise from an accident;

(2) are incurred not later than the third anniversary of the date of the accident; and

(3) are for:

(A) necessary medical, surgical, x-ray, or dental services, including prosthetic devices, and necessary ambulance, hospital, professional nursing, or funeral services;

(B) in the case of an income producer, replacement of income lost as the result of the accident; or

(C) in the case of a person injured in the accident who was not an income or wage producer at the time of the accident, reimbursement of necessary and reasonable expenses incurred for essential services ordinarily performed by the injured person for care and maintenance of the family or family household. (V.T.I.C. Art. 5.06-3, Sec. (b) (part).)

Source Law

(b) "Personal injury protection" consists of provisions of a motor vehicle liability policy which

provide for payment to the named insured in the motor vehicle liability policy and members of the insured's household, any authorized operator or passenger of the named insured's motor vehicle including a guest occupant, . . . of all reasonable expenses arising from the accident and incurred within three years from the date thereof for necessary medical, surgical, X-ray and dental services, including prosthetic devices, and necessary ambulance, hospital, professional nursing and funeral services, and in the case of an income producer, payment of benefits for loss of income as the result of the accident; and where the person injured in the accident was not an income or wage producer at the time of the accident, payments of benefits must be made in reimbursement of necessary and reasonable expenses incurred for essential services ordinarily performed by the injured person for care and maintenance of the family or family household. . . .

Revised Law

Sec. 1952.152. PERSONAL INJURY PROTECTION COVERAGE REQUIRED. (a) An insurer may not deliver or issue for delivery in this state an automobile liability insurance policy, including a policy provided through the Texas Automobile Insurance Plan Association under Chapter 2151, that covers liability arising out of the ownership, maintenance, or use of any motor vehicle unless the insurer provides personal injury protection coverage in the policy or supplemental to the policy.

(b) The coverage required by this subchapter does not apply if any insured named in the insurance policy rejects the coverage in writing. Unless the named insured requests in writing the coverage required by this subchapter, the insurer is not required to provide that coverage in or supplemental to a renewal insurance policy if the named insured rejected the coverage in connection with an insurance policy previously issued to the insured by the same insurer or by an affiliated insurer. (V.T.I.C. Art. 5.06-3, Sec. (a).)

Source Law

Art. 5.06-3. (a) No automobile liability insurance policy, including insurance issued pursuant to an assigned risk plan established under authority of Section 35 of the Texas Motor Vehicle Safety-Responsibility Act, covering liability arising out of the ownership, maintenance, or use of any motor vehicle shall be delivered or issued for delivery in this state unless personal injury protection coverage is provided therein or supplemental thereto. The coverage required by this article shall not be

applicable if any insured named in the policy shall reject the coverage in writing; provided, unless the named insured thereafter requests such coverage in writing, such coverage need not be provided in or supplemental to a renewal policy if the named insured has rejected the coverage in connection with a policy previously issued to him by the same insurer or by an affiliated insurer.

Revised Law

Sec. 1952.153. MAXIMUM REQUIRED AMOUNT OF PERSONAL INJURY PROTECTION. This subchapter does not require an insurer to provide personal injury protection coverage in an amount that exceeds $2,500 for all benefits, in the aggregate, for each person. (V.T.I.C. Art. 5.06-3, Sec. (b) (part).)

Source Law

(b) . . . up to an amount of $2,500 for each such person for payment . . . . The personal injury protection in this paragraph specified shall not exceed $2,500 for all benefits, in the aggregate, for each person.

Revised Law

Sec. 1952.154. LOSS OF INCOME BENEFITS. An insurer providing loss of income benefits under coverage required by this subchapter may require that the insured, as a condition of receiving those benefits, provide the insurer with reasonable medical proof of the insured's injury causing loss of income. (V.T.I.C. Art. 5.06-3, Sec. (b) (part).)

Source Law

(b) . . . The insurer providing loss of income benefits may require, as a condition of receiving such benefits, that the insured person furnish the insurer reasonable medical proof of his injury causing loss of income. . . .

Revised Law

Sec. 1952.155. BENEFITS PAYABLE WITHOUT REGARD TO FAULT OR COLLATERAL SOURCE; EFFECT ON SUBROGATION. (a) The benefits under coverage required by this subchapter are payable without regard to:

(1) the fault or nonfault of the named insured or recipient in causing or contributing to the accident; and

(2) any collateral source of medical, hospital, or wage continuation benefits.

(b) An insurer paying benefits under coverage required by

this subchapter does not have a right of subrogation or claim against any other person or insurer to recover any benefits by reason of the alleged fault of the other person in causing or contributing to the accident. (V.T.I.C. Art. 5.06-3, Sec. (c).)

Source Law

> (c) The benefits required by this Act shall be payable without regard to the fault or non-fault of the named insured or the recipient in causing or contributing to the accident, and without regard to any collateral source of medical, hospital, or wage continuation benefits. An insurer paying benefits pursuant to this Act shall have no right of subrogation and no claim against any other person or insurer to recover any such benefits by reason of the alleged fault of such other person in causing or contributing to the accident.

Revised Law

Sec. 1952.156. PAYMENT OF BENEFITS. (a) Subject to the requirements of this section and Section 1952.157, an insurer shall pay benefits under the coverage required by this subchapter periodically as claims for those benefits arise, but not later than the 30th day after the date the insurer receives satisfactory proof of a claim.

(b) The coverage required by this subchapter may:

(1) prescribe a period of not less than six months after the date of an accident within which the original proof of loss with respect to a claim for benefits must be presented to the insurer; and

(2) provide that an insurer may require reasonable medical proof of an alleged recurrence of an injury for which an original claim for benefits was made if a lapse occurs in the period of total disability or in the medical treatment of an injured person who:

(A) has received benefits under that coverage; and

(B) subsequently claims additional benefits based on the alleged recurrence.

(c) The aggregate benefits payable under the coverage required by this subchapter to any person may not exceed the maximum

limits prescribed in the insurance policy. (V.T.I.C. Art. 5.06-3, Sec. (d) (part).)

Source Law

> (d) All payments of benefits prescribed under this Act shall be made periodically as the claims therefor arise and within thirty (30) days after satisfactory proof thereof is received by the insurer subject to the following limitations:
>
> (1) The coverage described in this Act may prescribe a period of not less than six months after the date of accident within which the original proof of loss with respect to a claim for benefits must be presented to the insurer.
>
> (2) The coverage described in this Act may provide that in any instance where a lapse occurs in the period of total disability or in the medical treatment of an injured person who has received benefits under such coverage and such person subsequently claims additional benefits based upon an alleged recurrence of the injury for which the original claim for benefits was made, the insurer may require reasonable medical proof of such alleged recurrence; provided, that in no event shall the aggregate benefits payable to any person exceed the maximum limits prescribed in the policy.
>
> . . . .

Revised Law

Sec. 1952.157. ACTION FOR FAILURE TO PAY BENEFITS. (a) If the insurer fails to pay benefits under the coverage required by this subchapter when due, the person entitled to those benefits may bring an action in contract to recover the benefits.

(b) If the insurer is required to pay benefits described by Subsection (a), the person entitled to the benefits is entitled to recover reasonable attorney's fees, a penalty of 12 percent, and interest at the legal rate from the date those amounts became overdue. (V.T.I.C. Art. 5.06-3, Sec. (d) (part).)

Source Law

> (d) [All payments of benefits prescribed under this Act shall be made periodically as the claims therefor arise and within thirty (30) days after satisfactory proof thereof is received by the insurer subject to the following limitations:]
>
> . . .
>
> (3) In the event the insurer fails to pay such benefits when due, the person entitled to such benefits may bring an action in contract to recover the same; and, in the event the insurer is required to pay such benefits, the person entitled to such benefits shall be entitled to recover reasonable attorneys fees plus 12% penalty, plus interest thereon at the legal rate from the date such sums became overdue.

Revised Law

Sec. 1952.158. EXCLUSION OF BENEFITS. An insurer shall exclude benefits to an insured or the insured's personal representative under the coverage required by this subchapter if the insured's conduct contributed to the injury the insured sustained and that conduct:

(1) involved intentionally causing injury to the insured; or

(2) occurred while committing a felony or while seeking to elude lawful apprehension or arrest by a law enforcement official. (V.T.I.C. Art. 5.06-3, Sec. (e).)

Source Law

> (e) An insurer shall exclude benefits to any insured, or his personal representative, under a policy required by Section 1, when the insured's conduct contributed to the injury he sustained in any of the following ways:
>
> (1) Causing injury to himself intentionally.
>
> (2) While in the commission of a felony, or while seeking to elude lawful apprehension or arrest by a law enforcement official.

Revisor's Note

Section (e), V.T.I.C. Article 5.06-3, refers to a policy required by "Section 1." Neither Article 5.06-3 nor Section (e) contains a Section 1. It is clear from the context of the source law that "Section 1" is referring to Section 1 of Chapter 52, Acts of the 63rd Legislature, Regular Session, 1973, which enacted Article 5.06-3. The substance of Article 5.06-3 is revised throughout this subchapter. Therefore, the revised law substitutes a reference to "this subchapter" for the reference to "Section 1."

Revised Law

Sec. 1952.159. OFFSET AGAINST LIABILITY CLAIM. (a) If a liability claim is made by a guest or passenger described by Section 1952.151 against the owner or operator of the motor vehicle in which the guest or passenger was riding or against the owner's or

operator's liability insurer, the owner or operator of the motor vehicle or the owner's or operator's liability insurer is entitled to an offset, credit, or deduction against any award made to the guest or passenger in an amount equal to the amounts paid by the owner, the operator, or the owner's or operator's automobile liability insurer to the guest or passenger under personal injury protection.

(b) This subchapter does not authorize a direct action against a liability insurer if that right does not presently exist at law. (V.T.I.C. Art. 5.06-3, Sec. (h).)

Source Law

> (h) When any liability claim is made by any guest or passenger described in paragraph (b) hereof against the owner or operator of the motor vehicle in which he was riding or the owner's or operator's liability insurance carrier, the owner or operator of such motor vehicle or his liability insurance carrier shall be entitled to an offset, credit or deduction against any award made to such guest or passenger in an amount of money equal to the amounts paid by the owner, operator or his automobile liability insurance carrier under "personal injury protection" as defined in this Act to such guests or passengers; provided, however, that nothing herein shall be construed to authorize a direct action against a liability insurance company if such right does not presently exist at law.

Revised Law

Sec. 1952.160. INAPPLICABILITY TO ACCIDENT OR HEALTH INSURANCE. This subchapter applies only to an automobile insurance policy subject to this subtitle or Subchapter A, Chapter 5, and does not apply to any other accident or health insurance policy, regardless of whether the accident or health insurance policy provides indemnity against automobile-connected injuries. (V.T.I.C. Art. 5.06-3, Sec. (f).)

Source Law

> (f) This article applies only to motor vehicle insurance policies subject to this subchapter and does not apply to other accident or health policies even though they promise indemnity against automobile-connected injuries.

Revisor's Note

Section (f), V.T.I.C. Article 5.06-3, refers to an automobile insurance policy subject to "this

subchapter," meaning Subchapter A, V.T.I.C. Chapter 5. Portions of Subchapter A, Chapter 5, are revised in various chapters in this code. The provisions of Subchapter A that are revised and that regulate automobile insurance policies are revised in Subtitle C, Title 10, which includes this chapter. Other provisions of Subchapter A have not been revised. The revised law is drafted accordingly.

Revised Law

Sec. 1952.161. CERTAIN COVERAGE UNAFFECTED. This subchapter does not:

(1) affect the offering of medical payments coverage, disability benefits, or accidental death benefits, as presently prescribed by the commissioner; or

(2) prevent an insurer from providing benefits broader than the minimum benefits described by this subchapter, subject to the rules prescribed by the commissioner. (V.T.I.C. Art. 5.06-3, Sec. (g).)

Source Law

(g) Nothing contained in this Act shall affect the offering of medical payments coverage, disability benefits, and accidental death benefits, as presently prescribed by the State Board of Insurance; and nothing contained in this Act shall be construed to prevent an insurer from providing broader benefits than the minimum benefits enumerated in this Act subject to the rules and forms prescribed by the State Board of Insurance.

Revisor's Note

Section (g), V.T.I.C. Article 5.06-3, refers to "forms prescribed by the State Board of Insurance," meaning the commissioner of insurance for the reasons stated in Revisor's Note (1) to Section 1952.053. The revised law omits the reference to forms prescribed by the commissioner as unnecessary and misleading for the reason stated in Revisor's Note (2) to Section 1952.101.

[Sections 1952.162-1952.200 reserved for expansion]

SUBCHAPTER E. SHORT-TERM LIABILITY INSURANCE FOR CERTAIN MOTORISTS

Revised Law

Sec. 1952.201. APPLICABILITY OF SUBCHAPTER. This subchapter applies to an insurer authorized to write automobile insurance in this state, including an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, or other entity. (V.T.I.C. Art. 5.01C, Sec. 1(1).)

Source Law

Art. 5.01C
Sec. 1. In this article:
(1) "Insurer" means an insurance company, interinsurance exchange, mutual, capital stock company, county mutual, reciprocal association, Lloyd's plan insurer, or other entity authorized to write motor vehicle insurance in this state.

Revisor's Note

Section 1(1), V.T.I.C. Article 5.01C, refers to an "interinsurance exchange," a "mutual," a "county mutual," a "reciprocal association," and a "Lloyd's plan insurer." The revised law substitutes for the quoted language references to a "reciprocal or interinsurance exchange," a "mutual insurance company," a "county mutual insurance company," and a "Lloyd's plan" for the reason stated in Revisor's Note (2) to Section 1952.001.

Revised Law

Sec. 1952.202. DEFINITIONS. In this subchapter:

(1) "Motor vehicle" means any private passenger vehicle or utility type vehicle that has a gross weight of not more than 25,000 pounds.

(2) "Short-term liability insurance policy" means an insurance policy that:

(A) provides coverage for at least 24 hours but not for more than one week;

(B) meets the requirements of Chapter 601,

Transportation Code;

(C) covers liability for bodily injury, death, and property damage arising from the use or operation of a motor vehicle; and

(D) is not insurance assigned to an authorized insurer by the Texas Automobile Insurance Plan Association under Section 2151.102(a). (V.T.I.C. Art. 5.01C, Secs. 1(2), (3).)

Source Law

(2) "Motor vehicle" means any private passenger vehicle or utility type vehicle that has a gross weight of 25,000 pounds or less.

(3) "Short-term liability insurance policy" means an insurance policy that:

(A) provides coverage for at least 24 hours but not for more than one week;

(B) meets the requirements of Chapter 601, Transportation Code;

(C) covers liability for bodily injury, death, and property damage arising from the use or operation of a motor vehicle; and

(D) is not insurance assigned to an authorized insurance company by the Texas Automobile Insurance Plan Association under Section 4(a), Article 21.81, of this code.

Revised Law

Sec. 1952.203. SHORT-TERM LIABILITY INSURANCE PROGRAM. (a) The commissioner by rule may establish a program to provide for the sale of short-term liability insurance policies to nonresident motorists who are visiting this state.

(b) The commissioner may negotiate an agreement with any insurer under which the insurer will sell insurance policies described by this section. (V.T.I.C. Art. 5.01C, Sec. 2.)

Source Law

Sec. 2. (a) The commissioner by rule may establish a program to provide for the sale of short-term liability insurance policies to non-Texas resident motorists visiting this state.

(b) The commissioner may negotiate an agreement with any insurer under which the insurer will sell policies described by Subsection (a) of this section.

Revised Law

Sec. 1952.204. AGENT LICENSE REQUIRED. A person representing an insurer in selling short-term liability insurance policies under this subchapter must be licensed under Title 13.

(V.T.I.C. Art. 5.01C, Sec. 3.)

Source Law

Sec. 3. A person representing an insurer in selling short-term liability insurance policies under this article must be licensed under Subchapter A, Chapter 21, of this code.

Revisor's Note

Section 3, V.T.I.C. Article 5.01C, requires certain persons to be licensed under "Subchapter A, Chapter 21, of this code." Subchapter A, V.T.I.C. Chapter 21, is revised in various chapters in this code. The portions of Subchapter A, Chapter 21, relevant to licensing agents are revised in Title 13 of this code. The revised law is drafted accordingly.

Revised Law

Sec. 1952.205. SALE OF SHORT-TERM LIABILITY INSURANCE POLICIES. An insurer selling short-term liability insurance policies under this subchapter shall use policy forms adopted by the commissioner under Article 5.06 or filed and in effect as provided by Subchapter B, Chapter 2301, as applicable, unless the insurer is exempt from using those forms. (V.T.I.C. Art. 5.01C, Sec. 4.)

Source Law

Sec. 4. An insurer selling short-term liability insurance policies under this article must use the policy forms adopted by the commissioner under Article 5.06 of this code or filed and in effect as provided by Article 5.145 of this code unless the insurer is exempt from using those forms.

[Sections 1952.206-1952.250 reserved for expansion]

SUBCHAPTER F. GARAGE INSURANCE

Revised Law

Sec. 1952.251. DEFINITIONS. In this subchapter:

(1) "Garage customer" means a person or organization other than:

(A) the named insured under a garage insurance policy;

(B) an employee, director, officer, shareholder,

partner, or agent of the named insured; or

(C) a resident of the same household as:

(i) the named insured; or

(ii) an employee, director, officer, shareholder, partner, or agent of the named insured.

(2) "Garage insurance" means automobile insurance as defined by Article 5.01 issued to a named insured who is engaged in the business of selling, servicing, or repairing motor vehicles as defined by commissioner rule or order. (V.T.I.C. Art. 5.06-2, Sec. (1) (part).)

Source Law

> Art. 5.06-2. (1) Definitions. As used in this Act:
>
> (a) "Garage Insurance" means motor vehicle or automobile insurance as defined in Article 5.01 hereof issued to a named insured engaged in the business of selling, servicing or repairing motor vehicles as now or hereafter defined by rules, regulations or orders of the State Board of Insurance;
>
> (b) "Garage Customer" means any person or organization other than the named insured, or an employee, director, officer, stockholder, partner, or agent of the named insured; or a resident of the same household as the named insured, such employee, director, officer, stockholder, partner, or agent;
>
> . . . .

Revisor's Note

Section (1)(a), V.T.I.C. Article 5.06-2, refers to motor vehicles "as now or hereafter defined by rules, regulations or orders of the State Board of Insurance." The revised law omits "as now or hereafter" because under Section 311.027, Government Code (Code Construction Act), applicable to the revised law, a reference to a rule applies to all reenactments, revisions, and amendments of the rule. The reference to "regulations" is omitted from the revised law for the reason stated in Revisor's Note (2) to Section 1952.058.

Revised Law

Sec. 1952.252. GARAGE INSURANCE. (a) A garage insurance policy may provide that a garage customer is not an insured under

the policy and that the coverage under the policy does not apply to a garage customer except to the extent that any other insurance coverage that is collectible and available to the garage customer is not equal to the minimum financial responsibility limits specified by Chapter 601, Transportation Code.

(b) Notwithstanding any provision to the contrary in another insurance policy as to whether the insurance coverage described by Subsection (a) that is provided under that policy is primary, excess, or contingent insurance, or otherwise, the other insurance coverage is the primary insurance as to the garage customer.

(c) A garage insurance policy containing a provision described by Subsection (a) may not cover a garage customer except to the extent permitted by this section, notwithstanding the terms of the other insurance policy providing coverage described by Subsection (a). (V.T.I.C. Art. 5.06-2, Secs. (1) (part), (2).)

Source Law

> Art. 5.06-2. (1) Definitions. As used in this Act:
>
> . . .
>
> (c) "Financial Responsibility Limits" means the minimum limits specified by the Texas Motor Vehicle Safety-Responsibility Act.
>
> (2) A policy of garage insurance may contain a provision to the effect that garage customers are not insureds under the garage insurance policy and that the garage insurance shall not apply to garage customers, except to the extent that other valid and collectible insurance, if any, available to the garage customer is not equal to the financial responsibility limits. Notwithstanding any provision to the contrary in such other policy or policies of insurance as to whether such insurance is primary, excess, or contingent insurance, or otherwise, such other valid and collectible insurance shall be primary insurance as to the garage customer. Any garage insurance policy containing such a provision shall not cover garage customers except to such extent, notwithstanding the terms and provisions of such other policy or policies of insurance.

Revisor's Note

(1) Section (2), V.T.I.C. Article 5.06-2, refers to "valid and collectible" insurance. The revised law omits "valid" for the reason stated in the revisor's note to Section 1952.103.

(2) Section (2), V.T.I.C. Article 5.06-2, refers to the "terms and provisions" of an insurance policy. The revised law omits "provisions" because, in this context, "provisions" is included in the meaning of "terms."

Revisor's Note
(End of Subchapter)

Section (3), V.T.I.C. Article 5.06-2, provides that Article 5.06-2 applies only to "insurance policies issued or renewed or made subject to this Act by endorsement after the effective date hereof." The revised law omits this provision as obsolete. Article 5.06-2 was added by Chapter 35, Acts of the 61st Legislature, 2nd Called Session, 1969. That act took effect September 19, 1969. Any insurance policy issued before that date has, by now, been renewed. The omitted law reads:

> (3) This Act shall apply only to insurance policies issued or renewed or made subject to this Act by endorsement after the effective date hereof.

[Sections 1952.253-1952.300 reserved for expansion]

SUBCHAPTER G. REPAIR OF MOTOR VEHICLES

Revised Law

Sec. 1952.301. LIMITATION ON PARTS, PRODUCTS, OR REPAIR PERSONS OR FACILITIES PROHIBITED. (a) Except as provided by rules adopted by the commissioner, under an automobile insurance policy that is delivered, issued for delivery, or renewed in this state, an insurer may not directly or indirectly limit the insurer's coverage under a policy covering damage to a motor vehicle by:

(1) specifying the brand, type, kind, age, vendor, supplier, or condition of parts or products that may be used to repair the vehicle; or

(2) limiting the beneficiary of the policy from selecting a repair person or facility to repair damage to the vehicle.

(b) In settling a liability claim by a third party against an insured for property damage claimed by the third party, an insurer may not require the third-party claimant to have repairs made by a particular repair person or facility or to use a particular brand, type, kind, age, vendor, supplier, or condition of parts or products. (V.T.I.C. Art. 5.07-1, Secs. (a), (g).)

Source Law

> Art. 5.07-1. (a) Except as provided by rules duly adopted by the commissioner, under an auto insurance policy that is delivered, issued for delivery, or renewed in this state an insurer may not, directly or indirectly, limit its coverage under a policy covering damage to a motor vehicle by specifying the brand, type, kind, age, vendor, supplier, or condition of parts or products that may be used to repair the vehicle or by limiting the beneficiary of the policy from selecting a repair person or facility to repair damage to the motor vehicle covered under the policy.
>
> (g) In the settlement of liability claims by a third party against an insured for property damage claimed by the third party, an insurer may not require the third-party claimant to have repairs made by a particular repair person or facility or to use a particular brand, type, kind, age, vendor, supplier, or condition of parts or products.

Revisor's Note

Section (a), V.T.I.C. Article 5.07-1, refers to rules "duly" adopted by the commissioner of insurance. The revised law omits "duly" as unnecessary because the term does not add to the clear meaning of the law.

Revised Law

Sec. 1952.302. PROHIBITED ACTS IN CONNECTION WITH REPAIR OF MOTOR VEHICLE. In connection with the repair of damage to a motor vehicle covered under an automobile insurance policy, an insurer, an employee or agent of an insurer, an insurance adjuster, or an entity that employs an insurance adjuster may not:

(1) solicit or accept a referral fee or gratuity in exchange for referring a beneficiary or third-party claimant to a repair person or facility to repair the damage;

(2) state or suggest, either orally or in writing, to a beneficiary that the beneficiary must use a specific repair person

or facility or a repair person or facility identified on a preferred list compiled by an insurer for the damage repair or parts replacement to be covered by the policy; or

(3) restrict the right of a beneficiary or third-party claimant to choose a repair person or facility by requiring the beneficiary or third-party claimant to travel an unreasonable distance to repair the damage. (V.T.I.C. Art. 5.07-1, Sec. (b).)

Source Law

(b) In connection with the repair of damage to a motor vehicle covered under an auto insurance policy, an insurer, an employee of an insurer, an agent of an insurer, a solicitor of insurance for an insurer, an insurance adjuster, or an entity that employs an insurance adjuster may not:

(1) solicit or accept a referral fee or gratuity in exchange for referring a beneficiary or third-party claimant to a repair person or facility to repair the damage;

(2) state or suggest, either orally or in writing, to a beneficiary that a specific repair person or facility or a repair person or facility identified on a preferred list compiled by an insurer must be used by a beneficiary in order for the damage repair or parts replacement to be covered by the policy; or

(3) restrict a beneficiary's or third-party claimant's right to choose a repair person or facility by requiring the beneficiary or third-party claimant to travel an unreasonable distance to repair the damage.

Revisor's Note

Section (b), V.T.I.C. Article 5.07-1, refers to a "solicitor of insurance" for an insurer. 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. 1952.303. CONTRACTS BETWEEN INSURER AND REPAIR PERSON OR FACILITY. (a) A contract between an insurer and a repair person or facility, including an agreement under which the repair person

or facility agrees to extend discounts for parts or labor to the insurer in exchange for referrals by the insurer, may not result in a reduction of coverage under an insured's automobile insurance policy.

(b) The commissioner may adopt rules under Chapter 542 with respect to any fraudulent activity of any party to an agreement described by Subsection (a). (V.T.I.C. Art. 5.07-1, Secs. (c), (h).)

Source Law

> (c) A contract between an insurer and a repair person or facility, including an agreement under which the repair person or facility agrees to extend discounts for parts or labor to the insurer in exchange for referrals by the insurer, may not result in a reduction of coverage under the insured's auto insurance policy.
>
> (h) The commissioner may exercise the rule-making authority under Article 21.21-2 of this code with respect to any fraudulent activity of any party to an agreement described by Subsection (c) of this article.

Revised Law

Sec. 1952.304. PROVISION OF INFORMATION REGARDING REPAIRS. An insurer may not prohibit a repair person or facility from providing a beneficiary or third-party claimant with information that states:

(1) the description, manufacturer, or source of the parts used; and

(2) the amounts charged to the insurer for the parts and related labor. (V.T.I.C. Art. 5.07-1, Sec. (d).)

Source Law

> (d) An insurer may not prohibit a repair person or facility from providing a beneficiary or third-party claimant with information that states the description, manufacturer, or source of the parts used and the amounts charged to the insurer for the parts and related labor.

Revised Law

Sec. 1952.305. NOTICE OF RIGHTS REGARDING REPAIR OF MOTOR VEHICLE. (a) At the time a motor vehicle is presented to an insurer, an insurance adjuster, or other person in connection with

a claim for damage repair, the insurer, insurance adjuster, or other person shall provide to the beneficiary or third-party claimant notice of the provisions of this subchapter.

(b) The commissioner shall adopt a rule establishing the method or methods insurers must use to comply with the notice provisions of this section. (V.T.I.C. Art. 5.07-1, Sec. (e).)

Source Law

> (e) At the time the vehicle is presented to an insurer or an insurance adjuster or other person in connection with a claim for damage repair, the insurer or insurance adjuster or other person shall provide to the beneficiary or third-party claimant notice of the provisions of this article. The commissioner shall adopt a rule establishing the method or methods insurers shall use to comply with the notice provisions in this subsection.

Revised Law

Sec. 1952.306. COMPLAINTS. A beneficiary, third-party claimant, or repair person or facility may submit a written, documented complaint to the department with respect to an alleged violation of this subchapter. (V.T.I.C. Art. 5.07-1, Sec. (f).)

Source Law

> (f) Any beneficiary, third-party claimant, or repair person or facility may submit a written, documented complaint to the department with respect to an alleged violation of this article.

Revised Law

Sec. 1952.307. RULES. Rules adopted by the commissioner to implement this subchapter must include requirements that:

(1) any limitation described by Section 1952.301(a) be clearly and prominently displayed on the face of the insurance policy or certificate in lieu of an insurance policy; and

(2) the insured give written consent to a limitation described by Section 1952.301(a) after the insured is notified orally and in writing of the limitation at the time the insurance policy is purchased. (V.T.I.C. Art. 5.07-1, Sec. (i).)

Source Law

> (i) Any rules adopted by the commissioner to implement this article shall include, but not be limited to, requirements that:
>
> (1) any limitation described in Subsection

(a) of this section is clearly and prominently displayed on the face of the policy or certificate in lieu of a policy; and

(2) the insured give written consent to such a limitation, following both oral and written notification of any limitation at the time the policy is purchased.

Revisor's Note

Section (i), V.T.I.C. Article 5.07-1, states that rules shall "include, but not be limited to," certain requirements. "[B]ut not be limited to" is omitted as unnecessary because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, 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.

[Chapters 1953-2000 reserved for expansion]

SUBTITLE D. FIRE INSURANCE AND ALLIED LINES, INCLUDING RESIDENTIAL PROPERTY INSURANCE

CHAPTER 2001. GENERAL PROVISIONS: FIRE INSURANCE AND ALLIED LINES, INCLUDING RESIDENTIAL PROPERTY INSURANCE


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CHAPTER 2001. GENERAL PROVISIONS: FIRE INSURANCE AND ALLIED LINES, INCLUDING RESIDENTIAL PROPERTY INSURANCE

Revised Law

Sec. 2001.001. APPLICABILITY OF SUBTITLE. (a) Each insurance policy or contract insuring property in this state against loss by fire, including a policy or contract or portion of a policy or contract that insures the shore end of a marine risk against loss by fire, must be issued in accordance with:

(1) this chapter;

(2) Section 403.002;

(3) Subchapter C, Chapter 5;

(4) Subchapter H, Chapter 544;

(5) Subchapter D, Chapter 1806; and

(6) Chapters 252, 2002, 2003, 2004, 2005, 2006, and 2171.

(b) An insurer issuing an insurance policy or contract described by Subsection (a), including a fire insurance company, marine insurance company, fire and marine insurance company, and fire and tornado insurance company, is governed by the laws described by Subsection (a).

(c) This section applies to an insurer or to an insurance policy or contract regardless of:

(1) the kind and character of property insured;

(2) whether the property is:

(A) fixed or movable;

(B) stationary or in transit; or

(C) consigned or billed for shipment inside or outside the boundaries of this state or to a foreign country;

(3) whether the insurer is organized:

(A) under the laws of this state, another state, territory, or possession of the United States, or a foreign country; or

(B) by authority of the federal government; or

(4) the kind of insurer or the name of the insurer

issuing the policy or contract. (V.T.I.C. Art. 5.27 (part).)

Source Law

Art. 5.27. Every fire insurance company, every marine insurance company, every fire and marine insurance company, every fire and tornado insurance company, and each and every insurance company of every kind and name issuing a contract or policy of insurance, or contracts or policies of insurance against loss by fire on property within this State, whether such property be fixed or movable, stationary or in transit, or whether such property is consigned or billed for shipment within or beyond the boundary of this State or to some foreign county, whether such company is organized under the laws of this State or under the laws of any other state, territory or possession of the United States, or foreign country, or by authority of the Federal Government, [now holding certificate of authority to transact business in this State, shall be deemed to have accepted such certificate and to transact business thereunder, upon condition that it consents to the terms and provisions of this subchapter and that it agrees to transact business in this State, subject thereto;] it being intended that every contract or policy of insurance against the hazard of fire shall be issued in accordance with the terms and provisions of this subchapter, and the company issuing the same governed thereby, regardless of the kind and character of such property and whether the same is fixed or movable, stationary or in transit, including the shore end of all marine risks insured against loss by fire.

Revisor's Note

(1) V.T.I.C. Article 5.27 refers to a foreign "county." It is clear from the context that "county" is a typographical error and that the legislature intended to refer to a foreign "country." The revised law is drafted accordingly.

(2) V.T.I.C. Article 5.27 requires a fire insurance policy and an insurer that issues a fire insurance policy to comply with "this subchapter," meaning Subchapter C, V.T.I.C. Chapter 5. Included in Subchapter C, Chapter 5, were V.T.I.C. Articles 5.43-4, 5.44, 5.49, 5.53, and 5.54. Article 5.43-4 was revised in 1999 as Chapter 2154, Occupations Code, Article 5.44 was revised in 1987 as Section 417.008, Government Code, and Article 5.49 was revised, effective April 1, 2005, in part in Chapter 251 of this code. In addition, Articles 5.53 and 5.54 are revised

in part as Chapter 1807 of this code. The revised law does not reference the statutes revising those articles because those provisions do not regulate fire insurance policies or insurers with respect to issuing those policies.

Revised Law

Sec. 2001.002. RATES. (a) Rates for all lines of insurance subject to a law described by Section 2001.001(a) are determined as provided by Chapter 2251 and Article 5.13-2.

(b) The requirement imposed by Subsection (a) does not affect the requirement for the commissioner to conduct inspections of commercial property and prescribe a manual of rules and rating schedules for commercial property under a law described by Section 2001.001(a). (V.T.I.C. Art. 5.25, Sec. (b); Art. 5.28, Sec. (d).)

Source Law

[Art. 5.25]

(b) Notwithstanding Subsection (a) of this article, on and after the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003, rates for homeowners and residential fire and residential allied lines insurance coverage under this subchapter are determined as provided by Subchapter Q of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code, except that on and after December 1, 2004, rates for all lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. This subsection does not affect the requirement for the commissioner to conduct inspections of commercial property and prescribe a manual of rules and rating schedules for commercial property under this subchapter.

[Art. 5.28]

(d) Notwithstanding Subsection (a) of this article, on and after the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003, rates for homeowners and residential fire and residential allied lines insurance coverage under this subchapter are determined as provided by Subchapter Q of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code, except that on and after December 1, 2004, rates for all lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code.

Revisor's Note

Section (b), V.T.I.C. Article 5.25, and Section

(d), V.T.I.C. Article 5.28, provide that notwithstanding Section (a) of the respective articles, on and after the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003, rates for homeowners and residential fire and residential allied lines insurance coverage under Subchapter C, V.T.I.C. Chapter 5, are determined as provided by Subchapter Q of that chapter, and rates for other lines of insurance subject to Subchapter C of that chapter are determined as provided by V.T.I.C. Article 5.13-2, revised in part in Chapter 2251, except that on and after December 1, 2004, rates for all lines of insurance subject to Subchapter C of that chapter are determined as provided by V.T.I.C. Article 5.13-2. The revised law omits as executed the references to the law governing insurance rates before December 1, 2004.

In addition, the relevant provisions of Article 5.13-2 that are revised are contained in Chapter 2251 of this code. Although that chapter contains other provisions that are derived from V.T.I.C. Article 5.13-2C, the revised law appropriately refers to Chapter 2251 in its entirety because the provisions that are derived from Article 5.13-2C are necessary to construe the provisions of Article 5.13-2 that are revised in that chapter.

Revised Law

Sec. 2001.003. AUTHORITY TO REQUIRE SWORN STATEMENTS. For an insurer described by Section 2001.001, the department may require from the insurer or a director, officer, representative, or agent of the insurer a sworn statement covering any period that states:

(1) the rates and premiums collected for fire insurance on each class of risks and on all property in this state;

(2) the causes of fire, if known to the insurer or individual or if the insurer or individual possesses relevant information or data or can obtain the information or data at reasonable expense; and

(3) all necessary facts and information to allow the department to determine enforcement and to enforce a law described by Section 2001.001(a). (V.T.I.C. Art. 5.28, Sec. (a) (part).)

Source Law

> Art. 5.28. (a) Said Board is authorized and empowered to require sworn statements for any period of time from any insurance company affected by this law and from any of its directors, officers, representatives, general agents, state agents, special agents, and local agents of the rates and premiums collected for fire insurance on each class of risks, on all property in this State and of the causes of fire, if such be known, if they are in possession of such data, and information, or can obtain it at a reasonable expense; and said Board is empowered to require such statements showing all necessary facts and information to enable said Board . . . to determine and assist in the enforcement of the provisions of this law.

Revisor's Note

(1) Section (a), V.T.I.C. Article 5.28, refers to the "Board," meaning 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. Throughout this chapter, references to the board have been changed appropriately.

(2) Section (a), V.T.I.C. Article 5.28, refers to an "insurance company affected by this law" and to "the provisions of this law." The article is derived from Section 12, Chapter 106, General Laws, Acts of the

33rd Legislature, Regular Session, 1913, which refers to an insurance company affected by "this Act," meaning Chapter 106. Chapter 106 repealed the then existing laws regulating fire insurance and fire insurance companies and established a new system of regulating that insurance and those companies. Chapter 106 and amendments to that chapter were codified in 1951 as Subchapter C, V.T.I.C. Chapter 5. The relevant portions of Subchapter C that are revised are revised in Title 10, which includes this chapter, and elsewhere in this code. As explained in Revisor's Note (2) to Section 2001.001, Section 2001.001 describes the insurers affected by the relevant provisions of Subchapter C and does not reference the irrelevant statutes revising V.T.I.C. Articles 5.43-4 and 5.44. Therefore, the revised law substitutes a reference to an "insurer described by Section 2001.001" for the reference to an "insurance company affected by this law," and substitutes a reference to "a law described by Section 2001.001(a)" for the reference to "the provisions of this law."

(3) Section (a), V.T.I.C. Article 5.28, refers to the "representatives, general agents, state agents, special agents, and local agents" of certain insurers. The terms "general agent," "state agent," "special agent," and "local agent" are obsolete terms that describe the types of agents that may represent those insurers. Therefore, the revised law omits "general agents, state agents, special agents, and local agents" as obsolete terms that are included within the meaning of "representative" and "agent." Similar changes have been made throughout this chapter.

Revised Law

Sec. 2001.004. AUTHORITY TO INSPECT AND TAKE TESTIMONY

REGARDING RECORDS. (a) The commissioner or a person authorized by the commissioner may:

(1) visit:

(A) a general, local, or other office of an insurer engaged in the business of insurance in this state;

(B) the insurer's home office located outside this state, if applicable; and

(C) the office of any of the insurer's officers, directors, agents, or other representatives; and

(2) require the insurer or an officer, director, agent, or other representative of the insurer to produce for inspection by the commissioner or the commissioner's authorized representative all of the books, records, and papers of the insurer, officer, director, agent, or representative.

(b) The commissioner or the commissioner's authorized representative may:

(1) examine and make or have made copies of the books, records, and papers described by Subsection (a); and

(2) take testimony under oath regarding the books, records, and papers and compel the attendance of witnesses for that purpose. (V.T.I.C. Art. 5.28, Sec. (b).)

Source Law

(b) The said Board shall also have the right, at its discretion, either personally, or by someone duly authorized by it, to visit the office whether general, local or otherwise, of any insurance company doing business in this State, and the home office of said company outside of this State, if there be such, and the office of any officers, directors, general agents, state agents, local agents or representatives of such company, and there require such company, its officers, agents or representatives, to produce for inspection by said Board or any of its duly authorized representatives all books, records and papers of such company or such agents and representatives; and the said Board or its duly authorized agents or representatives shall have the right to examine such books and papers and make or cause to be made copies thereof; and shall have the right to take testimony under oath with reference thereto, and to compel the attendance of witnesses for such purpose.

Revisor's Note

(1) Section (b), V.T.I.C. Article 5.28,

provides that in addition to the powers provided by Section (a) of that article the commissioner of insurance "also" has certain additional powers. The revised law omits "also" 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.

(2) Section (b), V.T.I.C. Article 5.28, authorizes the commissioner of insurance or a person "duly" authorized by the commissioner to require certain persons to produce certain records for inspection by the commissioner or the commissioner's "duly authorized representatives" and authorizes the commissioner or the commissioner's "duly authorized agents or representatives" to examine and copy the records produced and take testimony regarding the records. The revised law omits "duly" as unnecessary because the word does not add to the clear meaning of the law. In addition, the revised law substitutes a reference to the commissioner's "authorized representative" for the reference to "authorized agents or representatives" in this context for consistency of terminology and because "authorized agent" is included within the meaning of "authorized representative."

(3) Section (b), V.T.I.C. Article 5.28, provides that the commissioner of insurance or an authorized person may require production of certain "books, records and papers," examine "such books and papers," make copies "thereof," and take testimony with reference "thereto." For consistency, the revised law refers to "books, records, and papers" in

each of those instances.

Revised Law

Sec. 2001.005. AUTHORITY TO REQUIRE PROVISION OF DATA. The department may require:

(1) any or all of the fire insurance companies engaged in the business of insurance in this state to jointly or separately provide to the department any data the company or companies possess, including maps, tariffs, inspection reports, and any data affecting fire insurance risks in this state or any part of this state; and

(2) any two or more of those companies or any joint agents or representatives of the companies to provide to the department for use in implementing a law described by Section 2001.001(a) any data the companies, agents, or representatives possess. (V.T.I.C. Art. 5.28, Sec. (c).)

Source Law

(c) Said Board shall be further empowered to require the fire insurance companies transacting business in this State or any of them, to furnish said Board with any and all data which may be in their possession, either jointly or severally, including maps, tariffs, inspection reports and any and all data affecting fire insurance risks in this State, or in any portion thereof, and said Board shall be empowered to require any two (2) or more of said companies, or any joint agent or representative of them, to turn over any and all such data in their possession, or any part thereof, to said Board for its use in carrying out the provisions of this law.

Revisor's Note

Section (c), V.T.I.C. Article 5.28, provides that, in addition to the powers provided by Sections (a) and (b) of that article, the Texas Department of Insurance is "further" empowered. The revised law omits "further" for the reason stated in Revisor's Note (1) to Section 2001.004.

Revised Law

Sec. 2001.006. REPORT OF INFORMATION RELATING TO CERTAIN FIRE LOSSES. (a) The state fire marshal, a fire marshal of a political subdivision of this state, the chief of a fire department

in this state, or a peace officer in this state may request an insurer investigating a fire loss of property in which damages or losses exceed $1,000 to release information in the insurer's possession relating to that loss. The insurer shall release the requested information and cooperate with the official. The requested information may include only:

(1) an insurance policy relevant to the fire loss under investigation and any application for a policy;

(2) policy premium payment records;

(3) the history of the insured's previous claims for fire loss; and

(4) material relating to the investigation of the loss, including:

(A) statements of any person;

(B) proof of loss; or

(C) other relevant evidence.

(b) This section does not authorize a public official or agency to adopt or require any type of periodic report by an insurer.

(c) An insurer that has reason to suspect that a fire loss to the property of a person insured by the insurer was caused by incendiary means and that receives a request for information under Subsection (a) shall:

(1) notify the requesting official and provide the official with all relevant material acquired during the insurer's investigation of the fire loss;

(2) cooperate with and take any action requested of the insurer by a law enforcement agency; and

(3) permit a person ordered by a court to inspect any of the insurer's records relating to the insurance policy and the loss.

(d) In the absence of fraud or malice, an insurer or a person who provided information on the insurer's behalf is not liable for damages in a civil action or subject to criminal prosecution for an

oral or written statement made or any other action taken that is necessary to supply information required under this section.

(e) An official or a department or agency employee who receives information under this section shall maintain the confidentiality of the information until the information is required to be released in a criminal or civil proceeding.

(f) An official described by Subsection (a) may be required to testify as to any information in the official's possession regarding the fire loss of property in a civil action in which a person seeks recovery for the loss from an insurer under an insurance policy.

(g) A person may not intentionally:

(1) refuse to release information requested under Subsection (a);

(2) refuse to notify the fire marshal of a fire loss required to be reported under Subsection (c);

(3) refuse to provide the fire marshal with relevant information required to be provided under Subsection (c); or

(4) fail to maintain the confidentiality of information that is confidential under Subsection (e). (V.T.I.C. Art. 5.46.)

Source Law

Art. 5.46. (A) The State Fire Marshal, any fire marshal of a political subdivision in Texas, or the chief of any established fire department in Texas, or any peace officer in Texas, may request any insurance company investigating a fire loss of real or personal property in which damages or losses exceed $1,000 to release information in its possession relative to that loss. The company shall release the information and cooperate with any official authorized to request such information pursuant to this section. The information may include but not exceed:

(1) any insurance policy relevant to a fire loss under investigation and any application for such a policy;

(2) policy premium payment records;

(3) history of previous claims made by the insured for fire loss;

(4) material relating to the investigation of the loss, including statements of any person, proof of loss, or other relevant evidence.

(5) The provisions of this section shall not be construed to authorize a public official or agency to promulgate or require any type or form of

periodic report by an insurer.

(B) If an insurance company has reason to suspect that a fire loss to its insured's real or personal property was caused by incendiary means and if it receives a request for information pursuant to Section (A) of this article, the company shall notify the requesting official and furnish him with all relevant material acquired during its investigation of the fire loss, cooperate with and take such action as may be requested of it by any law enforcement agency, and permit any person ordered by a court to inspect any of its records pertaining to the policy and the loss.

(C) In the absence of fraud or malice no insurance company or person who furnished information on its behalf is liable for damages in a civil action or subject to criminal prosecution for oral or written statement made or any other action taken that is necessary to supply information required pursuant to this section.

(D) The officials and departmental and agency personnel receiving any information furnished pursuant to this section shall hold the information in confidence until such time as its release is required pursuant to a criminal or civil proceeding.

(E) Any official referred to in Section (A) of this article may be required to testify as to any information in his possession regarding the fire loss of real or personal property in any civil action in which any person seeks recovery under a policy against an insurance company for the fire loss.

(F)(1) No person shall purposely refuse to release any information requested pursuant to Section (A) of this article.

(2) No person shall purposely refuse to notify the fire marshal of a fire loss required to be reported pursuant to Section (B) of this article.

(3) No person shall purposely refuse to supply the fire marshal with pertinent information required to be furnished pursuant to Section (B) of this article.

(4) No person shall purposely fail to hold in confidence information required to be held in confidence by Section (D) of this article.

Revisor's Note

(1) Sections (A), (B), and (E), V.T.I.C. Article 5.46, refer to "real or personal" property. The revised law omits the reference to "real or personal" as unnecessary because Section 311.005(4), Government Code (Code Construction Act), applicable to the revised law, defines "property" as real and personal property.

(2) Section (A)(5), V.T.I.C. Article 5.46, refers to any "type or form" of periodic report by an insurer. The reference to "form" is omitted from the revised law because "form" is included within the

meaning of "type."

(3) Section (F), V.T.I.C. Article 5.46, prohibits a person from "purposely" refusing or failing to take certain actions. The revised law substitutes "intentionally" for "purposely" because, in the context of this section, "purposely" and "intentionally" are synonymous and "intentionally" is more commonly used.

Revised Law

Sec. 2001.007. CRIMINAL PENALTY. (a) An officer or director of a fire insurance company described by Section 2001.001, or an agent or person acting on behalf of or employed by a fire insurance company described by Section 2001.001, commits an offense if the officer, director, agent, or person intentionally:

(1) performs or causes to be performed, alone or in conjunction with a corporation, company, or person, an act prohibited by a law described by Section 2001.001(a);

(2) fails to perform an act required to be performed by a law described by Section 2001.001(a);

(3) permits an act prohibited by a law described by Section 2001.001(a); or

(4) otherwise violates a law described by Section 2001.001(a).

(b) An offense under this section is a misdemeanor punishable by a fine of not less than $300 or more than $1,000. (V.T.I.C. Art. 5.48-1.)

Source Law

Art. 5.48-1. Any officer or director of any fire insurance company affected by the statutes of this State creating the State Insurance Commission, or any agent, or any one acting or employed by such company who alone or in conjunction with any corporation, company or person, shall wilfully do or cause to be done any act prohibited or declared to be unlawful by such statutes, or who wilfully fails to do any act required to be done by such statutes, or who shall wilfully permit any act directed not to be done, or who shall be guilty of any wilful infraction of such statutes, shall be fined not less than three hundred nor more than one thousand dollars.

Revisor's Note

(1) V.T.I.C. Article 5.48-1 imposes a criminal penalty on a fire insurance company "affected by the statutes of this State creating the State Insurance Commission" for certain violations of those statutes. The article is derived from Section 26, Chapter 106, General Laws, Acts of the 33rd Legislature, Regular Session, 1913, which refers to an insurance company "affected by this Act." The revised law substitutes "described by Section 2001.001" for the quoted language for the reason stated in Revisor's Note (2) to Section 2001.003.

(2) V.T.I.C. Article 5.48-1 refers to a person who "wilfully" engages in certain violations of this code. The revised law substitutes "intentionally" for "wilfully" because the terms are synonymous and "intentional" is the term prescribed by Section 6.02, Penal Code, which classifies culpable mental states in criminal offenses.

(3) V.T.I.C. Article 5.48-1 refers to a person who intentionally performs an act "prohibited or declared to be unlawful" by certain provisions of this code. The reference to "declared to be unlawful" is omitted from the revised law because "declared to be unlawful" is included within the meaning of "prohibited."

(4) V.T.I.C. Article 5.48-1 states that an offense under that article is punishable by a fine. The revised law adds a statement that the offense is a "misdemeanor" to conform to the way offenses are described by the Penal Code.

Revised Law

Sec. 2001.008. IMMUNITY FROM PROSECUTION. (a) A person is not excused from giving testimony or producing evidence when

legally required at the trial of another person charged with violating a law relating to fire insurance on the ground that the testimony or evidence may incriminate the person under the laws of this state.

(b) A person may not be prosecuted or subjected to a penalty or forfeiture for or because of a transaction, matter, or thing about which the person testifies or produces evidence under this section. (V.T.I.C. Art. 5.48-2.)

Source Law

> Art. 5.48-2. No person shall be excused from giving testimony or producing evidence when legally called upon to do so at the trial of another charged with violating any provision of the laws relating to fire insurance on the ground that it may incriminate him under the laws of this State; but no person shall 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 under this law.

Revised Law

Sec. 2001.009. LIMITATION ON COMPENSATION AND EXPENSES. The total amount of necessary compensation for experts, clerical personnel, and other department employees and necessary expenses, including travel expenses, incurred by the department in implementing the laws described by Section 2001.001(a) may not exceed the amount of the assessments on the gross premiums of all fire insurance companies engaged in the business of insurance in this state. (V.T.I.C. Art. 5.51 (part).)

Source Law

> Art. 5.51. The necessary compensation of experts, clerical force, and other persons employed by said Board, and all necessary traveling expenses, and such other expenses as may be necessary, incurred in carrying out the provisions of this subchapter, [shall be paid by warrants drawn by the Comptroller upon the order of said Board.] The total amount of all salaries and said other expenses shall not exceed the sum produced by the assessments on the gross premiums of all fire insurance companies doing business in this State.

Revisor's Note

V.T.I.C. Article 5.51 provides that the necessary compensation and expenses incurred by the Texas

Department of Insurance in implementing Subchapter C, V.T.I.C. Chapter 5, shall be paid by warrants drawn by the comptroller on the order of the department. The revised law omits that provision 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. The omitted law reads:

> Art. 5.51. [The necessary compensation of experts, clerical force, and other persons employed by said Board, and all necessary traveling expenses, and such other expenses as may be necessary, incurred in carrying out the provisions of this subchapter,] shall be paid by warrants drawn by the Comptroller upon the order of said Board. . . .

Revised Law

Sec. 2001.010. PUBLIC GUIDE RELATING TO COMMERCIAL PROPERTY RATING. (a) In this section, "rating agency" means a public or private legal entity that is authorized to conduct commercial property rating in this state.

(b) The commissioner shall make available to the public a generalized guide that:

(1) summarizes the procedures used by the department or other rating agency to rate nonresidential commercial buildings in this state; and

(2) specifies how different construction elements and techniques used in a building project affect the insurance rating of the completed building.

(c) The commissioner may charge a reasonable fee to cover the administrative costs of producing and distributing the guide.

(d) The commissioner shall review the information in the guide in January of each odd-numbered year and shall revise the guide as necessary to incorporate any changes that have occurred in the preceding biennium that affect the information. (V.T.I.C. Art. 5.25-1.)

Source Law

Art. 5.25-1. (a) The commissioner shall make available to the public a generalized guide that:

(1) summarizes the procedures used by the department or other rating agency to rate nonresidential commercial buildings in this state; and

(2) specifies how different construction elements and techniques used in a building project affect the insurance rating of the completed building.

(b) The commissioner may charge a reasonable fee to cover the administrative costs of producing and distributing the guide.

(c) The commissioner shall review the information in the guide in January of each odd-numbered year and shall revise the guide as necessary to incorporate any changes that have occurred in the preceding biennium that affect the information.

(d) For purposes of this article, "rating agency" means a public or private legal entity that is authorized to conduct commercial property rating in this state.

Revisor's Note
(End of Chapter)

(1) V.T.I.C. Article 5.42 provides in part that an insurance policy "heretofore issued" that provides that the policy is void if premiums are not paid before a date specified by the policy is in effect if the insurer or an agent of the insurer accepted the premium on the policy after that specified date. That article was derived without substantive change from Chapter 106, General Laws, Acts of the 33rd Legislature, Regular Session, 1913, which took effect July 2, 1913. Therefore, that provision applies only to policies that were issued before July 2, 1913, and that remain in effect. According to the Texas Department of Insurance, there are no policies described by Article 5.42 that remain in effect. For that reason, the revised law omits that provision as obsolete. The omitted law reads:

> Art. 5.42. . . . All policies heretofore issued which provide that said policies shall be void for non-payment of premiums at a certain specified time, shall be and the same are in full force and effect, provided, that the company or any of its agents have accepted the premium on said policies after the expiration of the dates

named in said provisions fixing the date of payment.

(2) V.T.I.C. Article 5.47 provides that if an insurer violates Subchapter C, V.T.I.C. Chapter 5, the commissioner of insurance shall, with the consent of the attorney general, cancel the insurer's certificate of authority to engage in the business of insurance in this state. Article 5.47 was derived without substantive change from Chapter 106, General Laws, Acts of the 33rd Legislature, Regular Session, 1913. That article is omitted from the revised law because it was impliedly repealed by Section 7, V.T.I.C. Article 1.10, which was enacted by Chapter 491, Acts of the 52nd Legislature, Regular Session, 1951. That section was revised in 1999 in relevant part as Section 82.051 of this code, which authorizes the commissioner of insurance to cancel or revoke an authorization if the holder of the authorization is found to be in violation of, or to have failed to comply with, this code or a rule of the commissioner, but which does not require the attorney general's consent to take that action. The omitted law reads:

> Art. 5.47. If any insurance company affected by the provisions of this subchapter shall violate any provision of this subchapter, the Board shall, by and with the consent of the Attorney General, cancel its certificate of authority to transact business in this State.

(3) V.T.I.C. Article 5.48 authorizes the commissioner of insurance, with the consent of the attorney general, to revoke the authorization of an insurer or an officer, agent, or other representative of the insurer if the commissioner determines that the insurer, officer, agent, or representative has violated Subchapter C, V.T.I.C. Chapter 5. In addition, that article provides that the revocation of an authorization under that article does not affect

the liability of the insurer, officer, agent, or representative for any other penalty provided by law. Finally, that article provides that an action, decision, or determination of the commissioner and the attorney general in a case under that article is subject to review by the courts of this state.

Article 5.48 was derived without substantive change from Chapter 106, General Laws, Acts of the 33rd Legislature, Regular Session, 1913. The parts of that article authorizing the commissioner, with the consent of the attorney general, to revoke an authorization are omitted from the revised law for the reason stated in Revisor's Note (2) to the end of this chapter. The revised law also omits the parts of the article providing for judicial review as duplicative of Subchapter D, Chapter 36, of this code, which provides for judicial review of an action, decision, or ruling of the commissioner. In addition, the revised law omits as unnecessary the part of Article 5.48 relating to the cumulative effect of that article. The omitted law reads:

> Art. 5.48. The Board, upon ascertaining that any insurance company or officer, agent or representative thereof, has violated any provision of this subchapter, may, at its discretion, and with the consent and approval of the Attorney General, revoke the certificate of authority of such company, officer, agent, or representative but such revocation of any certificate shall in no manner affect the liability of such company, officer, agent, or representative to the infliction of any other penalty provided by law. Any action, decision or determination of the Board and the Attorney General in such cases shall be subject to the review of the courts of this State as herein provided.

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CHAPTER 2002. POLICY PROVISIONS AND FORMS FOR FIRE INSURANCE AND ALLIED LINES, INCLUDING RESIDENTIAL PROPERTY INSURANCE

SUBCHAPTER A. POLICY PROVISIONS

Revised Law

Sec. 2002.001. ENDORSEMENTS REDUCING AMOUNT OF COVERAGE. An insurer may not use an endorsement to a policy form to which Article 5.35, Subchapter B, or Subchapter B, Chapter 2301, applies that reduces the amount of coverage that would otherwise be provided under the policy unless:

(1) the insured requests the endorsement; or

(2) the insurer provides the policyholder with a

written explanation of the change made by the endorsement before the effective date of the change. (V.T.I.C. Art. 5.36.)

Source Law

> Art. 5.36. An insurer may not use an endorsement to a policy form to which Article 5.35 of this code or Article 5.145 of this code applies that reduces the amount of coverage, unless requested by the insured, that would otherwise be provided under the policy unless the insurer provides the policyholder with a written explanation of the change made by the endorsement before the effective date of the change.

Revised Law

Sec. 2002.002. LIEN ON INSURED PROPERTY. A provision in an insurance policy issued by an insurer subject to this subtitle or Subchapter C, Chapter 5, is void if the provision states that the encumbrance of the insured property by a lien of any character at the time of or after the policy's issuance renders the policy void. (V.T.I.C. Art. 5.37.)

Source Law

> Art. 5.37. Any provision in any policy of insurance issued by any company subject to the provisions of this subchapter to the effect that if said property is encumbered by a lien of any character or shall after the issuance of such policy become encumbered by a lien of any character, then such encumbrance shall render such policy void, shall be of no force and effect. Any such provision within or placed upon any such policy shall be null and void.

Revisor's Note

(1) V.T.I.C. Article 5.37 refers to "this subchapter," meaning Subchapter C, V.T.I.C. Chapter 5. Portions of that subchapter have been revised in various titles of this code. The relevant provisions of Subchapter C, Chapter 5, that are revised are revised in Subtitle D, Title 10, of this code, which includes this chapter. For that reason, the revised law substitutes a reference to "this subtitle or Subchapter C, Chapter 5," for references to "this subchapter" throughout this chapter.

(2) V.T.I.C. Article 5.37 provides that certain provisions in an insurance policy "shall be of no force

and effect" and "shall be null and void." Throughout this subchapter, the revised law omits "shall be of no force and effect," "shall be null," and similar phrases because those phrases are included in the meaning of "is void."

Revised Law

Sec. 2002.003. COVERAGES FOR SPOUSES AND FORMER SPOUSES. A homeowners insurance policy or fire insurance policy promulgated under Article 5.35 or filed and in effect as provided by Subchapter B, Chapter 2301, may not be delivered, issued for delivery, or renewed in this state unless the policy contains the following language: "It is understood and agreed that this policy, subject to all other terms and conditions contained in this policy, when covering residential community property, as defined by state law, shall remain in full force and effect as to the interest of each spouse covered, irrespective of divorce or change of ownership between the spouses unless excluded by endorsement attached to this policy until the expiration of the policy or until canceled in accordance with the terms and conditions of this policy." (V.T.I.C. Art. 5.35-1.)

Source Law

Art. 5.35-1. A homeowner's policy or fire policy promulgated under Article 5.35 of this code or filed and in effect as provided by Article 5.145 of this code may not be delivered, issued for delivery, or renewed in this state unless the policy contains the following language: "It is understood and agreed that this policy, subject to all other terms and conditions contained in this policy, when covering residential community property, as defined by state law, shall remain in full force and effect as to the interest of each spouse covered, irrespective of divorce or change of ownership between the spouses unless excluded by endorsement attached to this policy until the expiration of the policy or until canceled in accordance with the terms and conditions of this policy."

Revised Law

Sec. 2002.004. JEWELRY COVERAGE. (a) In this section, "personal property insurance" means insurance against damage to or loss of tangible personal property, including coverage provided in

a homeowners insurance policy, residential fire and allied lines insurance policy, or farm and ranch owners insurance policy.

(b) This section applies to each insurer that provides personal property insurance in this state, including a county mutual insurance company, farm mutual insurance company, Lloyd's plan, and reciprocal or interinsurance exchange.

(c) An insurer that provides personal property insurance coverage in this state for jewelry may elect to pay either:

(1) the stated value of the jewelry item; or

(2) the actual cost of replacing the jewelry item with one of like kind and quality. (V.T.I.C. Art. 5.35-2.)

Source Law

Art. 5.35-2

Sec. 1. In this article, "personal property insurance" means insurance against damage to or loss of tangible personal property, including coverage provided in a homeowners policy, residential fire and allied lines policy, or farm and ranch owners policy.

Sec. 2. This article applies to each insurer that provides personal property insurance in this state, including a county mutual insurer, farm mutual insurer, Lloyd's plan, or reciprocal or interinsurance exchange.

Sec. 3. An insurer that provides personal property insurance coverage in this state for jewelry will have the option to elect either to pay the stated value or actual replacement of the jewelry item with one of like kind and quality.

Revised Law

Sec. 2002.005. COINSURANCE CLAUSES. (a) Except as otherwise provided by this section, an insurer subject to this subtitle or Subchapter C, Chapter 5, may not issue an insurance policy or contract covering property in this state that contains a clause that:

(1) requires the insured to obtain or maintain a larger amount of insurance than expressed in the policy or contract; or

(2) in any way provides that the insured is liable as a coinsurer with the insurer issuing the policy or contract for any part of the loss or damage that may be caused by fire to the property described in the policy or contract.

(b) A clause described by Subsection (a) is void.

(c) A coinsurance clause may be included in an insurance policy written on cotton, grain, or other products in the process of marketing, shipping, storing, or manufacturing.

(d) An insured may be given an option to accept an insurance policy or contract that contains a clause described by Subsection (a) covering a class of property other than the property described by Subsection (c), a private dwelling, or a stock of merchandise offered for sale at retail that has a value of less than $10,000, if the insured is allowed a reduction in the premium rate for the policy or contract. A clause to which this subsection applies is valid and binding. The commissioner may promulgate the premium rates that apply to a coinsurance clause under this subsection.

(e) The commissioner by order may authorize or require the use of any form of coinsurance clause in connection with an insurance policy that insures against the hazards of tornado, windstorm, and hail on any class of property. The commissioner may adopt rules with reference to:

(1) coinsurance clauses authorized or required by this subsection and the use of those clauses; and

(2) credits in premium rates for the use of coinsurance clauses authorized or required by this subsection. (V.T.I.C. Art. 5.38.)

Source Law

Art. 5.38. No company subject to the provisions of this subchapter may issue any policy or contract of insurance covering property in this State, which shall contain any clause or provision requiring the assured to take out or maintain a larger amount of insurance than expressed in such policy, nor in any way providing that the assured shall be liable as a co-insurer with the company issuing the policy for any part of the loss or damage which may be caused by fire to the property described in such policy, and any such clause or provisions, except as herein provided, shall be null and void, and of no effect; provided, co-insurance clauses and provisions may be inserted in policies written upon cotton, grain, or other products in process of marketing, shipping, storing or manufacturing.

Provided, further, it shall be optional with an insured to accept a policy or contract of insurance containing such clause or provision covering other

classes of property, except private dwellings, and except stocks of merchandise offered for sale at retail when of a value less than Ten Thousand ($10,000.00) Dollars, when a reduction in the rate is allowed for such policy, and said clause in such policy shall be valid and binding; and the Board of Insurance Commissioners shall have power to name the rates to apply when such co-insurance clause or provision shall be used.

Provided, further, that by appropriate order the Board of Insurance Commissioners may authorize, and in its discretion require the use of any form of co-insurance clauses on or in connection with insurance policies covering against the hazards of tornado, windstorm and hail, on any or all classes of property; the Board to make such rules and regulations with reference to such clauses and the use thereof, as well as credits in premium rates for the use thereof on policies covering against the hazards mentioned as it may deem proper.

Revisor's Note

(1) V.T.I.C. Article 5.38 refers to a "clause or provision" of an insurance policy or contract. The revised law omits "provision" because, in this context, "provision" is included in the meaning of "clause."

(2) V.T.I.C. Article 5.38 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. Throughout this chapter, references to the Board of Insurance Commissioners or the "Board" have been changed appropriately.

(3) V.T.I.C. Article 5.38 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. 2002.006. PROVISIONS GOVERNING CERTAIN CONDITIONS OR RISKS. (a) This chapter; Sections 403.002, 2001.001-2001.006, 2001.009, and 2001.010; Subchapter H, Chapter 544; Subchapter D, Chapter 1806; Chapters 2003, 2004, 2006, and 2171; and Articles 5.25, 5.25A, 5.25-3, 5.26, 5.27, 5.28, 5.29, 5.30, 5.31, 5.32, 5.34, 5.35, 5.39, 5.40, and 5.41 govern the following in the same manner and to the same extent those provisions govern fire insurance and fire insurance rates:

(1) insurance coverage for any of the following conditions or risks:

(A) weather or climatic conditions, including lightning, tornado, windstorm, hail, cyclone, rain, or frost and freeze;

(B) earthquake or volcanic eruption;

(C) smoke or smudge;

(D) excess or deficiency of moisture;

(E) flood;

(F) the rising water of an ocean or an ocean's tributary;

(G) bombardment, invasion, insurrection, riot, civil war or commotion, military or usurped power, or any order of a civil authority made to prevent the spread of a conflagration, epidemic or catastrophe;

(H) vandalism or malicious mischief;

(I) strike or lockout;

(J) explosion, as provided by Subsection (b);

(K) water or other fluid or substance resulting from:

(i) the breakage or leakage of a sprinkler, pump, or other apparatus erected for extinguishing fire, or a water pipe or other conduit or container; or

(ii) casual water entering a building

through a leak or opening in the building or by seepage through building walls; or

(L) accidental damage to a sprinkler, pump, fire apparatus, pipe, or other conduit or container described by Paragraph (K)(i);

(2) premium rates in this state for the insurance described by Subdivision (1); and

(3) all matters pertaining to the insurance described by Subdivision (1), except as provided by this section with respect to marine insurance as defined by Section 1807.001.

(b) In this section:

(1) "explosion" includes:

(A) the explosion of a pressure vessel, other than a steam boiler of more than 15 pounds pressure, in a building designed and used solely for residential purposes by not more than four families;

(B) an explosion of any kind originating outside of an insured building or outside of the building containing the insured property;

(C) the explosion of a pressure vessel that does not contain steam or that is not operated with steam coils or steam jets; and

(D) an electric disturbance causing or concomitant with an explosion in public service or public utility property; and

(2) insurance coverage for explosion does not include coverage for loss of or damage to any property of the insured resulting from the explosion of or injury to:

(A) a boiler, heater, or other fired pressure vessel;

(B) an unfired pressure vessel;

(C) a pipe or container connected with a boiler or vessel described by Paragraph (A) or (B);

(D) an engine, turbine, compressor, pump, or

wheel;

(E) an apparatus generating, transmitting, or using electricity; or

(F) any other machinery or apparatus connected with or operated by a boiler, vessel, or machine described by Paragraphs (A)-(E).

(c) This section does not apply to:

(1) a farm mutual insurance company operating under Chapter 911;

(2) a county mutual insurance company operating under Chapter 912;

(3) a mutual insurance company engaged in business under Chapter 12, Title 78, Revised Statutes, before that chapter's repeal by Section 18, Chapter 40, Acts of the 41st Legislature, 1st Called Session, 1929, as amended by Section 1, Chapter 60, General Laws, Acts of the 41st Legislature, 2nd Called Session, 1929, that retains the rights and privileges under the repealed law to the extent provided by those sections;

(4) the making of inspections or issuance of certificates of inspections on a boiler, apparatus, or machinery described by Subsection (b)(2), whether insured or otherwise; or

(5) the insurance of a vessel or craft, its cargo, marine builder's risk, marine protection and indemnity, or another risk commonly insured under a marine insurance policy, as distinguished from an inland marine insurance policy. (V.T.I.C. Art. 5.52, Secs. (a), (c); Art. 5.53 (part); Art. 5.54 (part).)

Source Law

Art. 5.52. (a) The writing of insurance against loss by 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, 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, or resulting from casual water entering through leaks or openings in buildings, or by seepage through building walls, including insurance against accidental injury of such sprinklers, pumps, fire apparatus, conduits or containers, and the rates to be collected therefor in this State, and all matters pertaining to such insurance except as hereinafter set out as to marine insurance as defined by Article 5.53 of this code, shall be governed and controlled by the provisions of Articles 5.25 to 5.48, inclusive, and also Articles 5.50 to 5.51, inclusive, of this subchapter and Article 5.67 of Subchapter D of this Chapter, in the same manner and to the same extent as fire insurance and fire insurance rates are now affected by the provisions of said articles of this code.

(c) The term "explosion" as used in this article shall not include insurance against loss of or damage to any property of the insured, resulting from the explosion of or injury to (a) any boiler, heater, or other fired pressure vessel; (b) any unfired pressure vessel; (c) pipes or containers connected with any of said boilers or vessels; (d) any engine, turbine, compressor, pump, or wheel; (e) any apparatus generating, transmitting or using electricity; (f) any other machinery or apparatus connected with or operating by any of the previously named boilers, vessels or machines; nor shall same include the making of inspections and issuance of certificates of inspections upon any such boiler, apparatus or machinery, whether insured or otherwise. Said term shall include, but shall not be limited to (1) the explosion of pressure vessels (except steam boilers of more than fifteen pounds pressure) in buildings designed and used solely for residential purposes by not more than four (4) families; (2) explosion of any kind originating outside of the insured buildings or outside of the building containing the property insured; (3) explosion of pressure vessels which do not contain steam or which are not operated with steam coils or steam jets; (4) electric disturbance causing or concomitant with an explosion in public service or public utility property.

Art. 5.53. . . . None of the terms contained in Article 5.52 shall be deemed to include insurance of vessels or craft, their cargoes, marine builder's risk, marine protection and indemnity, or other risk commonly insured under marine as distinguished from inland marine insurance policies. . . .

Art. 5.54. Nothing in Articles [5.49,] 5.52 and [5.53] of this subchapter shall ever be construed to apply to any farm mutual insurance company operating under Chapter 16 of this Code or to any company now operating under Chapter 12, of Title 78, which has heretofore been repealed. Nothing in Articles 5.52 and [5.53] of this subchapter shall ever be construed to apply to any county mutual insurance company operating under Chapter 17 of this Code.

Revisor's Note

(1) Section (a), V.T.I.C. Article 5.52, refers to the "writing of insurance against loss by"

specified occurrences. For drafting convenience and consistency throughout this code, the revised law substitutes "insurance coverage for any of the following conditions or risks" for the quoted language.

(2) Section (a), V.T.I.C. Article 5.52, provides that V.T.I.C. "Articles 5.25 to 5.48, inclusive, and also Articles 5.50 to 5.51, inclusive, . . . and Article 5.67" govern certain kinds of insurance coverage, including premium rates for that insurance, in the same manner and to the same extent those provisions govern fire insurance and fire insurance rates. Included in those articles are V.T.I.C. Articles 5.43-1, 5.43-2, and 5.43-3, V.T.I.C. Article 5.43-4, which was revised in 1999 as Chapter 2154, Occupations Code, V.T.I.C. Article 5.44, which was revised in 1987 as Section 417.008, Government Code, and V.T.I.C. Article 5.67, revised in this code as Section 2051.051. The revised law does not reference those provisions because they do not govern fire insurance or fire insurance rates.

(3) Section (a), V.T.I.C. Article 5.52, provides that the writing of insurance against certain risks is "governed and controlled" by specified laws. The revised law omits the reference to "controlled" because "controlled" is included in the meaning of "governed."

(4) Section (b), V.T.I.C. Article 5.52, provides that rain insurance and hail insurance on farm crops are governed by V.T.I.C. Article 5.13-2. The revised law omits this provision as unnecessary. Sections 2(a)(12) and (13), V.T.I.C. Article 5.13-2, revised as Sections 2251.003(b)(12) and (13) and 2301.003(b)(12) and (13) of this code, apply to all of

the kinds of insurance described by Section (a), V.T.I.C. Article 5.52, including rain insurance and hail insurance on farm crops, and it is unnecessary to repeat that in this chapter. The omitted law reads:

> (b) Notwithstanding Subsection (a) of this section, rain insurance and hail insurance on farm crops are governed by Article 5.13-2 of this code.

(5) Section (c), V.T.I.C. Article 5.52, refers to "include, but shall not be limited to." "[B]ut shall not be limited to" is omitted as unnecessary because Section 311.005(13), Government Code (Code Construction Act), and Section 312.011(19), Government Code, applicable to the revised law, 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.

[Sections 2002.007-2002.050 reserved for expansion]

SUBCHAPTER B. POLICY FORMS

Revised Law

Sec. 2002.051. POLICY FORMS AND ENDORSEMENTS FOR RESIDENTIAL PROPERTY INSURANCE. Notwithstanding Subsections (a)-(j), Article 5.35, policy forms and endorsements for residential property insurance in this state are regulated under Subchapter A, Chapter 2301, and Article 5.13-2. (V.T.I.C. Art. 5.35, Sec. (k)(1), as added Acts 78th Leg., R.S., Ch. 206.)

Source Law

> (k)(1) Notwithstanding Subsections (a)-(j) of this article, policy forms and endorsements for residential property insurance in this state are regulated under Article 5.13-2 of this code.

Revised Law

Sec. 2002.052. APPLICABILITY OF OTHER LAW TO RESIDENTIAL PROPERTY INSURANCE. An insurer may continue to use a policy form or endorsement promulgated, approved, or adopted by the commissioner under Article 5.35 before June 11, 2003, on

notification in writing to the commissioner that the insurer will continue to use the policy form or endorsement. (V.T.I.C. Art. 5.35, Sec. (k)(2), as added Acts 78th Leg., R.S., Ch. 206.)

Source Law

(2) An insurer may continue to use the policy forms and endorsements promulgated, approved, or adopted by the commissioner under this article before the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003, on notification in writing to the commissioner that the insurer will continue to use the policy forms and endorsements promulgated, approved, or adopted by the commissioner under this article.

Revisor's Note

Section (k)(2), V.T.I.C. Article 5.35, as added by Chapter 206, Acts of the 78th Legislature, Regular Session, 2003, refers to policy forms and endorsements promulgated, approved, or adopted under V.T.I.C. Article 5.35 "before the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003." That act took effect June 11, 2003. The revised law substitutes that date for the quoted language.

[Sections 2002.053-2002.100 reserved for expansion]

SUBCHAPTER C. ITEMS PROVIDED TO POLICYHOLDER IN CONNECTION WITH INSURANCE POLICY

Revised Law

Sec. 2002.101. RATE ANALYSIS. (a) On issuing a fire insurance policy, an insurer engaged in the business of fire insurance in this state shall provide the policyholder with a written analysis of the rate or premium charged for the policy showing the items of charge and credit that determine the rate or premium.

(b) Subsection (a) does not apply if the insurer has previously provided the policyholder with an analysis of the rate or premium. (V.T.I.C. Art. 5.30, Sec. (a) (part).)

Source Law

Art. 5.30. (a) When a policy of fire insurance shall be issued by any company transacting the business of fire insurance in this State, such company

shall furnish the policyholder with a written or printed analysis of the rate or premium charged for such policy, showing the items of charge and credit which determine the rate, unless such policyholder has theretofore been furnished with such analysis of such rate. . . .

Revisor's Note

Section (a), V.T.I.C. Article 5.30, refers to a "written or printed" analysis. The revised law omits the reference to "printed" because "printed" is included in the meaning of "written."

Revised Law

Sec. 2002.102. NOTICE OF RENEWAL. (a) An insurer, including a farm mutual insurance company, county mutual insurance company, Lloyd's plan, or reciprocal or interinsurance exchange, that renews a homeowners insurance policy, fire and residential allied lines insurance policy, farm and ranch owners insurance policy, or farm and ranch insurance policy must provide the policyholder with written notice of any difference between each form of the policy offered to the policyholder on renewal and the form of the policy held immediately before renewal.

(b) A notice provided under this section must be written in plain language.

(c) The commissioner may adopt rules as necessary to implement this section. (V.T.I.C. Art. 5.45.)

Source Law

Art. 5.45. (a) An insurer, including a farm mutual insurance company, county mutual insurance company, Lloyd's plan, or reciprocal or interinsurance exchange, that renews a policy of homeowners insurance, fire and residential allied lines insurance, farm and ranch owners insurance, or farm and ranch insurance must provide the policy holder with written notice of any difference in each form of the policy offered to the policy holder on renewal and the form of the policy held immediately before renewal.

(b) A notice provided under this article must be written in plain language.

(c) The commissioner may adopt rules as necessary to implement this article.

CHAPTER 2003. PROCEDURES FOR EVALUATING FIRE LOSS RISK

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CHAPTER 2003. PROCEDURES FOR EVALUATING FIRE LOSS RISK
SUBCHAPTER A. EVALUATING FIRE LOSS RISK

Revised Law

Sec. 2003.001. FIRE LOSS INFORMATION. (a) The department shall ascertain as soon as practicable the annual fire loss in this state.

(b) The department shall, in a manner that will aid in determining equitable insurance rates and methods to reduce annual fire loss and insurance rates of this state or subdivisions of this

state:

(1) obtain, make, and maintain records regarding the annual fire loss in this state; and

(2) collect data concerning the annual fire loss as necessary to enable the department to classify:

(A) fire losses in this state;

(B) the causes of those fire losses;

(C) the amount of the premiums collected for fire loss for each class of risk; and

(D) the amount paid for the fire losses.

(c) The commissioner may designate one or more advisory organizations or other agencies to gather, audit, and compile the fire loss experience of insurers. The insurers shall bear the costs incurred under this subsection.

(d) To implement this section, the department may:

(1) employ clerical personnel, inspectors, experts, and other assistants; and

(2) incur other necessary expenses. (V.T.I.C. Art. 5.25, Sec. (a) (part).)

Source Law

> Art. 5.25. (a) [The State Board of Insurance . . . .] Said Board shall have authority to employ clerical help, inspectors, experts and other assistants, and to incur such other expenses as may be necessary in carrying out the provisions of this law. Said Board shall ascertain as soon as practicable the annual fire loss in this State; obtain, make and maintain a record thereof and collect such data with respect thereto as will enable said Board to classify the fire losses of this State, the causes thereof, and the amount of premiums collected therefor for each class of risks and the amount paid thereon, in such manner as will aid in determining equitable insurance rates, methods of reducing such fire losses and reducing the insurance rates of the State, or subdivisions of the State. The Board may designate one or more advisory organizations or other agencies to gather, audit, and compile such experience of insurers, and the cost thereof shall be borne by such insurers.

Revisor's Note

Section (a), V.T.I.C. Article 5.25, refers to the "State Board of Insurance." Chapter 685, Acts of the

73rd Legislature, Regular Session, 1993, abolished that board 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.

Revised Law

Sec. 2003.002. FIRE SUPPRESSION RATINGS FOR BORDER MUNICIPALITIES. In assigning or evaluating a fire suppression rating for a municipality at or near the border between this state and another state or the United Mexican States, the commissioner shall consider the existence and capabilities of a fire department or volunteer fire department that:

(1) serves an adjoining or nearby municipality in the other state or the United Mexican States; and

(2) by agreement or by long-standing practice provides fire suppression services to the municipality in this state. (V.T.I.C. Art. 5.25-3 (part).)

Source Law

> Art. 5.25-3. The commissioner, . . . in assigning or evaluating a fire suppression rating for a municipality at or near the border between this state and another state or the United Mexican States, shall take into account the existence and capabilities of a fire department or volunteer fire department that serves an adjoining or nearby municipality in the other state or the United Mexican States and that by agreement or by long-standing practice provides fire suppression services to the Texas municipality.

Revised Law

Sec. 2003.003. CREDIT FOR REDUCING FIRE HAZARD. The commissioner may give a locality, municipality, or other political subdivision credit for:

(1) each fire hazard that the locality, municipality, or other political subdivision reduces or removes;

(2) additional fire-fighting equipment, increased police protection, or any other equipment or improvement that tends to reduce the fire hazard of the locality, municipality, or other

political subdivision; and

(3) a good fire record made by the locality, municipality, or other political subdivision. (V.T.I.C. Art. 5.33, Sec. (a).)

Source Law

Art. 5.33. (a) The commissioner may give each city, town, village, locality, or other political subdivision credit for each and every hazard they may reduce or entirely remove, and also for all added fire fighting equipment, increased police protection, or any other equipment or improvement that has a tendency to reduce the fire hazard of any such city, town, village, locality, or other political subdivision, and also to give credit for a good fire record made by any city, town, village, locality, or other political subdivision.

Revisor's Note

(1) Section (a), V.T.I.C. Article 5.33, refers to a "city, town, [or] village." The revised law substitutes "municipality" for "city, town, [or] village" because that is the term used in the Local Government Code.

(2) Section (a), V.T.I.C. Article 5.33, states that the commissioner of insurance may give credit for a fire hazard that a locality, municipality, or other political subdivision may "entirely remove." The revised law omits the term "entirely" because to "remove" something means to "entirely remove" it.

Revised Law

Sec. 2003.004. POLICYHOLDER CREDIT FOR REDUCING HAZARD. (a) The commissioner may require an insurer to give credit to a policyholder for a hazard that the policyholder reduces or removes.

(b) For purposes of this section, the following actions constitute a reduction in hazard by a policyholder:

(1) the installation of a new standard fire hydrant approved by the department within the required distance of a risk, as prescribed by the department; or

(2) the use of compressed air foam technology in

fire-fighting equipment.

(c) The insurer shall give credit in the proportion that the hazard is reduced or removed and shall refund to the policyholder the proportional part of the unearned premium charged for the hazard that is reduced or removed. (V.T.I.C. Art. 5.33, Secs. (b), (c), (d).)

Source Law

> (b) The commissioner may also compel any company to give any or all policy holders credit for any and all hazards said policy holder or holders may reduce or remove.
>
> (c) For the purposes of this Article, the installation of a new standard fire hydrant approved by the department within the required distance of a risk, as prescribed by the department, or the use of compressed air foam technology in fire-fighting equipment shall constitute a reduction in hazard by the policy holder or holders.
>
> (d) Said credit shall be in proportion to such reduction or removal of such hazard and said company or companies shall return to such policy holder or holders such proportional part of the unearned premium charged for such hazard that may be reduced or removed.

[Sections 2003.005-2003.050 reserved for expansion]

SUBCHAPTER B. MUNICIPAL FIRE LOSS LISTS

Revised Law

Sec. 2003.051. ANNUAL LIST OF INSURED FIRE LOSSES BY MUNICIPALITY. (a) The department shall compile for each municipality in this state a list for distribution to the municipality of the insured fire and lightning losses that:

(1) exceed $100; and

(2) are paid in the municipality for the preceding statistical year under policy forms:

(A) adopted or approved by the commissioner and authorized for use by Section 2301.052(b); or

(B) filed and in effect as provided by Section 2301.052(a).

(b) Each list must include:

(1) the name of each person recovering a loss under a policy form described by Subsection (a);

(2) the address or location where the loss occurred;

and

(3) the amount paid by the insurer on the loss.

(c) The department shall develop each list from information obtained from insurer reports of individual losses during the statistical year. (V.T.I.C. Art. 5.25-2, Secs. 1, 2.)

Source Law

Art. 5.25-2

Sec. 1. In this article, "list" means the list of fire and lightning losses in excess of $100 paid under policy forms adopted or approved by the commissioner under Article 5.35 of this code or filed and in effect as provided by Article 5.145 of this code in a particular city or town prepared by the department for distribution to the city or town.

Sec. 2. (a) The department shall compile for each city or town in Texas a list of the insured fire losses paid under policy forms adopted or approved by the commissioner under Article 5.35 of this code or filed and in effect as provided by Article 5.145 of this code in that city or town for the preceding statistical year.

(b) The list shall include:

(1) the names of persons recovering losses under policy forms adopted or approved by the commissioner under Article 5.35 of this code or filed and in effect as provided by Article 5.145 of this code;

(2) the addresses or locations where the losses occurred; and

(3) the amount paid by the insurance company on each loss.

(c) The department shall obtain the information to make the lists from insurance company reports of individual losses during the statistical year.

Revisor's Note

(1) Sections 1 and 2, V.T.I.C. Article 5.25-2, refer to "policy forms adopted or approved by the commissioner under Article 5.35 of this code or filed and in effect as provided by Article 5.145 of this code." Under V.T.I.C. Article 5.35, policy forms for fire and allied lines insurance were adopted or approved by the commissioner of insurance. The 78th Legislature enacted Chapter 206, Acts of the 78th Legislature, Regular Session, 2003, which became effective June 11, 2003. Section 21.22 of that act amended Article 5.35 to provide that policy forms for residential property insurance, including fire and

allied lines insurance, are now regulated under V.T.I.C. Article 5.13-2. However, under Section 2(b), V.T.I.C. Article 5.145, enacted by Section 2.01 of Chapter 206, an insurer may continue to use policy forms previously promulgated, approved, or adopted under Article 5.35. For clarity and to fully reflect the changes made by Chapter 206, the revised law substitutes "adopted or approved by the commissioner and authorized for use by Section 2301.052(b)," the revision of Section 2(b), V.T.I.C. Article 5.145, for "policy forms adopted or approved by the commissioner under Article 5.35 of this code."

(2) Section 1, V.T.I.C. Article 5.25-2, refers to a "city or town." Throughout this subchapter, the revised law substitutes "municipality" for "city or town" because "municipality" is the term used in the Local Government Code.

Revised Law

Sec. 2003.052. MUNICIPALITY'S REQUEST FOR LIST; RETURN REPORT. (a) The department shall provide to a municipality a copy of the list compiled under Section 2003.051 for the municipality on the request of the municipality or the municipality's authorized agent or fire marshal.

(b) Each municipality shall investigate the information contained in the list to determine the losses actually occurring within the limits of the municipality. The municipality shall report to the department:

(1) a list of the losses that actually occurred within the limits of the municipality;

(2) a list of the losses that did not occur within the limits of the municipality; and

(3) other evidence essential to establishing the losses occurring in the municipality. (V.T.I.C. Art. 5.25-2, Secs. 3, 4.)

Source Law

Sec. 3. Upon the request of any city or town, or its duly authorized agent or fire marshall, the department shall provide that city and town with a copy of the list for its particular area.

Sec. 4. Each city or town shall investigate its list to determine the losses actually occurring in its limits and shall make a report to the department, which report shall include:

(1) a list of the losses that actually occurred in the limits of the city or town;

(2) a list of any losses not occurring in the limits of the city or town; and

(3) other evidence essential to establishing the losses in the city or town.

Revisor's Note

Section 3, V.T.I.C. Article 5.25-2, refers to a request made by the "duly authorized agent or fire marshall" of a municipality. The revised law omits "duly" because the requirement that an agent be authorized is sufficient to ensure that the agent has proper authority to make the request.

Revised Law

Sec. 2003.053. LIST CORRECTIONS; USE. The department shall:

(1) make changes that the department considers appropriate to correct the list compiled under Section 2003.051 for a municipality; and

(2) use the corrected list to determine the fire record credit or debit for the municipality for the next year. (V.T.I.C. Art. 5.25-2, Sec. 5.)

Source Law

Sec. 5. The department shall make such changes or corrections as to it shall seem appropriate in order to correct the list of insured fire and lightning losses paid under policy forms adopted or approved by the commissioner under Article 5.35 of this code or filed and in effect as provided by Article 5.145 of this code in a particular city or town and said list of losses, as changed or corrected, shall be used to determine the fire record credit or debit for each particular city or town for the next year.

Revised Law

Sec. 2003.054. CHARGE FOR LIST AND FIRE RECORD SYSTEM. The commissioner shall set and collect a charge for compiling and

providing a list under this subchapter and as the commissioner considers appropriate for administering the fire record system. (V.T.I.C. Art. 5.25-2, Sec. 6.)

Source Law

> Sec. 6. The commissioner shall set and collect a charge for compiling and providing a list of fire and lightning losses paid under policy forms adopted or approved by the commissioner under Article 5.35 of this code or filed and in effect as provided by Article 5.145 of this code in a particular city or town and as the commissioner shall deem appropriate to administer the fire record system.

Revised Law

Sec. 2003.055. DEPARTMENT AUTHORITY TO REQUIRE PROVISION OF FIRE LOSS INFORMATION. To accumulate statistical information for the control and prevention of fires, the department may require each municipality in this state and each insurer engaged in business in this state to provide to the department a complete and accurate report that lists all fire and lightning losses occurring in this state that are reflected in the municipality's or insurer's records. (V.T.I.C. Art. 5.25-2, Sec. 7.)

Source Law

> Sec. 7. The department is authorized to require each and every city or town in the State of Texas and each and every insurance company or carrier of every type and character whatsoever doing business in the State of Texas to furnish to it a complete and accurate list of all fire and lightning losses occurring within the State of Texas and reflected in their records for the purpose of accumulating statistical information for the control and prevention of fires.

Revised Law

Sec. 2003.056. DISCRETIONARY PROVISION OF LIST. The department is not required to provide a list compiled under this subchapter if the fire record system is not in effect. (V.T.I.C. Art. 5.25-2, Sec. 8.)

Source Law

> Sec. 8. The department may, at its discretion, furnish such list only during such time as the fire record system remains in force and effect.

Revisor's Note

Section 8, V.T.I.C. Article 5.25-2, states that

the Texas Department of Insurance has discretion to provide a list while the fire record system remains "in force and effect." The revised law omits "force" from the quoted language because "in force" is included in the meaning of "in effect."

[Sections 2003.057-2003.100 reserved for expansion]

SUBCHAPTER C. VOLUNTARY INSPECTION PROGRAM

Revised Law

Sec. 2003.101. DEFINITIONS. In this subchapter:

(1) "Inspection" means a physical inspection of property for which residential property insurance is sought.

(2) "Inspection certificate" means a certificate issued under this subchapter by an inspector indicating that the condition of property meets or exceeds minimum standards.

(3) "Inspector" means a person authorized by the commissioner to perform inspections under this subchapter.

(4) "Minimum standards" means the standards adopted by the commissioner by rule regarding the insurability of property under this subchapter.

(5) "Residential property insurance" means insurance against loss to real or tangible personal property at a fixed location that is provided though a homeowners insurance policy, a residential fire and allied lines insurance policy, or a farm and ranch owners insurance policy. (V.T.I.C. Art. 5.33B, Sec. 2.)

Source Law

Sec. 2. In this article:

(a) "Residential property insurance" means insurance against loss to real or tangible personal property at a fixed location provided in a homeowners policy, residential fire and allied lines policy, or farm and ranch owners policy.

(b) "Inspection" means a physical inspection of the property for which residential property insurance is sought.

(c) "Inspection certificate" means a certificate issued by an inspector pursuant to this article indicating that the condition of the property meets or exceeds minimum standards.

(d) "Minimum standards" are those standards for property condition insurability under this article as the commissioner shall determine by rule.

(e) "Inspector" means a person authorized by the commissioner to perform inspections under this article.

Revised Law

Sec. 2003.102. RIGHT TO VOLUNTARY INSPECTION OF PROPERTY CONDITION. A person with an insurable interest in real or tangible personal property at a fixed location who desires to purchase residential property insurance may obtain an independent inspection of the condition of the property by an inspector authorized to perform inspections under this subchapter. (V.T.I.C. Art. 5.33B, Sec. 1.)

Source Law

Art. 5.33B

Sec. 1. Any person having an insurable interest in real or tangible personal property at a fixed location who desires to purchase residential property insurance may procure an independent inspection of the condition of the property by an inspector authorized to perform inspections under this article of the property proposed to be insured.

Revised Law

Sec. 2003.103. PLAN OF OPERATION. (a) The commissioner shall adopt a plan of operation for the voluntary inspection program.

(b) The plan of operation must include rules and standards for the voluntary inspection program, including:

(1) the manner and scope of the inspections to be performed;

(2) the contents of the written evaluation report;

(3) the form of the inspection certificate to be issued;

(4) the term during which an inspection certificate is valid;

(5) rules for the certification or licensing of persons authorized to perform inspections under the program; and

(6) the fee that may be charged a person requesting an inspection under the program. (V.T.I.C. Art. 5.33B, Sec. 3(a) (part).)

Source Law

Sec. 3. (a) The commissioner shall adopt a plan of operation for the Voluntary Inspection Program. The plan of operation shall include rules and standards for the inspection program, including but not limited to the following:

(1) the manner and scope of the inspections to be performed;

(2) the contents of the written evaluation report;

(3) the form of the inspection certificate to be issued;

(4) the term during which an inspection certificate shall remain valid;

(5) rules for the certification and licensing of persons who are authorized to perform inspections under this program, . . . and

(6) the fee which may be charged to the person requesting the inspection.

Revisor's Note

Section 3(a), V.T.I.C. Article 5.33B, refers to rules and standards for the voluntary inspection program "including but not limited to" specified items. Throughout this subchapter, the revised law omits "but not limited to" and similar phrases because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, 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. 2003.104. ELIGIBLE INSPECTORS. Persons who may be certified or licensed to perform inspections under this subchapter include:

(1) a person licensed to perform real property inspections under Chapter 1102, Occupations Code; and

(2) a designated employee or agent of a county or municipality that chooses to establish a voluntary inspection program to inspect residential properties within the territorial limits of the county or municipality. (V.T.I.C. Art. 5.33B, Sec. 3(a) (part).)

Source Law

Sec. 3. (a) . . . [The plan of operation shall include] . . .

(5) [rules for the certification and licensing of persons who are authorized to perform inspections under this program,] which group shall include, but not be limited to:

(i) persons licensed to perform real property inspections under the Real Estate Licensing Act;

(ii) designated employees or agents of a county or municipality which elects to establish a voluntary inspection program to inspect properties for residential properties within the territorial limits of the county or municipality; . . . .

Revisor's Note

Section 3(a)(5), V.T.I.C. Article 5.33B, refers to persons licensed to perform inspections of real property under the "Real Estate Licensing Act," meaning Article 6573a, Vernon's Texas Civil Statutes. The relevant part of that act was codified in 2001 as Chapter 1102, Occupations Code, which took effect in 2003. For the convenience of the reader, the revised law substitutes a reference to Chapter 1102, Occupations Code.

Revised Law

Sec. 2003.105. PRESUMPTION OF INSURABILITY. (a) The existence of an inspection certificate issued under this subchapter creates a presumption that the condition of the property inspected is adequate for the issuance of residential property insurance.

(b) If an inspection certificate is used in whole or in part to determine insurability, an insurer may require as a condition of issuing a residential property insurance policy that the applicant for that insurance provide a written statement that there has not been a material or substantial change to the property condition since the date of the inspection certificate.

(c) An insurer who receives an inspection certificate may not use the condition of the property as grounds to refuse to issue or renew residential property insurance unless the insurer:

(1) reinspects the property; and

(2) specifies the areas of deficiency in the insurer's

declination letter. (V.T.I.C. Art. 5.33B, Sec. 4.)

Source Law

Sec. 4. (a) The existence of an inspection certificate issued under this article creates a presumption that the property condition is adequate for residential property insurance to be issued.

(b) As a condition of issuing a policy if an inspection certificate is used in whole or in part to determine insurability, an insurer may require a written statement by the applicant for residential property insurance stating that there have been no material or substantial changes to the property condition since the date of the inspection certificate.

(c) An insurer who receives an inspection certificate may not use property condition as grounds for refusing to issue or renew residential property insurance unless the insurer reinspects the property and specifies the areas of deficiency in its declination letter.

Revised Law

Sec. 2003.106. ENFORCEMENT. The commissioner by rule may provide for the use of any disciplinary procedure authorized by this code to:

(1) maintain the integrity of the voluntary inspection program; or

(2) ensure compliance with this subchapter. (V.T.I.C. Art. 5.33B, Sec. 5.)

Source Law

Sec. 5. The commissioner may by rule provide for the use of any of the disciplinary procedures authorized in this code to maintain the integrity of the program or ensure compliance with this article.

Revised Law

Sec. 2003.107. RULES. In addition to the plan of operation adopted under Section 2003.103, the commissioner may adopt rules that are appropriate to accomplish the purposes of this subchapter. (V.T.I.C. Art. 5.33B, Sec. 6.)

Source Law

Sec. 6. The commissioner is authorized to adopt rules in addition to the plan of operation that are appropriate to accomplish the purposes of this article.

Revisor's Note
(End of Subchapter)

Section 3(b), V.T.I.C. Article 5.33B, states that

the commissioner of insurance by rule may encourage the coordination of inspections under the article with inspections under V.T.I.C. Article 5.33A. The revised law omits this provision as impliedly repealed because Article 5.33A was repealed by Section 21.48, Chapter 206, Acts of the 78th Legislature, Regular Session, 2003. The omitted law reads:

> (b) The commissioner may adopt rules to encourage the coordination of inspections under this article with inspections performed under article 5.33A.

CHAPTER 2004. RESIDENTIAL PROPERTY INSURANCE IN UNDERSERVED AREAS


Sec. 2004.001. DEFINITION . . . . . 972

Sec. 2004.002. DESIGNATION OF UNDERSERVED AREAS . . . . . 972

Sec. 2004.003. AUTHORIZATION FOR ISSUANCE OF INSURANCE . . . . 973

Sec. 2004.004. EXCLUSION OF CERTAIN COVERAGE . . . . . 974

Sec. 2004.005. AVAILABILITY OF COVERAGE . . . . . 974

Sec. 2004.006. POLICY FORMS . . . . . 975

Sec. 2004.007. INAPPLICABILITY OF CERTAIN LAWS TO PREMIUMS . . . . . 975

Sec. 2004.008. RATES . . . . . 976


CHAPTER 2004. RESIDENTIAL PROPERTY INSURANCE IN UNDERSERVED AREAS

Revised Law

Sec. 2004.001. DEFINITION. In this chapter, "residential property insurance" means insurance against loss to real or tangible personal property at a fixed location that is provided through a homeowners insurance policy, residential fire and allied lines insurance policy, or farm and ranch owners insurance policy. (V.T.I.C. Art. 5.35-3, Sec. 1(a) (part).)

Source Law

> (a) . . . For purposes of this article, residential property insurance means insurance coverage against loss to real or tangible personal property at a fixed location provided in a homeowners policy, residential fire and allied lines policy, or farm and ranch owners policy.

Revised Law

Sec. 2004.002. DESIGNATION OF UNDERSERVED AREAS. (a) The

commissioner by rule may designate an area as an underserved area for residential property insurance.

(b) In determining which areas to designate as underserved, the commissioner shall consider:

(1) whether residential property insurance is not reasonably available to a substantial number of owners of insurable property in the area; and

(2) any other relevant factor as determined by the commissioner. (V.T.I.C. Art. 5.35-3, Sec. 1(a) (part).)

Source Law

Art. 5.35-3

Sec. 1. (a) By rule the commissioner may determine and designate areas as underserved areas for residential property insurance. In determining which areas will be designated as underserved, the commissioner shall consider whether residential property insurance is not reasonably available to a substantial number of owners of insurable property in the underserved area and any other relevant factors as determined by the commissioner. . . .

Revisor's Note

Section 1(a), V.T.I.C. Article 5.35-3, authorizes the commissioner of insurance to "determine and designate" underserved areas. The revised law omits the reference to "determine" because, in context, "determine" is included in the meaning of "designate."

Revised Law

Sec. 2004.003. AUTHORIZATION FOR ISSUANCE OF INSURANCE. An insurer authorized to write property or casualty insurance in this state, including a Lloyd's plan and a reciprocal or interinsurance exchange, that writes residential property insurance in this state may write that insurance on forms adopted under this chapter. (V.T.I.C. Art. 5.35-3, Sec. 2.)

Source Law

Sec. 2. All insurers authorized to write property or casualty insurance in this state and writing residential property insurance in this state, including those insurers licensed under Chapters 18 and 19 of this code, are authorized to write insurance on the forms adopted under this article.

Revisor's Note

Section 2, V.T.I.C. Article 5.35-3, refers to "insurers licensed under Chapters 18 and 19 of this code." Chapters 18 and 19 were codified in 2001 as Chapters 941 and 942 of this code, respectively. Chapters 941 and 942 provide for the authorization of Lloyd's plans and reciprocal and interinsurance exchanges to engage in business. For the convenience of the reader, the revised law substitutes a reference to those entities for the reference to Chapters 18 and 19.

Revised Law

Sec. 2004.004. EXCLUSION OF CERTAIN COVERAGE. Insurance provided under this chapter may not include windstorm and hail insurance coverage for a risk eligible for that coverage under Chapter 2210. (V.T.I.C. Art. 5.35-3, Sec. 1(b).)

Source Law

(b) The property protection program for underserved areas operated under this article may not include windstorm and hail insurance coverage for a risk eligible for that coverage under Article 21.49 of this code.

Revisor's Note

Section 1(b), V.T.I.C. Article 5.35-3, refers to the "property protection program for underserved areas operated under this article." The revised law substitutes a reference to "[i]nsurance provided under this chapter" because Article 5.35-3 does not contain any other reference to a "property protection program" and the substituted phrase is consistent with the terminology used in this chapter and in the law being revised.

Revised Law

Sec. 2004.005. AVAILABILITY OF COVERAGE. In a designated underserved area, each insurer described by Section 2004.003 shall provide to the insurer's agents, and the agents shall offer to all

insureds, the full range of coverages prescribed under this chapter subject to the insurer's applicable rates and underwriting guidelines. (V.T.I.C. Art. 5.35-3, Sec. 5.)

Source Law

> Sec. 5. In the designated underserved areas, all insurers specified in Section 2 of this article shall make available to their agents and all agents shall offer all insureds the full range of coverages promulgated under this article subject to the applicable rates and underwriting guidelines of each such insurer.

Revised Law

Sec. 2004.006. POLICY FORMS. (a) The commissioner shall adopt policy forms for residential property insurance that are specifically for use in designated underserved areas. The policy forms must include a basic policy covering fire and allied lines perils with endorsements providing additional coverage at the insured's option.

(b) An insurer writing insurance in an underserved area may use the policy forms adopted under this chapter. (V.T.I.C. Art. 5.35-3, Sec. 3.)

Source Law

> Sec. 3. The commissioner shall adopt policy forms for residential property insurance specifically for use in the designated underserved areas. The policy forms adopted pursuant to this article shall include a basic policy covering fire and allied lines perils with endorsements providing additional coverages at the option of the insured. The adopted policy forms may be used by all insurers writing insurance in underserved areas.

Revised Law

Sec. 2004.007. INAPPLICABILITY OF CERTAIN LAWS TO PREMIUMS. The premium for an insurance policy written under this chapter is not:

(1) subject to tax under Chapter 221; and

(2) considered net direct premiums under Section 2210.003(7). (V.T.I.C. Art. 5.35-3, Secs. 6, 7.)

Source Law

> Sec. 6. The premium on all policies written pursuant to this article will not be subject to tax under Article 4.10 of this code.

Sec. 7. The premium on all policies written pursuant to this article will not be considered net direct premiums under the provisions of Section 3(g), Article 21.49, of this code.

Revised Law

Sec. 2004.008. RATES. Rates for coverage provided under this chapter are determined according to the provisions of this code applicable to the insurer providing the coverage. (V.T.I.C. Art. 5.35-3, Sec. 4.)

Source Law

Sec. 4. The rates for residential property insurance subject to this article shall be determined in accordance with the provisions of this code applicable to each insurer.

CHAPTER 2005. HOME WARRANTY AND HOME PROTECTION INSURANCE

Sec. 2005.001. DEFINITIONS . . . . . 976
Sec. 2005.002. AUTHORIZATION TO WRITE CERTAIN INSURANCE . . . . . 977
Sec. 2005.003. MANNER OF REGULATION . . . . . 978
Sec. 2005.004. LIMITS OF COVERAGE . . . . . 978

CHAPTER 2005. HOME WARRANTY AND HOME PROTECTION INSURANCE

Revised Law

Sec. 2005.001. DEFINITIONS. In this chapter:

(1) "Home protection insurance" means coverage insuring a purchaser of a home protection service or product against actual property loss.

(2) "Home protection service or product" means a service or product used for the protection of residential property, including a service or product provided by a person regulated under Chapter 1702, Occupations Code.

(3) "Home warranty insurance" means coverage:

(A) insuring performance by a builder of residential property of the builder's warranty obligations to a purchaser of the residential property; or

(B) insuring against named defects arising from

failure of the builder to construct residential property in accordance with specified construction standards. (V.T.I.C. Art. 5.53-A, Sec. 2.)

Source Law

Sec. 2. In this article:

(1) "Home warranty insurance" means coverage insuring:

(A) performance by builders of residential property of their warranty obligations to purchasers of such property; or

(B) against named defects arising from failure of the builder to construct residential property in accordance with specified construction standards.

(2) "Home protection insurance" means coverage insuring purchasers of home protection services or products against actual property loss.

(3) "Home protection service or product" means a service or product used for the protection of residential property, including a service or product provided by a person regulated under the Private Investigators and Private Security Agencies Act (Article 4413(29bb), Vernon's Texas Civil Statutes).

Revisor's Note

Section 2(3), V.T.I.C. Article 5.53-A, refers to the Private Investigators and Private Security Agencies Act (Article 4413(29bb), Vernon's Texas Civil Statutes). That statute was codified in 1999 as Chapter 1702, Occupations Code. The revised law is drafted accordingly.

Revised Law

Sec. 2005.002. AUTHORIZATION TO WRITE CERTAIN INSURANCE. An insurer authorized to engage in the business of fire insurance and allied lines or inland marine insurance may write home warranty insurance or home protection insurance in this state. (V.T.I.C. Art. 5.53-A, Sec. 1(a).)

Source Law

Art. 5.53-A

Sec. 1. (a) Any company licensed to engage in the business of fire insurance and its allied lines, or inland marine insurance, or both, is authorized to write home warranty insurance or home protection insurance in this state.

Revisor's Note

Section 1(a), V.T.I.C. Article 5.53-A, refers to

an insurer "licensed" to engage in the business of fire insurance and allied lines or inland marine insurance. The revised law substitutes "authorized" for "licensed" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 2005.003. MANNER OF REGULATION. Home warranty insurance or home protection insurance is not inland marine insurance, but is governed in the same manner and to the same extent as inland marine insurance. (V.T.I.C. Art. 5.53-A, Sec. 1(b).)

Source Law

(b) Insurance subject to this article is not inland marine insurance, but shall be governed in the same manner and to the same extent as inland marine insurance.

Revisor's Note

Section 1(b), V.T.I.C. Article 5.53-A, refers to "[i]nsurance subject to this article." For clarity, the revised law substitutes "[h]ome warranty insurance or home protection insurance" for the quoted language because those are the kinds of insurance subject to Article 5.53-A, revised as this chapter.

Revised Law

Sec. 2005.004. LIMITS OF COVERAGE. The amount of coverage under a home protection insurance policy may not exceed $2,000 for any single occurrence. (V.T.I.C. Art. 5.53-A, Sec. 1(c).)

Source Law

(c) The amount of coverage under a policy of home protection insurance may not exceed $2,000 for any single occurrence.

CHAPTER 2006. PREMIUM RATE DISCOUNTS

SUBCHAPTER A. OPTIONAL PREMIUM DISCOUNT FOR USE OF INSULATING CONCRETE FORM SYSTEM

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CHAPTER 2006. PREMIUM RATE DISCOUNTS
SUBCHAPTER A. OPTIONAL PREMIUM DISCOUNT FOR USE OF INSULATING CONCRETE FORM SYSTEM

Revised Law

Sec. 2006.001. DEFINITIONS. In this subchapter:

(1) "Applicant" includes:

(A) an applicant for new insurance coverage; and

(B) a policyholder renewing insurance coverage.

(2) "Insulating concrete form system" means a building construction system primarily used to frame exterior walls in which polystyrene foam forms are placed in the walls of a structure under construction and filled with concrete and steel reinforcing material to become a permanent part of the structure.

(3) "Insurer" means an insurer authorized to write property and casualty insurance in this state, including:

(A) a county mutual insurance company;

(B) a farm mutual insurance company;

(C) a Lloyd's plan; and

(D) a reciprocal or interinsurance exchange. (V.T.I.C. Art. 5.33E, Sec. 1.)

Source Law

Art. 5.33E

Sec. 1. In this article:

(1) "Applicant for insurance coverage" includes an applicant for new coverage and a policyholder renewing coverage.

(2) "Insurer" means an insurer authorized to write property and casualty insurance in this state. The term includes:

(A) a county mutual insurance company;

(B) a farm mutual insurance company;

(C) a Lloyd's plan; and

(D) a reciprocal or interinsurance exchange.

(3) "Insulating concrete form system" means a building construction system primarily used to frame exterior walls in which polystyrene foam forms are placed in walls of a structure under construction and filled with concrete and steel reinforcing material to become a permanent part of the structure.

Revised Law

Sec. 2006.002. OPTIONAL PREMIUM DISCOUNT. (a) In accordance with the rules adopted by the commissioner under this subchapter, an insurer may grant to an applicant a discount in the applicant's homeowners insurance premiums for insured property on receipt of written verification from the applicant that the property was constructed with an insulating concrete form system.

(b) The commissioner by rule shall prescribe the requirements for determining that a structure was constructed with an insulating concrete form system.

(c) Verification under this section must comply with the requirements prescribed by the commissioner. (V.T.I.C. Art. 5.33E, Secs. 2, 3(a) (part).)

Source Law

Sec. 2. (a) On receipt of written verification from an applicant for insurance coverage, an insurer may grant a discount, in accordance with the rules adopted by the commissioner under this article, in the applicant's homeowners' insurance premiums for covered property that is constructed using an insulating concrete form system.

(b) Verification under this section must comply with the requirements prescribed under Section 3 of this article.

Sec. 3. (a) The commissioner:

(1) shall adopt rules that prescribe the requirements for determining that a structure has been built using an insulating concrete form system; and . . . .

Revised Law

Sec. 2006.003. PROPERTY INSPECTION. (a) If determined

necessary by the commissioner, the rules adopted under this subchapter may require an inspection of the property to be insured.

(b) The applicant shall pay the costs of a required inspection. (V.T.I.C. Art. 5.33E, Sec. 3(b).)

Source Law

> (b) If determined necessary by the commissioner, the rules adopted under this section may require an inspection of the property to be insured. The applicant for insurance coverage shall pay the costs of any inspection required under this subsection.

Revised Law

Sec. 2006.004. PREMIUM DISCOUNT; EXCEPTION. (a) The commissioner by rule shall establish the premium discount under this subchapter based on sound actuarial principles.

(b) The commissioner may approve a premium discount greater or less than the discount established by rule under Subsection (a) if:

(1) the insurer files the proposed discount with the department; and

(2) the commissioner determines that the proposed discount is actuarially justified. (V.T.I.C. Art. 5.33E, Sec. 4.)

Source Law

> Sec. 4. (a) The commissioner shall establish by rule the amount of the premium discount applicable under this article based on sound actuarial principles.
>
> (b) The commissioner may approve a discount greater or less than the discount established under Subsection (a) of this section if:
>
> (1) the insurer files the proposed discount with the department; and
>
> (2) the commissioner determines that the proposed discount is actuarially justified.

Revised Law

Sec. 2006.005. RULES. The commissioner may adopt rules as necessary to implement this subchapter in addition to other rules adopted under this subchapter. (V.T.I.C. Art. 5.33E, Sec. 3(a)(part).)

Source Law

> Sec. 3. (a) [The commissioner:]
>
> . . .

(2) may adopt other rules as necessary to implement this article.

[Sections 2006.006-2006.050 reserved for expansion]

SUBCHAPTER B. OPTIONAL PREMIUM DISCOUNT FOR CERTAIN RESIDENTIAL PROPERTY INSURANCE POLICIES

Revised Law

Sec. 2006.051. DEFINITIONS. In this subchapter:

(1) "Affiliate" means an entity classified as an affiliate under Section 823.003.

(2) "Insurer" means an insurer authorized to write residential property insurance, including:

(A) a county mutual insurance company;

(B) a farm mutual insurance company;

(C) a Lloyd's plan; and

(D) a reciprocal or interinsurance exchange.

(3) "Residential property insurance" means property or property and casualty insurance covering a dwelling, including:

(A) homeowners insurance;

(B) residential fire and allied lines insurance;

(C) farm and ranch insurance; and

(D) farm and ranch owners insurance. (V.T.I.C. Art. 5.43, Sec. (a).)

Source Law

Art. 5.43. (a) In this article:

(1) "Affiliate" means an entity classified as an affiliate of an insurer under Section 823.003 of this code.

(2) "Insurer" means an insurer authorized to write residential property insurance, including a county mutual insurance company, farm mutual insurance company, Lloyd's plan, or reciprocal or interinsurance exchange.

(3) "Residential property insurance" means property or property and casualty insurance covering a dwelling, including homeowners insurance, residential fire and allied lines insurance, farm and ranch insurance, or farm and ranch owners insurance.

Revised Law

Sec. 2006.052. OPTIONAL PREMIUM DISCOUNT. (a) Except as provided by Section 2006.053, an insurer that issues a residential property insurance policy may:

(1) discount the premiums that would otherwise be charged for the policy by not less than three percent if the policyholder:

(A) has continuously been a residential property insurance policyholder with the insurer or an affiliate of the insurer; and

(B) has not filed a residential property insurance claim during the three years before the effective date of the policy; and

(2) increase the amount of the discount by one percent for each subsequent year in which the policyholder:

(A) has been a residential property insurance policyholder with the insurer or an affiliate of the insurer; and

(B) has not filed a residential property insurance claim.

(b) This section applies regardless of whether any of the policies that continuously covered the policyholder was a different kind of residential property insurance policy from the policy eligible for the premium discount. (V.T.I.C. Art. 5.43, Secs. (b), (d).)

Source Law

(b) An insurer that issues a residential property insurance policy in this state may:

(1) provide a discount of not less than three percent in the premiums that would otherwise be charged for the policy if the policyholder has continuously been a residential property insurance policyholder with that insurer or an affiliate of that insurer but has not filed a residential property insurance claim during the three years before the effective date of the policy; and

(2) increase the amount of the discount by one percent for each subsequent year in which the policyholder has been a residential property insurance policyholder with that insurer or an affiliate of that insurer but has not filed a residential property insurance claim.

(d) This article applies without regard to whether any of the policies that continuously covered the policyholder, as described by Subsections (b)(1) and (2) of this article, was a different type of residential property insurance policy from the policy eligible for the discount.

Revised Law

Sec. 2006.053. APPROVAL OF ACTUARIALLY JUSTIFIED PREMIUM DISCOUNT. The commissioner may approve a premium discount filed with the department that is greater or less than the discount specified by this subchapter if the commissioner determines the discount is actuarially justified. (V.T.I.C. Art. 5.43, Sec. (e) (part).)

Source Law

> (e) . . . The commissioner may approve a discount filed with the department that is greater or less than the discount specified by this article if the commissioner determines the discount is actuarially justified.

Revised Law

Sec. 2006.054. LIMIT ON PREMIUM DISCOUNT. An insurer that provides a premium discount under this subchapter is not required to provide the discount in an amount that exceeds 10 percent of the premiums that would otherwise be charged for the residential property insurance policy. (V.T.I.C. Art. 5.43, Sec. (c).)

Source Law

> (c) An insurer that provides a discount under this article is not required to provide a discount under this article that exceeds 10 percent of the premiums that would otherwise be charged for the residential property insurance policy.

Revised Law

Sec. 2006.055. RULES AND GUIDELINES. (a) The commissioner shall adopt rules as necessary to implement this subchapter.

(b) The commissioner by rule shall establish guidelines under which an insurer that provides a premium discount under this subchapter shall determine the appropriate discount based on sound actuarial principles. (V.T.I.C. Art. 5.43, Sec. (e) (part).)

Source Law

> (e) The commissioner shall adopt rules as necessary to implement this article and shall establish by rule guidelines under which an insurer that provides a discount under this article shall determine the appropriate discount based on sound actuarial principles. . . .

CHAPTER 2007. ASSESSMENT FOR RURAL FIRE PROTECTION

Sec. 2007.001. APPLICABILITY OF CHAPTER . . . . . 985
Sec. 2007.002. ASSESSMENT . . . . . 986
Sec. 2007.003. DETERMINATION OF ASSESSMENT . . . . . 986
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CHAPTER 2007. ASSESSMENT FOR RURAL FIRE PROTECTION

Revised Law

Sec. 2007.001. APPLICABILITY OF CHAPTER. This chapter applies only to an insurer that:

(1) is authorized to engage in business in this state, including a stock company, mutual insurance company, farm mutual insurance company, county mutual insurance company, Lloyd's plan, and reciprocal or interinsurance exchange; and

(2) writes a policy of:

(A) homeowners insurance;

(B) fire insurance;

(C) farm and ranch owners insurance;

(D) private passenger automobile physical damage insurance;

(E) commercial automobile physical damage insurance; or

(F) commercial multiple peril insurance. (V.T.I.C. Art. 5.102, Secs. 1(1), (2) (part), 2.)

Source Law

Art. 5.102
Sec. 1. In this article:
(1) "Insurer" means an insurer authorized to engage in business in this state, including a stock company, mutual, farm mutual, county mutual, Lloyd's plan, or reciprocal or interinsurance exchange.
(2) ["Net direct premium" means the gross

direct premium written and reported by an insurer on annual financial statements on:]

(A) policies of:

(i) homeowner's insurance;

(ii) fire insurance;

(iii) farm and ranch owner's insurance;

(iv) private passenger automobile physical damage insurance; and

(v) commercial automobile physical damage insurance; and

(B) . . . a commercial multiple peril policy.

Sec. 2. This article applies only to an insurer that writes an insurance policy described by Section 1(2) of this article.

Revised Law

Sec. 2007.002. ASSESSMENT. The comptroller shall assess against all insurers to which this chapter applies a combined total of $15 million for each 12-month period. (V.T.I.C. Art. 5.102, Sec. 3(a) (part).)

Source Law

Sec. 3. (a) The comptroller shall assess all insurers in an amount that totals $15 million for each 12-month period. . . .

Revised Law

Sec. 2007.003. DETERMINATION OF ASSESSMENT. (a) In this section, "net direct premium" means the gross direct premium written and reported by an insurer on annual financial statements on:

(1) an insurance policy described by Section 2007.001(2), other than a commercial multiple peril policy; and

(2) the nonliability portion of a commercial multiple peril policy.

(b) Each insurer shall pay a portion of the assessment in the proportion that the insurer's net direct premiums for the period for which the assessment is made bear to the aggregate net direct premiums written in this state by all insurers for that period. (V.T.I.C. Art. 5.102, Secs. 1(2) (part), 3(a) (part).)

Source Law

[Sec. 1]

(2) "Net direct premium" means the gross direct premium written and reported by an insurer on annual financial statements on:

[(A) policies of:

(i) homeowner's insurance;
(ii) fire insurance;
(iii) farm and ranch owner's insurance;
(iv) private passenger automobile physical damage insurance; and
(v) commercial automobile physical damage insurance; and]
(B) the nonliability portion of a commercial multiple peril policy.

Sec. 3. (a) . . . Each insurer shall pay a portion of the assessment in the proportion that the insurer's net direct premiums for the period for which the assessment is made bear to the aggregate net direct premiums written in this state for that period.

Revised Law

Sec. 2007.004. DATES OF ASSESSMENT AND PAYMENT. (a) The comptroller shall assess insurers under this chapter on or before September 1 of each year.

(b) An insurer shall pay the amount of the insurer's assessment on or after the 60th day after the date the comptroller assesses the insurer. (V.T.I.C. Art. 5.102, Secs. 3(b), (c).)

Source Law

(b) The comptroller shall assess the insurers on or before September 1 of each year.
(c) An insurer shall pay the amount assessed under this section on or after the 60th day after the date the comptroller assesses the insurer.

Revised Law

Sec. 2007.005. RECOVERY OF ASSESSMENT. An insurer may recover an assessment under this chapter by:

(1) reflecting the assessment as an expense in a rate filing required under this code; or

(2) charging the insurer's policyholders. (V.T.I.C. Art. 5.102, Sec. 3(d).)

Source Law

(d) An insurer may recover an assessment under this section by:
(1) reflecting the assessment as an expense in a rate filing required under this code; or
(2) charging the insurer's policyholders.

Revised Law

Sec. 2007.006. NOTICE TO POLICYHOLDERS. (a) An insurer that recovers an assessment by charging the insurer's policyholders under Section 2007.005 shall provide notice to each policyholder

regarding the amount of the assessment being recovered.

(b) The notice may be included on:

(1) a declarations page;

(2) a renewal certificate; or

(3) a billing statement.

(c) The commissioner by rule may adopt a form for providing the notice. (V.T.I.C. Art. 5.102, Sec. 3(e).)

Source Law

(e) An insurer that recovers an assessment under this section from the insurer's policyholders shall provide a notice to each policyholder of the amount of the assessment being recovered. The notice required by this subsection may be included on a declarations page, renewal certificate, or billing statement. The commissioner by rule may adopt a form for providing notice under this subsection.

Revised Law

Sec. 2007.007. VOLUNTEER FIRE DEPARTMENT ASSISTANCE FUND. The comptroller shall credit assessments collected under this chapter to the volunteer fire department assistance fund created under Section 614.104, Government Code. (V.T.I.C. Art. 5.102, Sec. 3(f).)

Source Law

(f) The comptroller shall credit assessments collected under this article to the volunteer fire department assistance fund created under Section 614.104, Government Code.

Revised Law

Sec. 2007.008. RULES; COOPERATION. (a) The comptroller and the commissioner shall adopt rules as necessary to implement this chapter.

(b) The comptroller and the department shall cooperate as necessary to implement this chapter. (V.T.I.C. Art. 5.102, Sec. 4.)

Source Law

Sec. 4. (a) The comptroller and the commissioner shall adopt rules as necessary to implement this article.

(b) The comptroller and the department shall cooperate as necessary to implement this article.

Revised Law

Sec. 2007.009. EXPIRATION OF CHAPTER. This chapter expires September 1, 2011. (V.T.I.C. Art. 5.102, Sec. 5.)

Source Law

Sec. 5. This article expires September 1, 2011.

[Chapters 2008-2050 reserved for expansion]

SUBTITLE E. WORKERS' COMPENSATION INSURANCE

CHAPTER 2051. GENERAL PROVISIONS: WORKERS' COMPENSATION INSURANCE

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CHAPTER 2051. GENERAL PROVISIONS: WORKERS' COMPENSATION INSURANCE

SUBCHAPTER A. APPLICABILITY AND CONSTRUCTION

Revised Law

Sec. 2051.001. DEFINITION. In this chapter, "insurance company" means a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan authorized to engage in the business of workers' compensation insurance in this state. (V.T.I.C. Art. 5.63.)

Source Law

> Art. 5.63. The words "Company" and "Association" used in this subchapter mean the Texas Employers Insurance Association, or any stock company, or any mutual company, or any reciprocal, or any interinsurance exchange, or Lloyd's association authorized to write Workmen's Compensation Insurance in this State.

Revisor's Note

(1) V.T.I.C. Article 5.63 defines terms "used in this subchapter," meaning Subchapter D, V.T.I.C. Chapter 5. Portions of Subchapter D, Chapter 5, are revised in various chapters in this subtitle. The revised law substitutes a reference to "this chapter" for the reference to "this subchapter" because the substance of the definitions contained in Article 5.63 is repeated in each of the chapters of this subtitle in which other articles from Subchapter D, V.T.I.C. Chapter 5, are revised and to which the definitions apply.

(2) V.T.I.C. Article 5.63 defines "company" and "association." The revised law substitutes "insurance company" for "company" and "association" for consistency of terms used in this chapter and the Labor Code. Throughout this chapter, references to "company" and "association" have been changed

appropriately.

(3) V.T.I.C. Article 5.63 defines "company" and "association" to include the Texas Employers Insurance Association. The Texas Employers Insurance Association was placed in receivership and liquidated in 2004. The revised law omits the reference to the Texas Employers Insurance Association accordingly.

(4) V.T.I.C. Article 5.63 refers to a "mutual company, or any reciprocal, or any interinsurance exchange, or Lloyd's association." For consistency of terminology within this code, the revised law substitutes references to a "mutual insurance company," a "reciprocal or interinsurance exchange," and a "Lloyd's plan" for the references to a "mutual company," "any reciprocal, or any interinsurance exchange," and "Lloyd's association," respectively.

Revised Law

Sec. 2051.002. CONSTRUCTION OF CERTAIN LAWS. The following shall be construed and applied independently of any other law that relates to insurance rates and forms or prescribes the duties of the commissioner or the department:

(1) this chapter;

(2) Subchapter D, Chapter 5;

(3) Chapter 251, as that chapter relates to workers' compensation insurance;

(4) Chapters 255, 426, 2052, and 2053; and

(5) Chapter 406A, Labor Code. (V.T.I.C. Art. 5.66 (part).)

Source Law

> Art. 5.66. . . . the provisions of this subchapter shall be construed and applied independently of any other law or laws, or parts of laws, having to do with the matter of insurance rates and forms or of fixing the duties of the Board.

Revisor's Note

V.T.I.C. Article 5.66 refers to "the Board,"

meaning the Board of Insurance Commissioners. Other provisions revised in this chapter refer to the State Board of Insurance. 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. Throughout this chapter, references to the Board of Insurance Commissioners, the State Board of Insurance, and "the board" have been changed appropriately.

[Sections 2051.003-2051.050 reserved for expansion]

SUBCHAPTER B. COMPENSATION AND EXPENSES

Revised Law

Sec. 2051.051. LIMITATION ON COMPENSATION AND EXPENSES. The total amount of necessary compensation of experts, clerical personnel, and other department employees, necessary travel expenses, and other expenses necessarily incurred to implement the purposes of the laws referenced in Sections 2051.002(1), (2), (3), (4), and (5) may not exceed the total amount assessed and collected from insurance companies writing workers' compensation insurance in this state. (V.T.I.C. Art. 5.67 (part).)

Source Law

> Art. 5.67. The necessary compensation of experts, the clerical force and other persons employed by the Board to carry out the purposes of this subchapter, and all necessary traveling expenses and such other expenses as may be necessarily incurred in carrying out such provisions [shall be paid] . . . . The total amount of all salaries and said other expenses shall not exceed the sum assessed and collected from companies and associations writing workmen's compensation insurance in this State.

Revisor's Note

V.T.I.C. Article 5.67 requires the comptroller, on the order of the Texas Department of Insurance, to draw warrants to pay certain compensation and expenses. The revised law omits the provision as unnecessary because Chapter 2103, Government Code, provides procedures for expenditures by state agencies, including the department. The omitted law reads:

> Art. 5.67. [The necessary compensation of experts, the clerical force and other persons employed by the Board to carry out the purposes of this subchapter, and all necessary traveling expenses and such other expenses as may be necessarily incurred in carrying out such provisions] shall be paid by warrants drawn by the Comptroller upon the order of said Board. . . .

[Sections 2051.052-2051.100 reserved for expansion]

SUBCHAPTER C. POLICYHOLDER DUTIES

Revised Law

Sec. 2051.101. DISCLOSURE BY POLICYHOLDER REQUIRED. (a) A policyholder shall fully disclose to the policyholder's insurance company:

(1) information concerning the policyholder's ownership, change of ownership, operations, or payroll; and

(2) the policyholder's records relating to workers' compensation insurance.

(b) The commissioner shall adopt rules necessary to implement this section. (V.T.I.C. Art. 5.65B, Secs. (a), (d).)

Source Law

> Art. 5.65B. (a) A policyholder shall make full disclosure to its insurance company of information concerning its true ownership, change of ownership, operations, or payroll and any of its records pertaining to workers' compensation insurance.
>
> (d) The board shall promulgate rules necessary to implement this article.

[Sections 2051.102-2051.150 reserved for expansion]

SUBCHAPTER D. DUTIES AND PROHIBITED ACTS; ENFORCEMENT

Revised Law

Sec. 2051.151. NOTICE OF CLAIMS INFORMATION TO POLICYHOLDER REQUIRED; ADMINISTRATIVE PENALTY. (a) Except as otherwise provided by Subsection (b), an insurance company that writes workers' compensation insurance in this state shall notify a policyholder of a claim that is filed against the policyholder's policy and, after the initial notice, the company shall notify the policyholder of:

(1) any proposal to settle the claim; or

(2) on receipt of a written request from the policyholder, any administrative or judicial proceeding relating to the resolution of the claim, including a benefit review conference conducted by the Texas Workers' Compensation Commission.

(b) A policyholder may waive the notice required by Subsection (a).

(c) An insurance company that writes workers' compensation insurance in this state, on the written request of a policyholder, shall provide to the policyholder:

(1) a list of:

(A) claims charged against the policy; and

(B) payments made and reserves established on each claim; and

(2) a statement explaining the effect of claims on premium rates.

(d) The insurance company shall provide the information described by Subsection (c) in writing not later than the 30th day after the date the company receives the policyholder's written request for the information. For purposes of this subsection, information is considered to be provided to the policyholder on the date the information is:

(1) received by the United States Postal Service; or

(2) personally delivered to the policyholder.

(e) An insurance company that fails to comply with this section commits a Class D administrative violation under Subtitle A, Title 5, Labor Code. (V.T.I.C. Art. 5.65A.)

Source Law

Art. 5.65A. (a) A company or association that writes workers' compensation insurance in this state shall notify each policyholder of any claim that is filed against the policy. Thereafter a company shall notify the policyholder of any proposal to settle a claim or, on receipt of a written request from the policyholder, of any administrative or judicial proceeding relating to the resolution of a claim, including a benefit review conference conducted by the Texas Workers' Compensation Commission.

(b) Each company or association that writes workers' compensation insurance in this state, on the written request of the policyholder, shall provide the policyholder with a list of claims charged against the policy, payments made and reserves established on each claim, and a statement explaining the effect of claims on premium rates. The company or association shall provide the information to the policyholder in writing not later than the 30th day after the date on which the company or association receives the policyholder's written request for the information. The information is considered to be provided on the date that the information is received by the United States Postal Service or personally delivered.

(c) An insurance carrier that fails to comply with this article commits a Class D administrative violation under the Texas Workers' Compensation Act (S.B. No. 1, Acts of the 71st Legislature, 2nd Called Session, 1989).

(d) Any policyholder may elect to waive the notification required by Subsection (a) of this article.

Revisor's Note

(1) Section (c), V.T.I.C. Article 5.65A, refers to an "insurance carrier" that fails to comply with V.T.I.C. Article 5.65A, revised as this section. The term "insurance carrier" as used in the Texas Workers' Compensation Act, Subtitle A, Title 5, Labor Code, is broader than the term "insurance company" as defined for purposes of this chapter in Section 2051.001, which is derived from V.T.I.C. Article 5.63. However, the revised law substitutes a reference to "insurance company" for the reference to "insurance carrier" because the duties prescribed and the sanction authorized by Article 5.65A apply only to insurance

companies and for consistency of terminology in this chapter.

(2) Section (c), V.T.I.C. Article 5.65A, refers to "the Texas Workers' Compensation Act (S.B. No. 1, Acts of the 71st Legislature, 2nd Called Session, 1989)." That Act was originally published as Article 8308-1.01 et seq., Vernon's Texas Civil Statutes, and was codified in 1993 as Subtitle A, Title 5, Labor Code. The revised law is drafted accordingly.

Revised Law

Sec. 2051.152. PROHIBITED ACTS BY PERSON; ADMINISTRATIVE PENALTY. (a) A person commits an administrative violation if the person:

(1) to obtain workers' compensation insurance coverage for the person or another person, intentionally or knowingly:

(A) makes a false statement;

(B) misrepresents or conceals a material fact;

(C) makes a false entry in, fabricates, alters, conceals, or destroys a document; or

(D) conspires to commit an act listed in Paragraph (A), (B), or (C); or

(2) intentionally and knowingly obtains or maintains:

(A) workers' compensation insurance coverage from an insurer that is not authorized to engage in business in this state; or

(B) alternative coverage from an insurer in violation of this code.

(b) An administrative violation under Subsection (a) is punishable by an administrative penalty not to exceed $5,000 assessed in accordance with the procedures established for an administrative violation under Chapter 415, Labor Code.

(c) Each day an administrative violation under Subsection (a)(2) occurs or continues is a separate violation. (V.T.I.C. Art. 5.65C, Secs. (a), (b), (f).)

Source Law

Art. 5.65C. (a) A person commits an administrative violation if the person, to obtain workers' compensation insurance coverage for himself or another, intentionally or knowingly:

(1) makes a false statement;

(2) misrepresents or conceals a material fact;

(3) makes a false entry in, fabricates, alters, conceals, or destroys a document; or

(4) conspires to commit an act listed in Subdivision (1), (2), or (3) of this subsection.

(b) An administrative violation under Subsection (a) of this article is punishable by an administrative penalty not to exceed $5,000 assessed in accordance with the procedures established for an administrative violation under Article 10, Texas Workers' Compensation Act (Article 8308-10.01 et seq., Vernon's Texas Civil Statutes).

(f) A person commits an administrative violation if the person knowingly and intentionally obtains or maintains workers' compensation insurance coverage from an insurer that is not authorized to do business in this state or obtains or maintains alternative coverage from an insurer in violation of this code. An administrative violation under this subsection is punishable by an administrative penalty not to exceed $5,000 assessed in accordance with the procedures established under Article 10, Texas Workers' Compensation Act (Article 8308-10.01 et seq., Vernon's Texas Civil Statutes). Each day of noncompliance is a separate violation.

Revisor's Note

Sections (b) and (f), V.T.I.C. Article 5.65C, refer to "Article 10, Texas Workers' Compensation Act (Article 8308-10.01 et seq., Vernon's Texas Civil Statutes)." That statute was codified in 1993 as Chapter 415, Labor Code. The revised law is drafted accordingly.

Revised Law

Sec. 2051.153. LIABILITY OF POLICYHOLDER FOR ADDITIONAL PREMIUM. (a) If a policyholder commits an administrative violation under Section 2051.152 and obtains workers' compensation insurance coverage at a premium that is less than the premium that would have been charged if the policyholder had not committed the administrative violation, the policyholder is liable to the insurer for:

(1) the difference between the premium due and the

premium actually charged; and

(2) reasonable interest and attorney's fees.

(b) For the purposes of this section, "insurer" includes the Texas Mutual Insurance Company. (V.T.I.C. Art. 5.65C, Sec. (d).)

Source Law

> (d) If a policyholder commits an administrative violation under this article and obtains workers' compensation insurance coverage at a premium less than the premium that would have been charged had the policyholder not committed the administrative violation, the policyholder is liable to the insurer for the difference between the premium due and the premium actually charged, plus reasonable interest and reasonable attorney fees. For the purposes of this subsection, "insurer" includes the Texas Mutual Insurance Company.

Revised Law

Sec. 2051.154. PROHIBITED ACT BY INSURER; ADMINISTRATIVE PENALTY. (a) An insurer commits an administrative violation if the insurer directly or indirectly requires a person to apply for or purchase an insurance policy, other than a workers' compensation insurance policy, as a condition of issuing a workers' compensation insurance policy.

(b) An insurer that violates this section is subject to administrative penalties under Chapter 84. (V.T.I.C. Art. 5.65C, Sec. (e).)

Source Law

> (e) An insurer commits an administrative violation if the insurer directly or indirectly requires a person to apply for or purchase a policy of insurance other than workers' compensation insurance as a condition attached to the issuance of a workers' compensation insurance policy by the insurer. An insurer that violates this subsection is subject to the administrative penalties under Article 1.10 of this code.

Revisor's Note

Section (e), V.T.I.C. Article 5.65C, refers to "administrative penalties under Article 1.10 of this code." The portion of V.T.I.C. Article 1.10 relating to administrative penalties was revised as Section 82.052 of this code and authorizes the commissioner of insurance to assess administrative penalties under

Chapter 84 of this code. The revised law substitutes a reference to Chapter 84 accordingly.

Revised Law

Sec. 2051.155. SANCTION OF AGENT REQUIRED. The commissioner shall impose a sanction in accordance with Chapter 82 against an agent who commits an administrative violation under Section 2051.152 or 2051.154. (V.T.I.C. Art. 5.65C, Sec. (c).)

Source Law

> (c) The State Board of Insurance shall sanction an agent who commits an administrative violation under this article in accordance with Section 7, Article 1.10 of this code.

Revised Law

Sec. 2051.156. CANCELLATION OF CERTIFICATE OF AUTHORITY REQUIRED. The commissioner shall cancel an insurance company's certificate of authority to engage in the business of workers' compensation insurance in this state on a second conviction of an officer or representative of the company for violating a provision of a law referenced in Section 2051.002(1), (2), (3), (4), or (5) relating to that business. (V.T.I.C. Art. 5.64.)

Source Law

> Art. 5.64. The Board shall cancel the license of any insurance company or association of persons to transact workmen's compensation insurance business in this State upon a second conviction of any officer or representative of such company or association for a violation of any provision of this subchapter relating to such business.

Revisor's Note

V.T.I.C. Article 5.64 refers to the "license" of an insurance company to engage in the business of workers' compensation insurance in this state. The revised law substitutes "certificate of authority" for "license" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 2051.157. PENALTY FOR CERTAIN VIOLATIONS. An officer

or other representative of an insurance company is subject to a fine of not less than $100 or more than $500 if the officer or other representative violates any provision of the following relating to the company's business:

(1) Subchapter A or B;

(2) Section 2051.156 or 2051.201;

(3) Chapter 426 or 2052;

(4) Subchapter A, C, or D, Chapter 2053;

(5) Section 2053.051, 2053.052, 2053.053, or 2053.055; or

(6) Article 5.66. (V.T.I.C. Art. 5.68-1.)

Source Law

Art. 5.68-1. Any officer or representative of any insurance company or association authorized to write workmen's compensation insurance in this State, who shall violate any provision of the laws relating to such business contained in chapter 10, Title "Insurance" of the Revised Statutes, relating to the State Insurance Commission and such business, shall be fined not less than one hundred nor more than five hundred dollars.

Revisor's Note

V.T.I.C. Article 5.68-1 refers to "any provision of the laws relating to such business contained in chapter 10, Title 'Insurance' of the Revised Statutes, relating to the State Insurance Commission and such business." Chapter 10, Title "Insurance," consisted of Articles 4878-4918, Vernon's Texas Civil Statutes, which were codified in 1951 in Subchapters C and D, V.T.I.C. Chapter 5. The relevant provisions of those subchapters relating to workers' compensation insurance were codified as V.T.I.C. Articles 5.55, 5.56, 5.57, 5.58, 5.59, 5.60, 5.61, 5.62, 5.63, 5.64, 5.65, 5.66, and 5.67 and govern rates and forms for workers' compensation insurance and reserves for workers' compensation insurance companies. The revised law is drafted accordingly.

In addition, the revised law omits the reference

to the State Insurance Commission as unnecessary. Under Chapter 224, Acts of the 40th Legislature, Regular Session, 1927, the functions of the State Insurance Commission were transferred to the Board of Insurance Commissioners. For the reasons stated in the revisor's note to Section 2051.002, those functions are now performed by the commissioner of insurance and the Texas Department of Insurance, but a reference to the commissioner and the department is not necessary when referring to the specified laws.

[Sections 2051.158-2051.200 reserved for expansion]

SUBCHAPTER E. RULES

Revised Law

Sec. 2051.201. RULEMAKING AUTHORITY: WORKERS' COMPENSATION INSURANCE. The commissioner may adopt and enforce all reasonable rules as are necessary to carry out the provisions of a law referenced in Section 2051.002(1), (2), (3), (4), or (5). (V.T.I.C. Art. 5.62.)

Source Law

Art. 5.62. The Board is hereby empowered to make and enforce all such reasonable rules and regulations not inconsistent with the provisions of this subchapter as are necessary to carry out its provisions.

Revisor's Note

V.T.I.C. Article 5.62 authorizes the Board of Insurance Commissioners, meaning the commissioner of insurance for the reason stated in the revisor's note to Section 2051.002, to "make and enforce" certain "rules and regulations not inconsistent with the provisions of this subchapter," meaning Subchapter D, V.T.I.C. Chapter 5. For consistency with the terminology used in this code and the administrative procedure law, Chapter 2001, Government Code, the revised law substitutes "adopt" for "make." The revised law also omits as unnecessary the reference to

"regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation, and that definition applies to the revised law. In addition, the revised law omits as unnecessary the reference to "not inconsistent with the provisions of this subchapter" because the commissioner of insurance does not have the authority to adopt rules that are inconsistent with a statute, and an express statement to that effect is unnecessary.

CHAPTER 2052. POLICY PROVISIONS AND FORMS FOR WORKERS' COMPENSATION INSURANCE

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CHAPTER 2052. POLICY PROVISIONS AND FORMS FOR WORKERS' COMPENSATION INSURANCE

Revised Law

Sec. 2052.001. DEFINITION. In this chapter, "insurance company" means a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan authorized to engage in the business of workers' compensation insurance in this state. (V.T.I.C. Art. 5.63.)

Source Law

Art. 5.63. The words "Company" and "Association" used in this subchapter mean the Texas Employers Insurance Association, or any stock company, or any mutual company, or any reciprocal, or any interinsurance exchange, or Lloyd's association authorized to write Workmen's Compensation Insurance in this State.

Revisor's Note

(1) V.T.I.C. Article 5.63 defines terms "used in this subchapter," meaning Subchapter D, V.T.I.C.

Chapter 5. The provisions of Subchapter D, Chapter 5, that are revised have been revised in various titles in this code. The revised law substitutes a reference to "this chapter" for the reference to "this subchapter" because the substance of the definitions contained in Article 5.63 is repeated in each of the chapters in which other articles from Subchapter D, V.T.I.C. Chapter 5, are revised and to which the definitions apply.

(2) V.T.I.C. Article 5.63 defines "company" and "association." The revised law substitutes "insurance company" for "company" and "association" for consistency of terms used in this chapter and the Labor Code. Throughout this chapter, references to "company" and "association" have been changed appropriately.

(3) V.T.I.C. Article 5.63 defines "company" and "association" to include the Texas Employers Insurance Association. The Texas Employers Insurance Association was placed in receivership and liquidated in 2004. The revised law omits the reference to the Texas Employers Insurance Association accordingly.

(4) V.T.I.C. Article 5.63 refers to a "mutual company, or any reciprocal, or any interinsurance exchange, or Lloyd's association." For consistency of terminology within this code, the revised law substitutes references to a "mutual insurance company," a "reciprocal or interinsurance exchange," and a "Lloyd's plan" for the references to a "mutual company," "any reciprocal, or any interinsurance exchange," and "Lloyd's association," respectively.

Revised Law

Sec. 2052.002. STANDARD POLICY FORMS AND UNIFORM POLICY; EXCEPTIONS. (a) The commissioner shall prescribe standard policy

forms and a uniform policy for workers' compensation insurance.

(b) In writing workers' compensation insurance in this state, an insurance company may not use a form other than one prescribed under this section unless the form is an endorsement:

(1) appropriate to the company's plan of operation; and

(2) submitted to and approved by the department. (V.T.I.C. Arts. 5.56 (part), 5.57 (part).)

Source Law

> Art. 5.56. The Board shall prescribe standard policy forms to be used by all companies or associations writing workmen's compensation insurance in this State. No company or association authorized to write workmen's compensation insurance in this State shall, except as hereinafter provided for, use any . . . policy forms other than those made, established and promulgated and prescribed by the Board.
>
> Art. 5.57. The Board shall prescribe a uniform policy for workmen's compensation insurance and no company or association shall thereafter use any other form in writing workmen's compensation insurance in this State, provided that any company or association may use any form of endorsement appropriate to its plan of operation, if such endorsement shall be first submitted to and approved by the Board, and . . . .

Revisor's Note

(1) V.T.I.C. Articles 5.56 and 5.57 refer to the "Board," meaning 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. Throughout this chapter, references to the Board of Insurance Commissioners have been changed appropriately.

(2) V.T.I.C. Article 5.56 refers to the use of

forms "made, established and promulgated and prescribed" by the department. The revised law omits the reference to "made, established and promulgated" as unnecessary because, with regard to forms, it is sufficient and appropriate to refer to forms "prescribed" by the department.

(3) V.T.I.C. Article 5.56 requires certain insurance companies to use a standard policy form in writing workers' compensation insurance "except as hereinafter provided for." The text of Article 5.56 was originally enacted by Section 2, Chapter 182, General Laws, Acts of the 38th Legislature, Regular Session, 1923, and subsequent text of that act provided two exceptions to the requirement that the specified insurance companies use the standard policy form. Section 4 of the act authorized an insurance company to continue using previously filed and approved forms until the standard policy form was prescribed, and Section 8 of the act, which was codified in 1951 as Article 5.57, Insurance Code, authorized an insurance company to use a form of endorsement appropriate to the company's plan of operation under certain circumstances. The revised law omits the quoted phrase as unnecessary because the exception provided by Section 4 of the act to which the phrase refers is executed, and the exception provided by Section 8 of the act to which the phrase refers is incorporated in the text of the revised law.

Revised Law

Sec. 2052.003. AGREEMENT REQUIRED TO BE CONTAINED IN APPLICATION AND POLICY. (a) A contract or other agreement with respect to workers' compensation insurance coverage that is not contained in the application and policy required by this chapter violates this subtitle and is void.

(b) An insurance company that uses a contract or other agreement described by Subsection (a) engages in conduct that constitutes sufficient grounds for the revocation of the company's certificate of authority to write workers' compensation insurance in this state. (V.T.I.C. Art. 5.57 (part).)

Source Law

> Art. 5.57. . . . any contract or agreement not written into the application and policy shall be void and of no effect and in violation of the provisions of this subchapter, and shall be sufficient cause for revocation of license to write workmen's compensation insurance within this State.

Revisor's Note

(1) V.T.I.C. Article 5.57 refers to an agreement that is "void and of no effect." The revised law omits the reference to "of no effect" as unnecessary because the phrase is included in the meaning of "void."

(2) V.T.I.C. Article 5.57 provides that certain contracts and other agreements with respect to workers' compensation insurance coverage violate "this subchapter," meaning Subchapter D, V.T.I.C. Chapter 5. The relevant provisions of Subchapter D, Chapter 5, are revised in Subtitle E, Title 10, of this code, which includes this chapter. Subtitle E also includes provisions derived from Subchapter G, V.T.I.C. Chapter 5, that relate to the Texas Mutual Insurance Company and do not apply to workers' compensation insurance policy provisions or violations generally. Accordingly, the revised law substitutes a reference to "this subtitle" for the reference to "this subchapter."

(3) V.T.I.C. Article 5.57 refers to the revocation of a "license" to write workers' compensation insurance in this state. The revised law substitutes "certificate of authority" for "license" because "certificate of authority" is the term used

throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 2052.004. POLICYHOLDER DIVIDENDS. (a) Subject to Subsections (b) and (c), this subtitle and Article 5.66 may not be construed to prohibit an insurance company, including the Texas Mutual Insurance Company, from issuing participating policies.

(b) A policyholder dividend under a workers' compensation insurance policy:

(1) does not take effect until approved by the department; and

(2) may not be approved by the department until the insurance company provides adequate reserves.

(c) For purposes of Subsection (b), reserves must be computed on the same basis for all classes of insurance companies operating under this subtitle and Article 5.66. (V.T.I.C. Art. 5.60, Sec. (c).)

Source Law

(c) This subchapter may not be construed to prohibit any stock company, mutual company, including the Texas Mutual Insurance Company, reciprocal or interinsurance exchange, or Lloyd's plan from issuing participating policies; however, a dividend to policyholders under Subtitle A, Title 5, Labor Code, may not take effect until approved by the department. Such a dividend may not be approved until adequate reserves have been provided, those reserves to be computed on the same basis for all classes of companies operating under this subchapter.

Revisor's Note

(1) Section (c), V.T.I.C. Article 5.60, provides that "[t]his subchapter," meaning Subchapter D, V.T.I.C. Chapter 5, may not be construed to prohibit certain insurance policies and refers to insurance companies operating under "this subchapter." The relevant provisions of Subchapter D, Chapter 5, are V.T.I.C. Article 5.66 and those articles that are revised in Subtitle E, Title 10, of this code, which includes this chapter. Subtitle E also includes

provisions derived from Subchapter G, V.T.I.C. Chapter 5, that relate to the Texas Mutual Insurance Company and could not be construed to prohibit the specified insurance policies. In addition, V.T.I.C. Article 5.63, revised in this chapter as Section 2052.001, defines "insurance company" in part as a mutual insurance company, which includes the Texas Mutual Insurance Company. Accordingly, the revised law substitutes references to "this subtitle and Article 5.66" for the references to "this subchapter."

(2) Section (c), V.T.I.C. Article 5.60, refers to a dividend to policyholders under "Subtitle A, Title 5, Labor Code." The revised law substitutes a reference to a policyholder dividend under "a workers' compensation insurance policy" because it is clear from the context that the reference to Subtitle A, Title 5, Labor Code, was intended to refer to that kind of policy. Subtitle A, Title 5, Labor Code, applies to and describes workers' compensation insurance policies generally, but does not specifically authorize an insurance company to issue a dividend to a policyholder under that kind of policy.

CHAPTER 2053. RATES FOR WORKERS' COMPENSATION INSURANCE

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CHAPTER 2053. RATES FOR WORKERS' COMPENSATION INSURANCE

SUBCHAPTER A. RATE FILINGS

Revised Law

Sec. 2053.001. DEFINITIONS. In this subchapter:

(1) "Filer" means an insurance company that files rates, prospective loss costs, or supplementary rating information under this subchapter.

(2) "Insurance company" means a person authorized to engage in the business of workers' compensation insurance in this state. The term includes the Texas Mutual Insurance Company.

(3) "Prospective loss cost" means that portion of a rate that:

(A) does not include a provision for expenses or profit, other than loss adjustment expenses; and

(B) is based on historical aggregate losses and loss adjustment expenses projected by development to the ultimate value of those losses and expenses and projected through trending to a future point in time.

(4) "Rate" means the cost of workers' compensation insurance per exposure unit, whether expressed as a single number or as a prospective loss cost, adjusted to account for the treatment of expenses, profit, and individual insurance company variation in loss experience, before applying individual risk variations based on loss or expense considerations. The term does not include a minimum premium.

(5) "Supplementary rating information" means any

manual, rating plan or schedule, plan of rules, rating rule, classification system, territory code or description, or other similar information required to determine the applicable premium for an insured. The term includes increased limits factors, classification relativities, deductible relativities, and other similar factors and relativities.

(6) "Supporting information" means:

(A) the experience and judgment of the filer and the experience or information of other insurance companies;

(B) the interpretation of any other information on which the filer relied;

(C) a description of methods used in making a rate; and

(D) any other information the department requires to be filed. (V.T.I.C. Art. 5.55, Secs. 1(1), (2), (3), (4), (6), (7).)

Source Law

Art. 5.55
Sec. 1. In this article:

(1) "Filer" means an insurer that files rates, prospective loss costs, or supplementary rating information under this article.

(2) "Insurer" means a person authorized and admitted by the Texas Department of Insurance to do insurance business in this state under a certificate of authority that includes authorization to write workers' compensation insurance. The term includes the Texas Mutual Insurance Company.

(3) "Prospective loss cost" means that portion of a rate that does not include provisions for expenses or profit, other than loss adjustment expenses, and that is based on historical aggregate losses and loss adjustment expenses projected by development to their ultimate value and through trending to a future point in time.

(4) "Rate" means the cost of workers' compensation insurance per exposure unit, whether expressed as a single number or as a prospective loss cost, with an adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, before any application of individual risk variations based on loss or expense considerations. The term does not include a minimum premium.

(6) "Supplementary rating information" means any manual, rating schedule, plan of rules, rating rules, classification systems, territory codes and descriptions, rating plans, and other similar information required to determine the applicable

premium for an insured. The term includes factors and relativities, such as increased limits factors, classification relativities, deductible relativities, or other similar factors.

(7) "Supporting information" means:

(A) the experience and judgment of the filer and the experience or information of other insurers;

(B) the interpretation of any other information relied on by the filer;

(C) descriptions of methods used in making the rates; and

(D) any other information required by the department to be filed.

Revisor's Note

(1) Section 1(2), V.T.I.C. Article 5.55, defines "insurer." Throughout this chapter, the revised law substitutes "insurance company" for "insurer" for consistency with the terminology used in the Labor Code with respect to workers' compensation insurance.

(2) Section 1(2), V.T.I.C. Article 5.55, refers to a person "authorized and admitted by the Texas Department of Insurance to do insurance business in this state." The revised law omits the reference to a person being "admitted" as unnecessary because a person who is authorized to engage in the business of insurance in this state necessarily has been admitted to engage in that business in this state. In addition, the revised law omits the reference to the department as unnecessary because the department is the only entity that authorizes a person to engage in the business of insurance in this state.

Revised Law

Sec. 2053.002. RATE STANDARDS. (a) In setting rates, an insurance company shall consider:

(1) past and prospective loss cost experience;

(2) operation expenses;

(3) investment income;

(4) a reasonable margin for profit and contingencies; and

(5) any other relevant factor.

(b) A rate may not be excessive, inadequate, or unfairly discriminatory.

(c) An insurance company may:

(1) group risks by classification to establish rates and minimum premiums; and

(2) modify classification rates to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in those risks on the basis of any factor listed in Subsection (a).

(d) In setting rates that apply only to policyholders in this state, an insurance company shall use available premium, loss, claim, and exposure information from this state to the full extent that the information is actuarially credible. The insurance company may use experience from outside this state as necessary to supplement information from this state that is not actuarially credible. (V.T.I.C. Art. 5.55, Secs. 2(b), (c), (d), (e).)

Source Law

(b) In setting rates, an insurer shall consider:

(1) past and prospective loss cost experience;

(2) operation expenses;

(3) investment income;

(4) a reasonable margin for profit and contingencies; and

(5) any other relevant factors.

(c) The insurer may group risks by classifications for the establishment of rates and minimum premiums and may modify classification rates to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in those risks on the basis of any factor listed in Subsection (b) of this section.

(d) Rates may not be excessive, inadequate, or unfairly discriminatory.

(e) In setting rates applicable solely to policyholders in this state, an insurer shall use available premium, loss, claim, and exposure information from this state to the full extent of the actuarial credibility of that information. The insurer may use experience from outside this state as necessary to supplement information from this state that is not actuarially credible.

Revisor's Note

Section 2(a), V.T.I.C. Article 5.55, states that rates established under Article 5.55 must be made in

accordance with the provisions of Section 2 of that article, which are revised as this section. The revised law omits Section 2(a) as unnecessary because the other provisions of Section 2 apply by their own terms to a rate established under Article 5.55. The omitted law reads:

> Sec. 2. (a) Rates under this article shall be made in accordance with the provisions of this section.

Revised Law

Sec. 2053.003. RATE FILING AND SUPPORTING INFORMATION. (a) Each insurance company shall file with the department all rates, supplementary rating information, and reasonable and pertinent supporting information for risks written in this state.

(b) An insurance company may not make a filing described by Subsection (a) more frequently than once every six months. (V.T.I.C. Art. 5.55, Sec. 3(a) (part).)

Source Law

> Sec. 3. (a) Each insurer shall file with the Texas Department of Insurance all rates, supplementary rating information, and reasonable and pertinent supporting information for risks written in this state. An insurer may not make such filing more frequently than every six months. . . .

Revisor's Note

Section 3(a), V.T.I.C. Article 5.55, refers to the Texas Department of Insurance. The revised law substitutes "department" for "Texas Department of Insurance" because Section 31.001 of this code contains a definition of "department" that applies to this chapter. Throughout this chapter, references to the Texas Department of Insurance have been changed appropriately.

Revised Law

Sec. 2053.004. PUBLIC INSPECTION OF INFORMATION. Each filing made, including any supporting information filed, under this subchapter is open to public inspection as of the date the filing is

made. (V.T.I.C. Art. 5.55, Sec. 4.)

Source Law

> Sec. 4. Each filing and any supporting information filed under this article is open to public inspection as of the date of the filing.

Revised Law

Sec. 2053.005. EFFECTIVE DATE OF RATE; HEARING. (a) A filer shall designate the date a rate proposed in a filing made under Section 2053.003 is to take effect. Subject to Subsections (b)-(d), the rate does not take effect until the department receives all necessary information required for the filing.

(b) A filing made under Section 2053.003 takes effect on the date designated by the filer under Subsection (a) unless the department, not later than the 30th day after the date the department receives the filing, notifies the filer that the filing is missing specific required information. The filer must provide the missing information not later than the 30th day after the date the filer is notified under this subsection.

(c) If the filer in good faith believes that information requested under Subsection (b) has already been provided to the department, the filer may request a hearing. The commissioner shall hold the hearing not later than the 30th day after the date the department receives the request for a hearing.

(d) The commissioner shall issue an order not later than the 30th day after the date of the hearing under Subsection (c). If the commissioner determines that the filing is still missing required information, the commissioner shall specify in the order the information that is missing. (V.T.I.C. Art. 5.55, Secs. 3(a) (part), (b).)

Source Law

> (a) . . . Subject to Subsection (b) of this section, a rate proposed in a filing made under this subsection does not take effect until all necessary information required for the filing is received by the department.
>
> (b) A filer shall designate the date on which the filing is to take effect. The filing takes effect on the designated date unless the board, not later than the 30th day after the date of the receipt of the

filing, advises the filer of what specific information that is required for the filing has not been included in the filing. The filer must provide the missing information not later than the 30th day after the date on which the filer is notified by the board of the missing information. If the filer in good faith believes that the requested information has already been provided, the filer may request a hearing. The board shall hold the hearing not later than the 30th day after the receipt of the hearing request from the filer. The board shall issue a decision not later than the 30th day after the date of the hearing. If the board determines that necessary information is still missing, the board shall specify in the decision the information that was not included in the filing.

Revisor's Note

Section 3(b), V.T.I.C. Article 5.55, refers to the "board," meaning the Board of Insurance Commissioners or the State Board of Insurance. Under Chapter 499, Acts of the 55th Legislature, Regular Session, 1957, administration of the insurance laws of this state 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 that board's functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the Board of Insurance Commissioners and State Board of Insurance have been changed appropriately.

Revised Law

Sec. 2053.006. DISAPPROVAL OF RATE FILING; HEARING. (a) The commissioner shall disapprove a rate filing made under Section 2053.003 if the commissioner determines that the filing does not meet the standards established under this subchapter.

(b) If the commissioner disapproves a rate filing, the commissioner shall issue an order specifying in what respects the filing fails to meet the requirements of this subchapter.

(c) A filer whose rate filing is disapproved is entitled to a hearing on written request made to the department not later than

the 30th day after the date the order disapproving the filing takes effect. (V.T.I.C. Art. 5.55, Sec. 5.)

Source Law

> Sec. 5. (a) The State Board of Insurance shall disapprove a rate filing if the board determines that the rate filing made under Section 3 of this article does not meet the standards established under this article.
>
> (b) If the board disapproves a rate filing, the board shall issue an order specifying in what respects the rate filing fails to meet the requirements of this article. The filer is entitled to a hearing on written request made to the board not later than the 30th day after the effective date of the disapproval order.

Revised Law

Sec. 2053.007. DISAPPROVAL OF RATE; HEARING. (a) The commissioner may issue an order after a hearing disapproving a rate that is in effect. The commissioner must provide the insurance company that filed the rate written notice of the hearing not later than the 10th day before the date of the hearing.

(b) The commissioner shall issue an order disapproving a rate under Subsection (a) not later than the 15th day after the close of the hearing. The order must:

(1) specify in what respects the rate fails to meet the requirements of this subchapter; and

(2) state the date further use of the rate is prohibited.

(c) An order issued under this section does not affect an insurance policy made or issued in accordance with this code before the expiration of the period stated in the order. (V.T.I.C. Art. 5.55, Sec. 6.)

Source Law

> Sec. 6. (a) The State Board of Insurance may issue a disapproval order only after notice and hearing. The board must provide at least 10 days' written notice to the insurer that made the rate filing.
>
> (b) The disapproval order must be issued not later than the 15th day after the close of a hearing and must specify how the rate fails to meet the requirements of this article. The disapproval order must state the date on which the further use of that rate is prohibited. A disapproval order does not affect a policy made or issued in accordance with this code before the expiration of the period established

in the order.

Revised Law

Sec. 2053.008. EFFECT OF DISAPPROVAL ORDER. (a) If a workers' compensation insurance policy is issued and the commissioner subsequently disapproves the rate or filing that governs the premium charged on the policy, the policyholder may:

(1) continue the policy at the original rate;

(2) cancel the policy without penalty; or

(3) enter into an agreement with the insurance company issuing the policy to amend the policy to reflect the premium that would have been charged based on the insurance company's most recently approved rate.

(b) An amendment under Subsection (a)(3) may not take effect before the date further use of the rate is prohibited under an order issued under Section 2053.007. (V.T.I.C. Art. 5.55, Sec. 7(a).)

Source Law

> Sec. 7. (a) If a policy is issued and the board subsequently disapproves the rate or filing that governs the premium charged on the policy:
>
> (1) the policyholder may continue the policy at the original rate;
>
> (2) the policyholder may cancel the policy without penalty; or
>
> (3) the policyholder and the insurer may agree to amend the policy to reflect the premium that would have been charged based on the insurer's most recently approved rate; the amendment may not take effect before the date on which further use of the rate is prohibited under the disapproval order.

Revised Law

Sec. 2053.009. GRIEVANCE. (a) The office of public insurance counsel or an insured who is aggrieved with respect to a filing made under Section 2053.003 that is in effect may apply to the department in writing for a hearing on the filing. The application must specify the grounds for the applicant's grievance.

(b) The commissioner shall hold a hearing on an application filed under Subsection (a) not later than the 30th day after the date the department receives the application if the department determines that:

(1) the application is made in good faith;

(2) the applicant would be aggrieved as alleged if the grounds specified in the application were established; and

(3) the grounds specified in the application otherwise justify holding the hearing.

(c) The department shall provide written notice of a hearing under Subsection (b) to the applicant and to each insurance company that made the filing not later than the 10th day before the date of the hearing. The notice must specify:

(1) which of the grounds specified in the application are in question; and

(2) whether the insurance company's entire filing will be considered at the hearing or whether the hearing is limited to consideration of the grounds specified in the application.

(d) If, after the hearing, the commissioner determines that the filing does not meet the requirements of this subchapter, the commissioner shall issue an order specifying:

(1) in what respects the filing fails to meet those requirements;

(2) the date the filing is no longer in effect, which must be within a reasonable period that is not less than 60 days after the date the order is issued; and

(3) whether the order applies with respect to all insureds affected by the filing or only with respect to the applicant, if the applicant was an aggrieved insured.

(e) The department shall send copies of the order issued under Subsection (d) to the applicant and each affected insurance company.

(f) An order issued under Subsection (d) does not affect an insurance policy or contract made or issued before the expiration of the period stated in the order. (V.T.I.C. Art. 5.55, Secs. 3(c), (d).)

Source Law

(c) An insured that is aggrieved with respect to any filing in effect or the office of public insurance counsel may make a written application to the board for

a hearing on the filing. The application must specify the grounds on which the applicant bases the grievance. If the board finds that the application is made in good faith, that the applicant would be so aggrieved if the grounds in the application are established, and that those grounds otherwise justify holding the hearing, the board shall hold a hearing not later than the 30th day after the date of receipt of the application. The board must give at least 10 days' written notice to the applicant and to each insurer that made the filing in question. The notice must specify which of the grounds in the application are in question and whether the hearing is limited to consideration of the specific application of the aggrieved insured or to the entire filing.

(d) If, after the hearing, the board finds that the filing does not meet the requirements of this article, the board shall issue an order specifying how the filing fails to meet the requirements of this article and stating the date on which, within a reasonable period of not less than 60 days after the order date, the filing is no longer in effect. The board order must specify whether the order applies only to the applicant or to all insureds affected by the filing. The board shall send copies of the order to the applicant and to each affected insurer. An order issued under this subsection does not affect a contract or policy made or issued before the expiration of the period established in the order.

Revisor's Note

Section 3(d), V.T.I.C. Article 5.55, states that an order issued by the commissioner of insurance under that section stating that a filing made under Article 5.55 does not comply with that article must also state whether the order applies only with respect to the applicant who filed the grievance on which the order is based or with respect to all insureds affected by the filing. Under Section 3(c), Article 5.55, revised in this section, the applicant could be either an aggrieved insured or the office of public insurance counsel. It is clear from the context of Section 3(d) that the commissioner's order could apply to the aggrieved insured or to all insureds, but not to the office of public insurance counsel. The revised law is drafted accordingly.

Revised Law

Sec. 2053.010. ADMINISTRATIVE PENALTY. (a) The commissioner may assess an administrative penalty against an

insurance company if the commissioner determines, based on a pattern of charges for premiums, that the company is consistently overcharging or undercharging the company's policyholders for workers' compensation insurance.

(b) An administrative penalty under this section must be:

(1) assessed in accordance with Section 415.021, Labor Code; and

(2) set by the commissioner in an amount reasonable and necessary to deter overcharging or undercharging of policyholders. (V.T.I.C. Art. 5.55, Sec. 7(b).)

Source Law

(b) If the board determines, based on a pattern of charges for premiums, that an insurer is consistently overcharging or undercharging, the board may assess an administrative penalty. The penalty shall be assessed in accordance with Article 10, Texas Workers' Compensation Act (Article 8308-10.01 et seq., Vernon's Texas Civil Statutes), and set by the board in an amount reasonable and necessary to deter the overcharging or undercharging of policyholders.

Revisor's Note

Section 7(b), V.T.I.C. Article 5.55, refers to Article 10, Texas Workers' Compensation Act (Article 8308-10.01 et seq., Vernon's Texas Civil Statutes). The portion of that statute relating to the assessment of an administrative penalty was codified in 1993 as Section 415.021, Labor Code. The revised law is drafted accordingly.

[Sections 2053.011-2053.050 reserved for expansion]

SUBCHAPTER B. RATE ADMINISTRATION

Revised Law

Sec. 2053.051. HAZARD CLASSIFICATION SYSTEM. (a) For workers' compensation insurance, the department shall:

(1) determine hazards by class; and

(2) establish classification relativities applicable to an employer's payroll in each of the classes at levels adequate to the risks to which the relativities apply.

(b) The classification relativities established under

Subsection (a)(2):

(1) must be designed to encourage safety;

(2) may be territorially based; and

(3) may reflect a difference in losses between employers of high wage earners and employers of low wage earners within the same class.

(c) The department shall revise the classification system at least once every five years. (V.T.I.C. Art. 5.60, Secs. (a), (d) (part).)

Source Law

> Art. 5.60. (a) For workers' compensation insurance, the Board shall determine hazards by classes and fix classification relativities applicable to the payroll in each of the classes as shall be adequate to the risks to which they apply. The relativities:
>
> (1) shall be designed to encourage safety;
>
> (2) may be territorially based; and
>
> (3) may reflect differences in losses between employers of high and low wage earners within the same class.
>
> (d) The Board shall revise the classification system and . . . not later than March 1, 1993, and subsequently shall revise the system and . . . at least once every five years.

Revisor's Note

Section (d), V.T.I.C. Article 5.60, directs the "Board," meaning the Texas Department of Insurance for the reason stated in the revisor's note to Section 2053.005, to revise the classification system established under Section (a), V.T.I.C. Article 5.60, "not later than March 1, 1993," and subsequently at least once every five years. The revised law omits the reference to "not later than March 1, 1993," as executed.

Revised Law

Sec. 2053.052. EXPERIENCE RATING PLAN. (a) The commissioner shall adopt a uniform experience rating plan for workers' compensation insurance. The plan must:

(1) encourage accident prevention; and

(2) account for:

(A) the peculiar hazard and experience of individual risks, past and prospective, inside and outside this state; and

(B) any other relevant factor.

(b) The commissioner shall revise the rating plan at least once every five years.

(c) The commissioner may adopt reasonable rules and plans requiring the interchange of loss experience necessary for the application of the rating plan. (V.T.I.C. Art. 5.58, Sec. (h); Art. 5.60, Secs. (b), (d) (part).)

Source Law

[Art. 5.58]

(h) Interchange of Rating Plan Data. Reasonable rules and plans may be promulgated by the commissioner after due consideration, requiring the interchange of loss experience necessary for the application of rating plans promulgated by the commissioner under this subchapter.

[Art. 5.60]

(b) The Board shall adopt a uniform experience rating plan. The rating plan shall encourage the prevention of accidents and consider the peculiar hazard and experience of individual risks, past and prospective, within and outside this state, and all other relevant factors.

(d) The Board shall revise the . . . rating plans not later than March 1, 1993, and subsequently shall revise the . . . plans at least once every five years.

Revisor's Note

(1) Section (h), V.T.I.C. Article 5.58, states that the commissioner of insurance may adopt reasonable rules and plans "after due consideration." The revised law omits "after due consideration" as unnecessary because the requirement that a rule or a plan be reasonable implies that the commissioner will give the rule or plan due consideration before adopting that rule or plan.

(2) Section (h), V.T.I.C. Article 5.58, refers to the rating plans adopted by the commissioner of

insurance under "this subchapter," meaning Subchapter D, V.T.I.C. Chapter 5. Subchapter D, Chapter 5, is revised in various chapters in this code. The portions of Subchapter D, Chapter 5, relating to the adoption of rating plans are in Section (b), V.T.I.C. Article 5.60, which is revised in this section. The revised law is drafted accordingly.

(3) Section (d), V.T.I.C. Article 5.60, directs the "Board," meaning the commissioner of insurance for the reason stated in the revisor's note to Section 2053.005, to revise the rating plan established under Section (b), V.T.I.C. Article 5.60, "not later than March 1, 1993," and subsequently at least once every five years. The revised law omits the reference to "not later than March 1, 1993," as executed.

Revised Law

Sec. 2053.053. USE OF HAZARD CLASSIFICATIONS REQUIRED. A stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan authorized to engage in the business of workers' compensation insurance in this state may not use hazard classifications other than the classifications established by the department. (V.T.I.C. Arts. 5.56 (part), 5.63.)

Source Law

> Art. 5.56. . . . No company or association authorized to write workmen's compensation insurance in this State shall . . . use any classifications of hazards, rates of premium, or . . . other than those made, established and promulgated and prescribed by the Board.

> Art. 5.63. The words "Company" and "Association" used in this subchapter mean the Texas Employers Insurance Association, or any stock company, or any mutual company, or any reciprocal, or any interinsurance exchange, or Lloyd's association authorized to write Workmen's Compensation Insurance in this State.

Revisor's Note

(1) V.T.I.C. Article 5.56 refers to the use of "classifications of hazards, [or] rates of premium

. . . made, established and promulgated and prescribed." The revised law substitutes a reference to "classifications established" for the quoted phrase with respect to hazard classifications for consistency of terminology in this code. In addition, the revised law omits the quoted language with respect to premium rates as impliedly repealed by Article 18, Chapter 12, Acts of the 72nd Legislature, 2nd Called Session, 1991, under which the legislature abolished the authority of the commissioner of insurance to adopt workers' compensation insurance rates and amended V.T.I.C. Article 5.55, revised in this chapter as Subchapter A, to provide for the filing of rates by workers' compensation insurance companies and the use of those rates unless they are disapproved.

(2) V.T.I.C. Article 5.63 defines terms "used in this subchapter," meaning Subchapter D, V.T.I.C. Chapter 5, which includes V.T.I.C. Article 5.56 and other articles revised in this chapter. The revised law incorporates the substance of the definitions or applies definitions derived from Article 5.63 to each provision in this chapter that is derived from articles to which the definitions apply. In addition, the substance of the definitions contained in Article 5.63 is repeated in each of the chapters of this subtitle in which other articles from Subchapter D, V.T.I.C. Chapter 5, are revised.

(3) V.T.I.C. Article 5.63 defines "company" and "association." The revised law substitutes "insurance company" for "company" and "association" for the reason stated in Revisor's Note (1) to Section 2053.001. Throughout this chapter, references to "company" and "association" have been changed appropriately.

(4) V.T.I.C. Article 5.63 defines "company" and "association" to include the Texas Employers Insurance Association. The Texas Employers Insurance Association was placed in receivership and liquidated in 2004. Throughout this chapter, the revised law omits references to the Texas Employers Insurance Association accordingly.

(5) V.T.I.C. Article 5.63 refers to a "mutual company, or any reciprocal, or any interinsurance exchange, or Lloyd's association." For consistency of terminology within this code, the revised law throughout this chapter substitutes references to a "mutual insurance company," a "reciprocal or interinsurance exchange," and a "Lloyd's plan" for the references to a "mutual company," "any reciprocal, or any interinsurance exchange," and "Lloyd's association," respectively.

Revised Law

Sec. 2053.054. USE OF INCURRED CLAIMS EXPERIENCE IN FUTURE RATINGS REQUIRED. (a) Regardless of a change in a policyholder's ownership, control, management, or operations, incurred claims experience must be used in future ratings to ensure that an employer does not evade an unfavorable or high-cost experience.

(b) On application by an affected party, the department may modify a rating under Subsection (a) on proof that a change in a policyholder's management or operations is clearly designed to result in a probable reduction of the insured's loss experience.

(c) The commissioner shall adopt rules necessary to implement this section. (V.T.I.C. Art. 5.65B, Secs. (a) (part), (b), (c), (d).)

Source Law

Art. 5.65B. (a) A policyholder [shall make full disclosure . . . concerning] its true ownership, change of ownership, operations, or payroll and . . . .

(b) To the end that no employer shall evade an

unfavorable or high cost experience, incurred experience shall be used in future ratings regardless of any change in ownership, control, management, or operations.

(c) The board, on application of an affected party, may modify the rating on proof that a change in management or operations is clearly probable to reduce the loss experience of the insured.

(d) The board shall promulgate rules necessary to implement this article.

Revised Law

Sec. 2053.055. RATE ADJUSTMENT. If the commissioner determines that an insurance company's rates do not meet with the standards imposed by Section 2053.002, the commissioner may order the insurance company to adjust the rates to meet those standards. An insurance company may appeal an order under this section in accordance with Subchapter D, Chapter 36. (V.T.I.C. Art. 5.58, Sec. (a) (part).)

Source Law

(a) [The commissioner shall develop reasonable statistical plans, . . . to aid in determining whether rates meet] the standards imposed under Section 2, Article 5.55 of this code. If the commissioner determines that any insurer's rates do not meet those standards, the commissioner may order the insurer to adjust its rates to meet those standards. An order of the commissioner under this article may be appealed under Article 1.04 of this code. . . .

Revisor's Note
(End of Subchapter)

(1) Section 2(f), V.T.I.C. Article 5.55, states that the premium rates promulgated by the State Board of Insurance for 1991 continue in effect for all workers' compensation insurance policies issued before the "rate change date." Section 1(5), V.T.I.C. Article 5.55, defines "rate change date" and directs the Texas Department of Insurance to publish notice of the rate change date in the Texas Register. The Texas Workers' Compensation Insurance Fund issued its first policy on January 1, 1992. Thus, the "rate change date" was in March of 1992. The revised law omits Sections 1(5) and 2(f) as executed because, according to the department, no workers' compensation insurance

policy issued before the "rate change date" remains in effect. The omitted law reads:

> [Sec. 1]
> (5) "Rate change date" means the later of March 1, 1992, or the 60th day after the date of issuance of the first insurance policy by the Texas Workers' Compensation Insurance Fund under Article 5.76-3 of this code. The department shall publish notice of the rate change date in the Texas Register.
>
> [Sec. 2]
> (f) Premium rates promulgated by the State Board of Insurance for 1991 continue to apply to all workers' compensation insurance policies issued before the rate change date.

(2) V.T.I.C. Article 5.60A requires the State Board of Insurance to conduct rate hearings, provides procedures for those hearings, and requires the board to consider changes in workers' compensation laws when setting workers' compensation insurance rates. The revised law omits Article 5.60A as impliedly repealed. Article 18, Chapter 12, Acts of the 72nd Legislature, 2nd Called Session, 1991, abolished the board's function of promulgating workers' compensation insurance rates and authorized insurance companies to set the rates, file the rates with the Texas Department of Insurance, and use the rates unless the rates are disapproved. The omitted law reads:

> Art. 5.60A. (a) The Board shall conduct an annual hearing to review rates to be charged for workers' compensation insurance written in this state under this subchapter. The hearing shall be conducted under the contested case provisions of the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes).
> (b) The Board shall conduct a hearing six months prior to the annual hearing to revise rates to establish the methodology and sources of data to be used in reviewing rates. The hearing shall be conducted under the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes).
> (c) To assist the Board in making rates and to provide additional information on certain trends that may affect the costs

of workers' compensation insurance, the executive director of the Texas Workers' Compensation Commission or a person designated by that officer shall testify at any rate hearing conducted under this article. The testimony shall relate to trends in:

(1) claims resolution of workers' compensation cases; and

(2) cost components in workers' compensation cases.

(d) The testimony of the executive director or designee is subject to cross-examination by the Board and any party to the hearing.

(e) The Board shall consider changes in the workers' compensation laws when setting workers' compensation insurance rates.

[Sections 2053.056-2053.100 reserved for expansion]

SUBCHAPTER C. STATISTICAL PLANS; AGENT

Revised Law

Sec. 2053.101. STATISTICAL PLANS FOR REPORTING LOSS EXPERIENCE AND OTHER DATA. The commissioner shall develop and may periodically modify reasonable statistical plans for workers' compensation insurance to be used by each insurance company in recording and reporting the insurance company's loss experience and other data required by the department, so that the total loss and expense experience of all insurance companies is made available at least annually in the form and detail necessary to assist in determining whether an insurance company's rates meet the standards imposed under Section 2053.002. (V.T.I.C. Art. 5.58, Sec. (a) (part).)

Source Law

Art. 5.58. (a) Recording and Reporting of Loss Experience and Other Data. The commissioner shall develop reasonable statistical plans, which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss experience and such other data as may be required, in order that the total loss and expense experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid in determining whether rates meet the standards imposed under Section 2, Article 5.55 of this code. . . .

Revised Law

Sec. 2053.102. TREATMENT OF PAYMENTS UNDER STATISTICAL PLAN. A statistical plan developed under Section 2053.101 must

require the following payments to be reported separately and not to be considered as a loss or expense for purposes of computing a premium rate modifier or surcharge of an insured:

(1) a direct payment made by an insurance company to influence public policy; and

(2) any amount paid by an insurance company:

(A) as damages in an action against the insurance company for malice or bad faith; or

(B) as a fine or penalty. (V.T.I.C. Art. 5.58, Sec. (e).)

Source Law

(e) Payments Excluded From Rates. In any statistical plan developed by the commissioner, direct expenditures by an insurer to influence public policy and any amounts paid by an insurer as damages in a suit against the insurer for malice or bad faith or as fines or penalties shall be reported separately, and the expenditures and payments shall not be considered as a loss or expense for the calculation of any premium rate modifier or surcharge of an insured.

Revisor's Note

Section (e), V.T.I.C. Article 5.58, refers to certain "expenditures" and "expenditures and payments" made by a workers' compensation insurance company. The revised law substitutes "payments" for "expenditures" and "payments and expenditures" for consistent use of terminology within this chapter.

Revised Law

Sec. 2053.103. STATISTICAL AGENT. (a) The commissioner may designate or contract with a qualified organization to serve as the statistical agent for the commissioner under this subchapter as provided by Subchapter E, Chapter 38.

(b) The statistical agent may provide to one or more advisory organizations any information provided by the agent to the commissioner under this subchapter. (V.T.I.C. Art. 5.58, Sec. (a) (part).)

Source Law

(a) . . . The commissioner may designate or

contract with a qualified organization to serve as the statistical agent for the commissioner under this article as provided by Article 21.69 of this code. The statistical agent may provide to one or more advisory organizations the information provided by the statistical agent to the commissioner under this article.

Revisor's Note

Section (a), V.T.I.C. Article 5.58, refers to the designation of a statistical agent and the information provided by that agent under Article 5.58. That article is revised in this chapter as Sections 2053.052 and 2053.055 and as this subchapter and Subchapter D. The provisions relating to statistical agents are revised in this subchapter, and the revised law is drafted accordingly.

[Sections 2053.104-2053.150 reserved for expansion]

SUBCHAPTER D. REPORTING REQUIREMENTS AND EXCHANGE OF INFORMATION

Revised Law

Sec. 2053.151. WORKERS' COMPENSATION CLAIMS REPORTS AND INFORMATION. (a) The following information must be reported on each workers' compensation claim:

(1) the hazard classification of the affected employee;

(2) the date of injury;

(3) the social security number of the claimant;

(4) the severity classification of the claim, including separate classifications for:

(A) claims in which death benefits are paid;

(B) claims in which lifetime income benefits are paid;

(C) claims in which only temporary income benefits are paid;

(D) claims in which impairment income benefits are paid;

(E) claims in which supplemental income benefits are paid; and

(F) claims in which only medical benefits are paid;

(5) the amount paid in periodic payments;

(6) the amount paid in lump-sum payments;

(7) the amount paid for:

(A) temporary income benefits;

(B) impairment income benefits;

(C) supplemental income benefits; and

(D) death and burial benefits;

(8) the total amount paid for:

(A) income, death, or burial benefits; and

(B) medical benefits;

(9) the total amount of incurred losses for:

(A) income, death, or burial benefits; and

(B) medical benefits;

(10) the amount paid to:

(A) doctors and other health care providers; and

(B) hospitals and other health care facilities; and

(11) other information required by the commissioner.

(b) For purposes of Subsection (a), the commissioner shall establish standards and procedures for categorizing insurance and medical benefits required to be reported on each workers' compensation claim. In establishing the standards, the commissioner shall consult with the Texas Workers' Compensation Commission to ensure that the data collection methodology will yield data necessary for research and medical cost containment efforts.

(c) The commissioner may allow the information required by Subsection (a) to be reported in the aggregate for each risk for claims in which benefit payments are less than $5,000. The commissioner may adjust the $5,000 threshold for aggregate reporting to account for inflationary changes.

(d) A person may not distribute or otherwise disclose a

social security number or any other information collected under Subsection (a) that would disclose the identity of a claimant. (V.T.I.C. Art. 5.58, Secs. (b), (c), (d), (g).)

Source Law

(b) Standards and Procedures. For purposes of Subsection (c) of this article, the commissioner shall establish standards and procedures for categorizing insurance and medical benefits reported on each workers' compensation claim. The commissioner shall consult with the Texas Workers' Compensation Commission and the Research and Oversight Council on Workers' Compensation in establishing these standards to ensure that the data collection methodology will also yield data necessary for research and medical cost containment efforts.

(c) Content of Detailed Claim Information Reports. The following information shall be reported on each workers' compensation claim:

(1) the hazard classification of the affected employee;

(2) the date of injury;

(3) the social security number of the claimant;

(4) the severity classification of the claim, including separate classifications for claims in which death benefits are paid, claims in which lifetime income benefits are paid, claims in which only temporary income benefits are paid, claims in which impairment benefits are paid, claims in which supplemental benefits are paid, and claims in which only medical benefits are paid;

(5) the amount paid in periodic payments;

(6) the amount paid in lump-sum payments;

(7) the amount paid for temporary income benefits;

(8) the amount paid for impairment income benefits;

(9) the amount paid for supplemental income benefits;

(10) the amount paid for death and burial benefits;

(11) the total amount paid for income, death, or burial benefits;

(12) the total amount of incurred losses for income, death, or burial benefits;

(13) the amount paid to doctors and other health care providers;

(14) the amount paid to hospitals and other health care facilities;

(15) the total amount paid for medical benefits;

(16) the total amount of incurred losses for medical benefits; and

(17) other information required by the commissioner.

(d) Information Confidential. A person may not distribute or otherwise disclose a social security number or any other information collected under Subsection (c) of this article which would disclose the identity of any claimant.

(g) Reports of Aggregate Data. The commissioner may permit the information required by Subsection (c)

of this article to be reported in the aggregate for each risk for claims in which benefit payments are less than $5,000. The commissioner may adjust the dollar threshold for aggregate reporting to account for inflationary changes.

Revisor's Note

(1) Section (b), V.T.I.C. Article 5.58, requires the commissioner of insurance to consult with the Research and Oversight Council on Workers' Compensation. The revised law omits this reference as unnecessary because Chapter 10, Acts of the 78th Legislature, 3rd Called Session, 2003, abolished that council and transferred its functions to the Texas Department of Insurance. It is unnecessary to substitute a requirement that the commissioner consult with the department because, under Section 31.021 of this code, the commissioner is the chief executive and administrative officer of the department.

(2) Section (c)(4), V.T.I.C. Article 5.58, refers to "impairment benefits" and "supplemental benefits." The revised law substitutes "impairment income benefits" for "impairment benefits" and "supplemental income benefits" for "supplemental benefits" for consistency with terminology used elsewhere in this section and in the Labor Code.

Revised Law

Sec. 2053.152. UPDATE AND TRANSMISSION OF CLAIMS REPORTS. (a) An insurance company, in accordance with the filing requirements of a statistical plan developed under Section 2053.101, shall update and transmit to the commissioner or the commissioner's statistical agent a claims report filed under Section 2053.151.

(b) Each insurance company that writes at least one-half of one percent of the workers' compensation insurance in this state shall report the company's data in a compatible electronic format prescribed by the commissioner. The commissioner shall take

necessary measures to ensure the accuracy of the data and the adequacy of the electronic format for the data. (V.T.I.C. Art. 5.58, Sec. (f).)

Source Law

> (f) Transmission of Claims Reports. The claims reports filed under Subsection (c) of this article shall be updated by each insurer and transmitted to the commissioner or the commissioner's statistical agent in accordance with the filing requirements of the commissioner's statistical plan. Each insurer writing at least one-half of one percent of the workers' compensation insurance in this state shall report its data in a compatible electronic format prescribed by the commissioner. The commissioner shall take necessary measures to ensure the accuracy of the data and the adequacy of the format for data reported in an electronic format.

Revised Law

Sec. 2053.153. EXCHANGE OF INFORMATION AND CONSULTATION WITH OTHERS. To further the uniform administration of rating laws relating to workers' compensation insurance, the commissioner and each insurance company may:

(1) exchange information and experience data with the National Association of Insurance Commissioners and with insurance supervisory officials, insurance companies, and advisory organizations in other states; and

(2) consult and cooperate with a person or entity described by Subdivision (1) with respect to ratemaking and the application of rating systems. (V.T.I.C. Art. 5.58, Sec. (i).)

Source Law

> (i) Consultation with Other States. In order to further uniform administration of rating laws, the commissioner and every insurer may exchange information and experience data with the National Association of Insurance Commissioners, insurance supervisory officials, insurers, and advisory organizations in other states and may consult and cooperate with them with respect to rate-making and the application of rating systems.

Revisor's Note

Section (i), V.T.I.C. Article 5.58, refers to "rating laws." The revised law substitutes "rating laws relating to workers' compensation insurance" for "rating laws" for accuracy because Article 5.58

applies only to workers' compensation insurance.

Revised Law

Sec. 2053.154. LOSS STATEMENT AND PAYROLL REPORT. (a) For purposes of this section, "insurance company" means a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan authorized to engage in the business of workers' compensation insurance in this state. The term includes the Texas Mutual Insurance Company.

(b) The department may require an insurance company to submit a sworn statement or report showing:

(1) the payroll reported to the insurance company;

(2) incurred losses by classification; and

(3) other information the department determines may be necessary to implement the department's duties.

(c) The department shall prescribe the necessary forms for a statement or report required by Subsection (b) with consideration of the methods and forms used for similar purposes in other states so that uniformity of statistics will not be affected. (V.T.I.C. Arts. 5.59, 5.63.)

Source Law

> Art. 5.59. The department may require sworn statements from any insurance company, including the Texas Mutual Insurance Company, showing the payroll reported to the company and incurred losses by classifications and such other information which in the judgment of the department may be necessary to carry out its duties. The department shall prescribe the necessary forms for such statements and reports, having due regard to the methods and forms in use in other states for similar purpose in order that uniformity of statistics may not be disturbed.

> Art. 5.63. The words "Company" and "Association" used in this subchapter mean the Texas Employers Insurance Association, or any stock company, or any mutual company, or any reciprocal, or any interinsurance exchange, or Lloyd's association authorized to write Workmen's Compensation Insurance in this State.

Revisor's Note

V.T.I.C. Article 5.59 refers to "sworn statements" the Texas Department of Insurance may require from an insurance company. The revised law

substitutes a reference to "a sworn statement or report" for consistency of terminology within this section.

[Sections 2053.155-2053.200 reserved for expansion]

SUBCHAPTER E. OPTIONAL DEDUCTIBLE PLANS

Revised Law

Sec. 2053.201. DEFINITION. In this subchapter, "insurance company" means a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan authorized to engage in the business of workers' compensation insurance in this state. (V.T.I.C. Art. 5.63.)

Source Law

> Art. 5.63. The words "Company" and "Association" used in this subchapter mean the Texas Employers Insurance Association, or any stock company, or any mutual company, or any reciprocal, or any interinsurance exchange, or Lloyd's association authorized to write Workmen's Compensation Insurance in this State.

Revised Law

Sec. 2053.202. ESTABLISHMENT OF OPTIONAL DEDUCTIBLE PLANS. (a) The department shall require each insurance company writing workers' compensation insurance in this state to offer at least three optional deductible plans adopted under this section that allow a policyholder to self-insure for the amount of the deductible.

(b) The commissioner by rule shall allow an employer to enter into an agreement with an insurer for a negotiated deductible that exceeds the highest deductible available under a plan described by Subsection (a). (V.T.I.C. Art. 5.55C, Secs. (a), (b).)

Source Law

> Art. 5.55C. (a) The Board shall require each company or association that writes workers' compensation insurance in this state to offer optional deductible plans to allow policyholders to self-insure for the deductible amount.
>
> (b) Not later than January 1, 1992, the Board shall promulgate at least three plans with varying deductible options. In addition, the Board by rule shall permit an employer to enter into an agreement

with an insurer for a negotiated deductible in excess of the largest promulgated deductible.

Revisor's Note

Section (b), V.T.I.C. Article 5.55C, directs the State Board of Insurance to adopt at least three plans with varying deductible options "not later than January 1, 1992." The revised law omits the quoted language as executed.

Revised Law

Sec. 2053.203. PAYMENT OF CLAIMS; REIMBURSEMENT. (a) An insurance company issuing a deductible policy under this subchapter shall service all claims that arise during the policy period, including those claims payable, wholly or partly, from the deductible amount.

(b) A deductible policy must provide that:

(1) the insurance company issuing the policy shall pay all benefits that are payable from the deductible amount; and

(2) the policyholder shall make reimbursements periodically, rather than at the time claim costs are incurred.

(c) The commissioner shall adopt rules to provide for adequate security for reimbursement of the amount paid by an insurance company that is payable from the deductible amount. (V.T.I.C. Art. 5.55C, Secs. (d), (e).)

Source Law

(d) A deductible policy must provide that the company or association will make all payments for benefits that are payable from the deductible amount and that reimbursement by the policyholder shall be made periodically, rather than at the time claim costs are incurred. The State Board of Insurance shall promulgate rules that provide for adequate security for reimbursement of the amount paid by the company or association which is payable from the deductible.

(e) The company or association shall service all claims that arise during the policy period, including those claims payable, in whole or in part, from the deductible amount.

Revised Law

Sec. 2053.204. RATE REDUCTION. (a) The department shall perform an actuarial analysis to determine the amount of rate reduction applicable to a deductible policy under this subchapter

as compared to a standard workers' compensation insurance policy without a deductible.

(b) In years subsequent to the year in which the actuarial analysis described by Subsection (a) is performed, the department shall determine the amount of rate reduction according to rating procedures adopted by the commissioner.

(c) When establishing procedures for the computation of experience modifiers, the commissioner may allow the exclusion of any claim amount paid under a deductible by an employer. (V.T.I.C. Art. 5.55C, Sec. (c).)

Source Law

> (c) The Board shall perform an actuarial analysis to determine the amount of rate reduction applicable to policies under this article as opposed to standard policies without a deductible. In subsequent years, the Board shall determine the amount of rate reduction according to rating procedures adopted by the Board. When establishing procedures for the calculation of experience modifiers, the Board may allow the exclusion of the claim amount paid under the deductible by the employer.

Revised Law

Sec. 2053.205. PROHIBITED CONDUCT. A person who is employed by a policyholder who self-insures the deductible amount as provided by this subchapter may not be required to pay any portion of the deductible amount or be harassed, discharged, or otherwise discriminated against because the person, in good faith:

(1) is considering initiating or has initiated a workers' compensation claim;

(2) has retained a representative to represent the person regarding a claim;

(3) has testified or will testify at an administrative or judicial proceeding under Subtitle A, Title 5, Labor Code;

(4) has reported a hazardous working condition or hazardous practice to the Texas Workers' Compensation Commission; or

(5) has taken or is considering taking any other action that may result in a requirement that the policyholder pay a

deductible amount through a self-insurance plan. (V.T.I.C. Art. 5.55C, Secs. (f), (g)(1).)

Source Law

(f) A person who is employed by a policyholder who self-insures the deductible amount as provided under this article may not be required to pay any of the deductible amount.

(g)(1) A person who is employed by a policyholder who self-insures the deductible amount as provided under this article may not be harassed, discharged, or otherwise discriminated against because the employee, in good faith:

(A) is considering initiating a workers' compensation claim;

(B) has initiated a workers' compensation claim;

(C) has retained a representative to represent the employee regarding a claim;

(D) has testified or is about to testify at an administrative or judicial proceeding under the Texas Workers' Compensation Act (S.B. No. 1, Acts of the 71st Legislature, 2nd Called Session, 1989);

(E) has reported a hazardous working condition or hazardous practice to the commission; or

(F) has taken any other action or is considering taking any other action that may result in the policyholder being required to pay a deductible amount through the self-insurance plan.

Revisor's Note

(1) Section (g)(1)(D), V.T.I.C. Article 5.55C, refers to the Texas Workers' Compensation Act (S.B. No. 1, Acts of the 71st Legislature, 2nd Called Session, 1989). That statute was codified in 1993 as Subtitle A, Title 5, Labor Code. The revised law is drafted accordingly. Throughout this chapter, a citation to the Texas Workers' Compensation Act has been changed appropriately.

(2) Section (g)(1)(E), V.T.I.C. Article 5.55C, refers to "the commission" to which an employee reports a hazardous working condition. The revised law substitutes a reference to "the Texas Workers' Compensation Commission" for "the commission" because that is the commission to which an employee would report a hazardous working condition.

Revised Law

Sec. 2053.206. VIOLATION OF SUBCHAPTER. (a) A person commits a Class A administrative violation under Subtitle A, Title 5, Labor Code, if the person engages in conduct that violates this subchapter.

(b) Liability for damages for a violation of this subchapter is determined exclusively under Subtitle A, Title 5, Labor Code. (V.T.I.C. Art. 5.55C, Secs. (g)(2), (h).)

Source Law

[(g)]

(2) Liability for damages for violations of this article shall be determined exclusively pursuant to the Texas Workers' Compensation Act (S.B. No. 1, Acts of the 71st Legislature, 2nd Called Session, 1989).

(h) Any person who engages in conduct prohibited under this article commits a Class A administrative violation under the Texas Workers' Compensation Act (S.B. No. 1, Acts of the 71st Legislature, 2nd Called Session, 1989).

[Sections 2053.207-2053.250 reserved for expansion]

SUBCHAPTER F. PREMIUM INCENTIVES AND SURCHARGE FOR SMALL EMPLOYERS

Revised Law

Sec. 2053.251. DEFINITIONS. In this subchapter:

(1) "Insurance company" means a stock company, mutual insurance company, reciprocal or interinsurance exchange, or Lloyd's plan authorized to engage in the business of workers' compensation insurance in this state.

(2) "Premium" means workers' compensation insurance premium.

(3) "Small employer" means an employer:

(A) who is not experience-rated by the department for workers' compensation insurance purposes; and

(B) whose annual premium is less than $5,000. (V.T.I.C. Art. 5.55B, Sec. (a); Art. 5.63; New.)

Source Law

Art. 5.55B. (a) In this article "small employer" means an employer who is not experience-rated by the State Board of Insurance for

workers' compensation insurance purposes and whose annual workers' compensation premium is less than $5,000.

Art. 5.63. The words "Company" and "Association" used in this subchapter mean the Texas Employers Insurance Association, or any stock company, or any mutual company, or any reciprocal, or any interinsurance exchange, or Lloyd's association authorized to write Workmen's Compensation Insurance in this State.

Revisor's Note

The revised law adds a definition of "premium" for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 2053.252. PLAN FOR PREMIUM DISCOUNT AND SURCHARGE. The commissioner shall adopt a plan under which each insurance company writing workers' compensation insurance in this state shall:

(1) grant a premium discount to a small employer who qualifies for a discount under this subchapter; and

(2) assess a surcharge as provided by Section 2053.254. (V.T.I.C. Art. 5.55B, Sec. (b) (part).)

Source Law

(b) The Board shall promulgate a plan by which all insurance companies writing workers' compensation insurance in this state shall grant a discount to small employers who qualify under this article and by which surcharges are assessed [against small employers who experience two or more employee compensable lost-time injuries during a one-year period.]

Revised Law

Sec. 2053.253. ELIGIBILITY FOR PREMIUM DISCOUNT. (a) A small employer who has not experienced a compensable employee lost-time injury during the most recent one-year period for which statistics are available shall receive a discount of 10 percent on the amount of the employer's premium.

(b) A small employer who has not experienced a compensable employee lost-time injury during the most recent two-year period for which statistics are available shall receive a discount of 15

percent on the amount of the employer's premium.

(c) A small employer who has experienced one or more compensable employee lost-time injuries during the most recent one-year period for which statistics are available is not eligible for a discount on the amount of the employer's premium. (V.T.I.C. Art. 5.55B, Secs. (c), (d), (e).)

Source Law

> (c) A small employer who has not experienced a compensable employee lost-time injury during the most recent one-year period for which statistics are available shall receive a discount of 10 percent on the amount of the employer's workers' compensation insurance premium.
>
> (d) A small employer who has not experienced a compensable employee lost-time injury during the most recent two-year period for which statistics are available shall receive a discount of 15 percent on the amount of the employer's workers' compensation insurance premium.
>
> (e) A small employer who has experienced one compensable employee lost-time injury during the most recent one-year period for which statistics are available is not eligible for a discount on the amount of the employer's workers' compensation insurance premium.

Revisor's Note

Section (e), V.T.I.C. Article 5.55B, refers to the ineligibility of a small employer to receive a premium discount if the employer has experienced "one compensable employee lost-time injury" during a certain period. The revised law substitutes "one or more compensable employee lost-time injuries" for "one compensable employee lost-time injury" because it is clear from the context of the source law that the legislature intended that a small employer who experienced more than one compensable employee lost-time injury during the period prescribed by that section would also be ineligible for a premium discount.

Revised Law

Sec. 2053.254. ASSESSMENT OF PREMIUM SURCHARGE. A small employer who has experienced two or more compensable employee

lost-time injuries during the most recent one-year period for which statistics are available shall be assessed a surcharge of 10 percent on the amount of the employer's premium. (V.T.I.C. Art. 5.55B, Secs. (b) (part), (f).)

Source Law

> (b) [The Board shall promulgate a plan . . . by which surcharges are assessed] against small employers who experience two or more employee compensable lost-time injuries during a one-year period.
>
> (f) A small employer who has experienced two or more compensable employee lost-time injuries during the most recent one-year period for which statistics are available shall be assessed a surcharge of 10 percent on the amount of the employer's workers' compensation premium.

Revised Law

Sec. 2053.255. MAXIMUM DISCOUNT AND ASSESSMENT. For any annual premium, a small employer may not:

(1) receive a discount of more than 15 percent; or

(2) be required to pay a surcharge of more than 10 percent. (V.T.I.C. Art. 5.55B, Sec. (g) (part).)

Source Law

> (g) . . . For any annual workers' compensation premium, a small employer may not receive a discount of more than 15 percent, and a small employer may not be required to pay a surcharge of more than 10 percent.

Revised Law

Sec. 2053.256. DISCOUNTS AND SURCHARGES NOT CUMULATIVE. (a) The discounts and surcharges established under this subchapter are not cumulative.

(b) A small employer is entitled to receive the discount under this subchapter in addition to any lesser deviation in the rate used to write an insurance policy under Sections 2053.051 and 2053.052(a) and (b). (V.T.I.C. Art. 5.55B, Sec. (g) (part).)

Source Law

> (g) The discounts and surcharges established under this article are not cumulative; however, a small employer is entitled to receive the discount provided by this article in addition to any lesser deviation in the rate at which a policy is written under Article 5.60 of this code. . . .

Revisor's Note

Section (g), V.T.I.C. Article 5.55B, refers to the rate at which a policy is written under V.T.I.C. Article 5.60, which is revised in various chapters in this code. The provisions of that article relating to the rates at which policies are written are revised in this chapter as Sections 2053.051 and 2053.052(a) and (b). The revised law is drafted accordingly.

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CHAPTER 2054. TEXAS MUTUAL INSURANCE COMPANY

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2054.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of directors of the company.

(2) "Commission" means the Texas Workers' Compensation Commission.

(3) "Company" means the Texas Mutual Insurance Company.

(4) "Workers' compensation insurance" means insurance for a risk under:

(A) Subtitle A, Title 5, Labor Code;

(B) Chapter 504, Labor Code;

(C) the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Section 901 et seq.);

(D) the Federal Mine Safety and Health Act of 1977 (30 U.S.C. Section 801 et seq.);

(E) the Defense Base Act (42 U.S.C. Sections 1651-1654);

(F) the federal Employers' Liability Act (45 U.S.C. Section 51 et seq.);

(G) the Nonappropriated Fund Instrumentalities Act (5 U.S.C. Sections 8171-8173);

(H) the Outer Continental Shelf Lands Act (43 U.S.C. Section 1331 et seq.); or

(I) the Merchant Marine Act of 1920 (46 App. U.S.C. Section 861 et seq.). (V.T.I.C. Art. 5.76-3, Secs. 1(1), (2), (3), (5).)

Source Law

Art. 5.76-3

Sec. 1. In this article:

(1) "Board" means the board of directors of the company.

(2) "Commission" means the Texas Workers' Compensation Commission.

(3) "Company" means the Texas Mutual Insurance Company.

(5) "Workers' compensation insurance" means the insurance for any risk under:

(A) Subtitle A, Title 5, Labor Code (the Texas Workers' Compensation Act);

(B) the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Section 901);

(C) the Federal Mine Safety and Health Act of 1977 (33 U.S.C. Section 801 et seq.);

(D) the Defense Base Act (42 U.S.C. Sections 1651-1654);

(E) the federal Employers' Liability Act (45 U.S.C. Section 51 et seq.);

(F) the Nonappropriated Fund Instrumentalities Act (5 U.S.C. Sections 8171-8173);

(G) the Outer Continental Shelf Lands Act (43 U.S.C. Section 1331 et seq.);

(H) the Merchant Marine Act of 1920 (46 U.S.C. Section 861 et seq.); or

(I) Chapter 504, Labor Code.

Revisor's Note

(1) Section 1, V.T.I.C. Article 5.76-3, defines terms for purposes of "this article," meaning Article 5.76-3. Although some provisions of this chapter are derived from V.T.I.C. Article 5.76-4, the revised law applies the defined terms to the entire chapter and substitutes "this chapter" for "this article" in this section and throughout this chapter because both articles relate to the operation of the Texas Mutual Insurance Company, and it is therefore appropriate to refer to provisions derived from both articles.

(2) Section 1(4), V.T.I.C. Article 5.76-3, defines "fund" to mean the Texas Workers' Compensation Insurance Fund. The revised law omits the definition as unnecessary because the full name of the fund is used throughout the revised law as appropriate. The omitted law reads:

(4) "Fund" means the Texas Workers' Compensation Insurance Fund.

Revised Law

Sec. 2054.002. REFERENCE TO TEXAS WORKERS' COMPENSATION INSURANCE FUND. A reference in state law to the Texas Workers' Compensation Insurance Fund means the Texas Mutual Insurance Company. (V.T.I.C. Art. 5.76-3, Sec. 2(a) (part).)

Source Law

> Sec. 2. (a) Effective September 1, 2001, the Texas Workers' Compensation Insurance Fund . . . shall be called the Texas Mutual Insurance Company. A reference in the laws of this state to the Texas Workers' Compensation Insurance Fund means the Texas Mutual Insurance Company. . . .

Revisor's Note

Section 2(a), V.T.I.C. Article 5.76-3, provides that "[e]ffective September 1, 2001, the Texas Workers' Compensation Insurance Fund . . . shall be called the Texas Mutual Insurance Company." The revised law omits the quoted language as executed and, throughout this chapter, substitutes a reference to the Texas Mutual Insurance Company for references to the Texas Workers' Compensation Insurance Fund.

Revised Law

Sec. 2054.003. OPERATION AS DOMESTIC MUTUAL INSURANCE COMPANY. (a) The company operates as a domestic mutual insurance company under Chapter 883. The company is subject to that chapter, but is not subject to Chapter 826.

(b) The company:

(1) has the legal rights of a mutual insurance company operating under Chapter 883 and of an individual in this state; and

(2) may bring a suit in the company's own name without any procedural prerequisites to the exercise of that power.

(c) The company is not a state agency. (V.T.I.C. Art. 5.76-3, Secs. 2(a) (part), (b) (part), (h), 21(c).)

Source Law

> Sec. 2. (a) . . . the Texas Workers' Compensation Insurance Fund shall operate as, and exercise the powers of, a domestic mutual insurance company in accordance with Chapter 15 of this code, and

. . . .

(b) The company is subject to Chapter 15 of this code, other than Article 15.22 of this code. . . .

(h) In addition to other rights of the company under this article, the company has the legal rights of a mutual insurance company operating under Chapter 15 of this code, and of a private person in this state, and has the power to sue in its own name. No procedure is a prerequisite to the exercise of the power by the company to sue.

[Sec. 21]

(c) The company is not a state agency.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 5.76-3, provides that the Texas Workers' Compensation Insurance Fund, renamed by that section as the Texas Mutual Insurance Company, shall operate as, "and exercise the powers of," a domestic mutual insurance company. The revised law omits the quoted language as unnecessary because the Texas Mutual Insurance Company's operation as a domestic insurance company necessarily implies that the company has the authority to exercise the powers of a domestic mutual insurance company.

(2) Section 2(a), V.T.I.C. Article 5.76-3, provides that the Texas Mutual Insurance Company operates as a domestic mutual insurance company under V.T.I.C. Chapter 15, and Section 2(h), Article 5.76-3, provides that the company has the legal rights of a mutual insurance company under Chapter 15. Section 2(b), Article 5.76-3, revised in relevant part as Subsection (a) of this section, also states that the company is subject to Chapter 15, other than V.T.I.C. Article 15.22. Chapter 15 is revised as Chapter 883 of this code, with the exception of Article 15.22, which is revised as Chapter 826 of this code. The revised law substitutes a reference to Chapter 883 of this code for the references to Chapter 15 in Sections 2(a) and (h), but does not reference Chapter 826 of this code

because of the statement of inapplicability of Article 15.22, revised as that chapter, that is contained in Section 2(b).

(3) Section 2(h), V.T.I.C. Article 5.76-3, specifies certain rights of the Texas Mutual Insurance Company that are "[i]n addition to other rights of the company under this article." The revised law omits the quoted language as unnecessary 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 provision applies to this revision.

Revised Law

Sec. 2054.004. INSURANCE COMPANY UNDER TEXAS WORKERS' COMPENSATION ACT. The company is an insurance company for purposes of Subtitle A, Title 5, Labor Code. (V.T.I.C. Art. 5.76-3, Sec. 21(a).)

Source Law

Sec. 21. (a) The company is an insurance company for purposes of Subtitle A, Title 5, Labor Code (the Texas Workers' Compensation Act).

Revised Law

Sec. 2054.005. APPLICABILITY OF CODE. The company is subject to this code. (V.T.I.C. Art. 5.76-3, Sec. 18(c) (part).)

Source Law

(c) The company is subject to all provisions of this code and . . . .

Revised Law

Sec. 2054.006. AUTHORITY OF COMMISSIONER AND DEPARTMENT. (a) The commissioner may regulate the company to the same extent that the commissioner may regulate a mutual insurance company.

(b) The company is subject to the jurisdiction of the commissioner and department in the same manner as a private

insurance company. (V.T.I.C. Art. 5.76-3, Secs. 18(c) (part), 21(b).)

Source Law

> [Sec. 18]
> (c) [The company is subject] . . . to the jurisdiction of the commissioner and the department in the same manner as private insurance carriers.
>
> [Sec. 21]
> (b) All regulatory authority granted to the commissioner relating to a mutual insurance company is applicable to the company.

Revised Law

Sec. 2054.007. APPLICABILITY OF OPEN MEETINGS LAW. (a) Except as otherwise provided by Subsection (b), Chapter 551, Government Code, applies to the company.

(b) The board may hold closed meetings to consider:

(1) information relating to claims, rates, or the company's underwriting guidelines; or

(2) other information that would give advantage to a competitor or bidder. (V.T.I.C. Art. 5.76-3, Sec. 2(d) (part).)

Source Law

> (d) Except as otherwise provided by this subsection, the company is subject to the open meetings law, Chapter 551, Government Code, and . . . . The board may hold closed meetings to consider and . . . information relating to claims, rates, the company's underwriting guidelines, and other information that would give advantage to competitors or bidders.

Revised Law

Sec. 2054.008. APPLICABILITY OF PUBLIC INFORMATION LAW. (a) In this section, "investigation file" means information the company compiles or maintains with respect to a company investigation authorized by law.

(b) To the extent consistent with this section, Chapter 552, Government Code, applies to the company.

(c) The board may refuse to disclose:

(1) information relating to claims, rates, or the company's underwriting guidelines; or

(2) other information that would give advantage to a

competitor or bidder.

(d) Except as provided by Subsection (e), a company investigation file:

(1) is confidential and not subject to required disclosure under Chapter 552, Government Code; and

(2) may be disclosed only:

(A) in a criminal proceeding;

(B) in a hearing conducted by the commission;

(C) on a judicial determination of good cause; or

(D) to a governmental agency, political subdivision, or regulatory body if the disclosure is necessary or proper for the enforcement of a law of this state, another state, or the United States.

(e) Disclosure of information in an investigation file that is contained in or derived from a claim file, an employer injury report, or an occupational disease report is governed by any confidentiality provision applicable to that information. (V.T.I.C. Art. 5.76-3, Secs. 2(d) (part), 10.)

Source Law

[Sec. 2]

(d) Except as otherwise provided by this subsection, the company is subject to . . . the open records law, Chapter 552, Government Code. The board may . . . refuse to release information relating to claims, rates, the company's underwriting guidelines, and other information that would give advantage to competitors or bidders.

Sec. 10. (a) Information maintained in the investigation files of the company is confidential and may not be disclosed except:

(1) in a criminal proceeding;

(2) in a hearing conducted by the commission;

(3) on a judicial determination of good cause; or

(4) to a governmental agency, political subdivision, or regulatory body if the disclosure is necessary or proper for the enforcement of the laws of this or another state or of the United States.

(b) Company investigation files are not open records for purposes of the open records law, Chapter 552, Government Code.

(c) Information in an investigation file that is information in or derived from a claim file, or an employer injury report or occupational disease report, is governed by the confidentiality provisions relating to that information.

(d) For purposes of this section, "investigation file" means any information compiled or maintained by the company with respect to a company investigation authorized by law.

Revised Law

Sec. 2054.009. CONFLICTS WITH CERTAIN INSURANCE LAWS. To the extent of a conflict between this chapter and Chapter 883 or another law of this state applicable to a nonlife mutual insurance company, this chapter prevails. (V.T.I.C. Art. 5.76-3, Sec. 2(b) (part).)

Source Law

(b) . . . In the event of a conflict between this article and Chapter 15 of this code or another law of this state applicable to a nonlife mutual insurance company, this article controls.

Revisor's Note

Section 2(b), V.T.I.C. Article 5.76-3, provides that Article 5.76-3, revised in this chapter, controls to the extent of a conflict between the article and V.T.I.C. Chapter 15. Chapter 15 is revised as Chapters 826 and 883 of this code. The revised law substitutes a reference to Chapter 883 of this code for the reference to Chapter 15 and does not reference Chapter 826 of this code for the reason stated in Revisor's Note (2) to Section 2054.003.

[Sections 2054.010-2054.050 reserved for expansion]

SUBCHAPTER B. BOARD OF DIRECTORS

Revised Law

Sec. 2054.051. BOARD OF DIRECTORS; COMPOSITION. (a) The company is governed by a board composed of nine members.

(b) The governor, with the advice and consent of the senate, shall appoint five board members. The company's policyholders shall elect the remaining members. (V.T.I.C. Art. 5.76-3, Sec. 3(a) (part).)

Source Law

Sec. 3. (a) The company is governed by a board of directors composed of nine members, . . . . Five members shall be appointed by the governor with the advice and consent of the senate. The remaining

members shall be elected by the company's policyholders.

Revised Law

Sec. 2054.052. QUALIFICATIONS. (a) Each board member must be a resident of this state.

(b) An individual may not serve as a board member if the individual, another individual related to the individual within the second degree by consanguinity or affinity, or another individual residing in the same household with the individual:

(1) is registered or licensed under this code or is required to be registered or licensed under this code;

(2) is employed by or acts as a consultant to a person registered or licensed under this code or required to be registered or licensed under this code;

(3) owns, controls, has a financial interest in, or participates in the management of an organization registered or licensed under this code or required to be registered or licensed under this code;

(4) receives a substantial tangible benefit from the company or the department; or

(5) is an officer, employee, or consultant of an association in the field of insurance.

(c) Subsection (b) does not prohibit an individual from serving as a board member if the individual is only a policyholder or a consumer of insurance or insurance products.

(d) An individual who is ineligible to serve on the board under Subsection (b) may not serve as a board member until the first anniversary of the date the condition that makes the individual ineligible ends. (V.T.I.C. Art. 5.76-3, Secs. 3(a) (part), (d), (h), (i).)

Source Law

Sec. 3. (a) . . . all of whom shall be citizens of this state.

(d) A person may not serve as a member of the board if the person, an individual related to the person within the second degree by consanguinity or affinity, or an individual residing in the same

household with the person:

(1) is registered or licensed under this code or is required to be registered or licensed under this code;

(2) is employed by or acts as a consultant to a person registered or licensed under this code or required to be registered or licensed under this code;

(3) owns, controls, has a financial interest in, or participates in the management of an organization registered or licensed under this code or required to be registered or licensed under this code;

(4) receives a substantial tangible benefit from the company or the Texas Department of Insurance; or

(5) is an officer, employee, or consultant of an association in the field of insurance.

(h) Subsection (d) of this section does not prohibit a person who is only a policyholder or a consumer of insurance or insurance products from serving as a member of the board.

(i) A person who is ineligible to serve on the board under Subsection (d) of this section may not serve as a member of the board for one year after the date on which the condition that makes the person ineligible ends.

Revisor's Note

Section 3(a), V.T.I.C. Article 5.76-3, provides that members of the Texas Mutual Insurance Company's board of directors must be "citizens of this state." The revised law substitutes "resident" for "citizen" because in the context of this section, "citizen" and "resident" are synonymous, and "resident" is more commonly used.

Revised Law

Sec. 2054.053. PRESIDING OFFICER; OTHER OFFICERS. (a) The governor shall designate a board member as the presiding officer to serve in that capacity at the pleasure of the governor.

(b) The board members shall elect annually any other officers the board considers necessary to perform the board's duties. (V.T.I.C. Art. 5.76-3, Sec. 3(k) (part).)

Source Law

(k) The governor shall designate a member of the board as the chairman of the board to serve in that capacity at the pleasure of the governor. The members of the board shall elect annually any other officers the board considers necessary for the performance of its duties. . . .

Revised Law

Sec. 2054.054. TERMS. (a) Board members serve staggered six-year terms, with the terms of three members expiring July 1 of each odd-numbered year.

(b) A board member whose term has expired shall continue to serve until the member's successor is appointed by the governor or is elected by the company's policyholders, as applicable. (V.T.I.C. Art. 5.76-3, Sec. 3(b).)

Source Law

> (b) The members of the board of directors serve staggered six-year terms, with the terms of three members expiring July 1 of each odd-numbered year. A member of the board whose term has expired shall continue to serve until the member's replacement is elected by the policyholders or appointed by the governor, as applicable.

Revised Law

Sec. 2054.055. VACANCIES. (a) The governor shall fill a vacancy in the appointed board members by appointment with the advice and consent of the senate.

(b) A vacancy in the elected board members shall be filled as provided by the company's bylaws.

(c) If a vacancy occurs before the date the vacating member's term expires, the successor member shall be appointed or elected for a term that expires on the same date as the vacating member's term. (V.T.I.C. Art. 5.76-3, Sec. 3(c).)

Source Law

> (c) The governor shall fill a vacancy in the appointed directors by appointment with the advice and consent of the senate. A vacancy in the elected directors shall be filled as provided by the company's bylaws. If a vacancy occurs before the date on which the vacating member's term is set to expire, the successor member shall be elected or appointed for a term to expire on the same date as the vacating member's term.

Revised Law

Sec. 2054.056. GROUNDS FOR REMOVAL. (a) It is a ground for removal from the board if a member:

(1) does not have at the time of appointment or election the qualifications required by Section 2054.052;

(2) does not maintain during service on the board the qualifications required by Section 2054.052;

(3) cannot because of illness or disability discharge the member's duties for a substantial part of the term for which the member is appointed or elected; or

(4) is absent from more than half of the regularly scheduled board meetings that the member is eligible to attend during a calendar year.

(b) The validity of a board action is not affected by the fact that it is taken when a ground for removal of a board member exists. (V.T.I.C. Art. 5.76-3, Secs. 3(e), (f).)

Source Law

(e) It is a ground for removal from the board if a member:

(1) does not have at the time of appointment the qualifications required by this section;

(2) does not maintain during service on the board the qualifications required by this section;

(3) cannot because of illness or disability discharge the member's duties for a substantial part of the term for which the member is appointed; or

(4) is absent from more than half of the regularly scheduled board meetings that the member is eligible to attend during a calendar year.

(f) The validity of an action of the board is not affected by the fact that it is taken when a ground for removal of a board member exists.

Revisor's Note

Section 3(e), V.T.I.C. Article 5.76-3, which relates to the grounds for removal of board members, refers only to board members who are "appointed." Section 3(a), Article 5.76-3, revised in relevant part as Section 2054.051, provides for the appointment of five members of the Texas Mutual Insurance Company's board of directors and the election of the remaining board members. Section 3(d), Article 5.76-3, revised in Section 2054.052, establishes the qualifications for board members and makes no distinction between appointed members and elected members. The revised law is drafted to add appropriate references to

elected board members so that the grounds for removal apply equally to appointed and elected board members.

Revised Law

Sec. 2054.057. PROCEDURES FOR REMOVAL. (a) If the president of the company has knowledge that a potential ground for removal of a board member exists, the president shall notify the presiding officer of the board of the potential ground.

(b) If the potential ground for removal involves an appointed board member, the presiding officer shall notify the governor and the attorney general that a potential ground for removal exists.

(c) If the potential ground for removal involves the presiding officer, the president shall notify the next highest board officer, who shall notify the governor and the attorney general that a potential ground for removal exists.

(d) If the potential ground for removal involves an elected board member, the board shall act on the potential ground for removal as provided by the company's bylaws. (V.T.I.C. Art. 5.76-3, Sec. 3(g).)

Source Law

(g) If the president has knowledge that a potential ground for removal exists, the president shall notify the chairman of the board of the potential ground. If the potential ground for removal involves an appointed board member, the chairman shall then notify the governor and the attorney general that a potential ground for removal exists. If the potential ground for removal involves the chairman, the president shall notify the next highest officer of the board, who shall notify the governor and the attorney general that a potential ground for removal exists. If the potential ground for removal involves a board member elected by the policyholders, the board shall act on the potential ground for removal as provided by the company's bylaws.

Revisor's Note

Section 3(g), V.T.I.C. Article 5.76-3, refers to the "chairman" of the board. The revised law substitutes "presiding officer" for "chairman" in this section and throughout the revised law because, in the context in which the term is used, the terms are

synonymous, and "presiding officer" is more modern and is gender-neutral.

Revised Law

Sec. 2054.058. COMMITTEES AND SUBCOMMITTEES. The board may create committees and subcommittees. (V.T.I.C. Art. 5.76-3, Sec. 3(k) (part).)

Source Law

(k) . . . The board may create committees and subcommittees.

Revised Law

Sec. 2054.059. MEETINGS. (a) The board shall hold a meeting at least once each calendar quarter, at other times at the call of the presiding officer, and at times established by the company's bylaws.

(b) A special meeting may be called by any two board members on two days' notice. (V.T.I.C. Art. 5.76-3, Sec. 3(l).)

Source Law

(l) The board shall hold meetings at least once each calendar quarter and at other times at the call of the chairman and at times established in the company's bylaws. Special meetings may be called by any two members of the board on two days notice.

Revised Law

Sec. 2054.060. QUORUM. Five board members constitute a quorum. (V.T.I.C. Art. 5.76-3, Sec. 3(m).)

Source Law

(m) Five board members constitutes a quorum.

Revised Law

Sec. 2054.061. COMPENSATION. A board member is entitled to receive:

(1) fees for service on the board commensurate with industry standards; and

(2) actual and necessary travel expenses and any other expense incurred in performing the member's duties. (V.T.I.C. Art. 5.76-3, Sec. 3(j).)

Source Law

(j) Each member shall receive fees for service on the board commensurate with industry standards and actual and necessary travel expenses and expenses incurred in the performance of the member's duties as a member.

[Sections 2054.062-2054.100 reserved for expansion]

SUBCHAPTER C. MANAGEMENT OF COMPANY

Revised Law

Sec. 2054.101. GENERAL POWERS OF BOARD. The board has full authority over the company and may:

(1) perform any act necessary or convenient to administer the company or in connection with the company's insurance business; and

(2) function in all aspects as the governing body of a domestic mutual insurance company. (V.T.I.C. Art. 5.76-3, Sec. 4(a) (part).)

Source Law

Sec. 4. (a) The board has full power, authority, and jurisdiction over the company. The board may perform all acts necessary or convenient in the administration of the company or in connection with the insurance business to be carried on by the company. In this regard, the board is empowered to function in all aspects as a governing body of a domestic mutual insurance company. . . .

Revisor's Note

Section 4(a), V.T.I.C. Article 5.76-3, refers to the board of directors of the Texas Mutual Insurance Company having "full power, authority, and jurisdiction" over the company. The references to "power" and "jurisdiction" are omitted from the revised law because in this context, "power" and "jurisdiction" are included within the meaning of "full authority."

Revised Law

Sec. 2054.102. GENERAL DUTIES OF BOARD RELATING TO WORKERS' COMPENSATION INSURANCE. The board shall:

(1) provide for engaging in the business of workers' compensation insurance and for the delivery in this state of

workers' compensation insurance to the same extent as any other insurance company engaging in the business of workers' compensation insurance in this state;

(2) propose rates for workers' compensation insurance issued by the company; and

(3) exercise any other authority necessary to engage in the business of workers' compensation insurance. (V.T.I.C. Art. 5.76-3, Sec. 4(a) (part).)

Source Law

Sec. 4. (a) . . . The board shall:

(1) provide for the delivery in this state of workers' compensation insurance and for the transaction of workers' compensation insurance business to the same extent as any other insurance carrier transacting workers' compensation insurance business in this state;

(2) propose rates for workers' compensation insurance issued by the company; and

(3) exercise any other authority necessary to conduct a workers' compensation insurance business.

Revised Law

Sec. 2054.103. APPOINTMENT OF PRESIDENT. (a) The board shall appoint a president who serves at the pleasure of the board.

(b) The president must have proven successful experience as an executive at the general management level in the business of insurance.

(c) The president shall receive compensation as set by the board. (V.T.I.C. Art. 5.76-3, Sec. 4(d).)

Source Law

(d) The board shall appoint a president who shall serve at the pleasure of the board. The president must have proven successful experience as an executive at the general management level in the business of insurance. The president shall receive compensation as set by the board.

Revised Law

Sec. 2054.104. APPOINTMENT OF INTERNAL AUDITOR. The board shall appoint an internal auditor who serves at the pleasure of the board. (V.T.I.C. Art. 5.76-3, Sec. 4(c).)

Source Law

(c) The board shall appoint an internal auditor. The internal auditor serves at the pleasure of the

board.

Revised Law

Sec. 2054.105. PERSONAL LIABILITY OF BOARD MEMBERS, OFFICERS, AND EMPLOYEES. In connection with the administration, management, or conduct of the company, the company's business, or a related matter, a board member, the president, or an officer or employee of the company is not personally liable in the individual's private capacity for an act performed or a contract or other obligation entered into or undertaken in the individual's official capacity in good faith and without intent to defraud. (V.T.I.C. Art. 5.76-3, Sec. 6.)

Source Law

> Sec. 6. Neither a member of the board nor the president or any officer or employee of the company is personally liable in the person's private capacity for any act performed or for any contract or other obligation entered into or undertaken in an official capacity in good faith and without intent to defraud, in connection with the administration, management, or conduct of the company, its business, or other related affairs.

Revised Law

Sec. 2054.106. PRINCIPAL OFFICE. The board shall maintain the company's principal office in Travis County. (V.T.I.C. Art. 5.76-3, Sec. 3(n).)

Source Law

> (n) The board shall maintain the principal office of the company in Travis County, Texas.

Revised Law

Sec. 2054.107. CERTAIN RELATIONSHIPS WITH OTHER INSURERS PROHIBITED. The company may not have:

(1) an affiliate, spin-off, or subsidiary that writes a line of insurance other than workers' compensation insurance; or

(2) interlocking boards of directors with an insurer that writes a line of insurance other than workers' compensation insurance. (V.T.I.C. Art. 5.76-3, Sec. 4(b).)

Source Law

> (b) The company may not have affiliates, interlocking boards of directors, spinoffs, or subsidiaries that write lines of insurance other than

workers' compensation insurance.

Revised Law

Sec. 2054.108. PROGRAM AND FACILITY ACCESSIBILITY. (a) The company shall comply with federal and state laws that relate to program and facility accessibility.

(b) The president shall prepare and maintain a written plan that describes the manner in which an individual who does not speak English can be provided reasonable access to the company's programs and services.

(c) The board shall develop and implement policies that provide the public with a reasonable opportunity to appear before the board and to speak on any issue under the company's jurisdiction. (V.T.I.C. Art. 5.76-3, Secs. 19(c), (d).)

Source Law

(c) The company shall comply with federal and state laws related to program and facility accessibility. The president shall also prepare and maintain a written plan that describes how a person who does not speak English can be provided reasonable access to the company's programs and services.

(d) The board shall develop and implement policies that provide the public with a reasonable opportunity to appear before the board and to speak on any issue under the jurisdiction of the company.

[Sections 2054.109-2054.150 reserved for expansion]

SUBCHAPTER D. OPERATION OF COMPANY; FINANCIAL ADMINISTRATION

Revised Law

Sec. 2054.151. PURPOSES OF COMPANY. The company shall:

(1) serve as a competitive force in the marketplace;

(2) guarantee the availability of workers' compensation insurance in this state; and

(3) serve as an insurer of last resort as provided by Subchapter H. (V.T.I.C. Art. 5.76-3, Sec. 2(c).)

Source Law

(c) The company shall:

(1) serve as a competitive force in the marketplace;

(2) guarantee the availability of workers' compensation insurance in this state; and

(3) serve as an insurer of last resort as provided under Article 5.76-4 of this code.

Revised Law

Sec. 2054.152. PAYMENT OF TAXES, FEES, AND OTHER CHARGES. The company shall pay the following in the same manner as a domestic mutual insurance company authorized to engage in the business of insurance and to write workers' compensation insurance in this state:

(1) taxes, including maintenance and premium taxes;

(2) fees; and

(3) payments due in lieu of taxes. (V.T.I.C. Art. 5.76-3, Secs. 11(a), (b).)

Source Law

Sec. 11. (a) The company shall pay premium taxes, maintenance taxes, and the maintenance tax surcharge established under Article 5.76-5 of this code in the same manner as a domestic mutual insurance carrier authorized by the department to write workers' compensation insurance in this state.

(b) The company shall pay taxes and fees or any payments due in lieu of taxes in the same manner as a domestic mutual insurance carrier authorized and admitted by the department to engage in the business of insurance in this state under a certificate of authority that includes authorization to write workers' compensation insurance.

Revisor's Note

Section 11(a), V.T.I.C. Article 5.76-3, refers to "the maintenance tax surcharge established under Article 5.76-5 of this code." The revised law omits the quoted language as obsolete and unnecessary. In 1991, the legislature created the Texas Workers' Compensation Insurance Fund as a corporate body for the purpose of providing workers' compensation insurance coverage to Texas employers. To raise money for the Texas Workers' Compensation Insurance Fund, the Texas Public Finance Authority issued $300 million in bonds to be discharged under Section 10(a), V.T.I.C. Article 5.76-5, through maintenance tax surcharges assessed against each insurance company writing workers' compensation insurance in this state, each certified self-insurer, and the Texas Workers'

Compensation Insurance Fund. For tax years 1991-1996, the surcharge was collected, but after the bonds were defeased, the surcharge was no longer collected and the legislature required the Texas Workers' Compensation Insurance Fund to reimburse the surcharge to insurance companies, who in turn had to refund the surcharge to their policyholders. In January 2000, the Texas Department of Insurance adopted procedures and forms for this process, outlined in Rule XX of the Texas Basic Manual of Rules, Classification and Experience Rating Plan for Workers' Compensation and Employers' Liability Insurance. That rule expired December 31, 2001. The final maturity date of the bonds issued under Article 5.76-5 was December 1, 2004, and on that date, the bonds were fully paid.

Revised Law

Sec. 2054.153. MEMBERSHIP IN TEXAS PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION. (a) In this section, "association" means the Texas Property and Casualty Insurance Guaranty Association.

(b) The company is:

(1) a member of and protected by the association; and

(2) subject to assessment under Chapter 462.

(c) Notwithstanding Subsection (b), the company is liable only for an assessment by the association regarding a claim with a date of injury occurring on or after January 1, 2000, and the association, with respect to an insolvency of the company, is liable only for a claim with a date of injury occurring on or after that date. (V.T.I.C. Art. 5.76-3, Secs. 11(c), (d).)

Source Law

(c) The company is a member of and is protected by the Texas Property and Casualty Insurance Guaranty Association. The company is subject to assessment under the Texas Property and Casualty Insurance Guaranty Act (Article 21.28-C, Insurance Code).

(d) Notwithstanding any other provision of this section, the company is only liable for assessments by

the Texas Property and Casualty Insurance Guaranty Association regarding, and that association, with respect to an insolvency of the company, is only liable for, a claim with a date of injury that occurs on or after January 1, 2000.

Revised Law

Sec. 2054.154. COMPANY ASSETS; STATE LIABILITY. (a) All money, revenues, and other assets of the company belong solely to the company and are governed by the laws applicable to domestic mutual insurance companies.

(b) The state:

(1) covenants with the company's policyholders, persons receiving workers' compensation benefits, and the company's creditors that the state will not borrow, appropriate, or direct payments from the company's money, revenues, or other assets for any purpose; and

(2) has no liability or responsibility to those policyholders, persons receiving benefits, or creditors if the company is placed in conservatorship or receivership or becomes insolvent. (V.T.I.C. Art. 5.76-3, Sec. 12(a).)

Source Law

Sec. 12. (a) All revenues, monies, and assets of the company belong solely to the company and are governed by the laws applicable to domestic mutual insurance companies. The State of Texas covenants with the policyholders of the company, persons receiving workers' compensation benefits, and the company's creditors that the state will not borrow, appropriate, or direct payments from those revenues, monies, and/or assets for any purpose. The state has no liability to or responsibility to the policyholders, persons receiving workers' compensation benefits, or the creditors of the company if the company is placed in conservatorship or receivership, or becomes insolvent.

Revised Law

Sec. 2054.155. REQUIRED RESERVES. The company shall establish and maintain reserves for losses on an actuarially sound basis in accordance with Chapter 426. (V.T.I.C. Art. 5.76-3, Sec. 12(b).)

Source Law

(b) The company shall establish and maintain reserves for losses on an actuarially sound basis in accordance with Article 5.61 of this code.

Revised Law

Sec. 2054.156. RATIO OF CERTAIN PREMIUMS TO SURPLUS. The company shall maintain a ratio of net written premiums on policies written after reinsurance to surplus of not more than three to one. (V.T.I.C. Art. 5.76-3, Sec. 12(c).)

Source Law

(c) The company must maintain a ratio of net written premiums on policies written after reinsurance to surplus of not more than 3.0 to one.

Revised Law

Sec. 2054.157. DISSOLUTION PROHIBITED. The company may not be dissolved. (V.T.I.C. Art. 5.76-3, Sec. 2(j).)

Source Law

(j) The company may not be dissolved.

[Sections 2054.158-2054.200 reserved for expansion]

SUBCHAPTER E. EXAMINATIONS, REPORTS, AND FILINGS

Revised Law

Sec. 2054.201. EXAMINATION BY DEPARTMENT. (a) The department shall examine the company in the manner and under the conditions specified by Chapters 86 and 401 for the examination of insurers.

(b) The company shall pay the costs of the examination. (V.T.I.C. Art. 5.76-3, Secs. 18(a), (b).)

Source Law

Sec. 18. (a) The department shall conduct an examination of the company in the manner and under the conditions provided by Articles 1.15 through 1.19 of this code for the examination of insurance carriers.

(b) The company shall pay the costs of the examination.

Revisor's Note

Section 18(a), V.T.I.C. Article 5.76-3, requires the Texas Department of Insurance to examine the Texas Mutual Insurance Company in the manner and under the conditions provided by V.T.I.C. Articles 1.15-1.19. Those articles are revised in this code in Chapters 86 and 401. Chapter 401 includes provisions derived from

V.T.I.C. Article 1.04A. The revised law references Chapter 401 in its entirety because the provisions of Article 1.04A contained in that chapter are necessary to construe the referenced provisions relating to examination of an insurer and it is clear from the text of Article 1.04A and of the portion of Section 18(c), V.T.I.C. Article 5.76-3, revised in this chapter as Section 2054.005, that Article 1.04A applies to the Texas Mutual Insurance Company.

Revised Law

Sec. 2054.202. PROVIDING INFORMATION TO LEGISLATURE. The company shall provide requested information to each appropriate legislative committee in the manner requested by the committee. (V.T.I.C. Art. 5.76-3, Sec. 4(e).)

Source Law

(e) The company shall provide requested information to appropriate legislative committees in the manner requested by those committees.

Revised Law

Sec. 2054.203. ANNUAL ACCOUNTING OF MONEY RECEIVED AND DISBURSED. Each year, the company shall prepare a complete and detailed written report accounting for all money the company received and disbursed during the preceding fiscal year. (V.T.I.C. Art. 5.76-3, Sec. 2(i).)

Source Law

(i) The company shall prepare annually a complete and detailed written report accounting for all funds received and disbursed by the company during the preceding fiscal year.

Revisor's Note

Section 2(i), V.T.I.C. Article 5.76-3, refers to certain "funds." The revised law substitutes "money" for "funds" because, in context, the terms are synonymous and the former is more commonly used.

Revised Law

Sec. 2054.204. ANNUAL STATEMENTS. (a) The company shall

file annual statements with the department and commission in the same manner as is required of other workers' compensation insurance companies.

(b) The department shall include in the department's annual report under Section 32.021 a report on the company's condition. (V.T.I.C. Art. 5.76-3, Sec. 12(e).)

Source Law

> (e) The company shall file annual statements with the department and the commission in the same manner as required of other workers' compensation insurance carriers, and the commissioner shall include a report on the company's condition in the commissioner's annual report under Section 32.021 of this code.

Revisor's Note

Section 12(e), V.T.I.C. Article 5.76-3, requires the commissioner of insurance to include a report on the Texas Mutual Insurance Company's condition in the "commissioner's" annual report under Section 32.021 of this code. The revised law substitutes a reference to the Texas Department of Insurance for the reference to the commissioner because Section 32.021 requires the department to file that annual report.

Revised Law

Sec. 2054.205. PUBLICATION AND FILING OF AUDITED REPORT. The board shall:

(1) publish an independently audited report analyzing the company's activities and fiscal condition during the preceding fiscal year; and

(2) file the audited report with the department for submission simultaneously with its annual financial report. (V.T.I.C. Art. 5.76-3, Sec. 16(a).)

Source Law

> Sec. 16. (a) The board shall publish an independently audited report analyzing the company's activities and fiscal condition during the preceding fiscal year and shall file the report with the department. The board shall file the audited report with the department for submission simultaneously with its annual financial report.

Revised Law

Sec. 2054.206. ADDITIONAL REPORTS. The company shall file with the department and the commission all reports required of other workers' compensation insurance companies. (Art. 5.76-3, Sec. 16(b).)

Source Law

(b) The company shall file with the department and the commission all reports required of other workers' compensation insurers.

Revised Law

Sec. 2054.207. PERIODIC REPORTS TO BOARD. The president shall make periodic reports to the board regarding:

(1) the company's status; and

(2) the company's investments. (V.T.I.C. Art. 5.76-3, Sec. 13.)

Source Law

Sec. 13. The president shall make periodic reports to the board with regard to the status of the company and its investments.

[Sections 2054.208-2054.250 reserved for expansion]

SUBCHAPTER F. GENERAL POWERS AND DUTIES RELATING TO INSURANCE

Revised Law

Sec. 2054.251. RATEMAKING AUTHORITY. (a) Except as provided by this section, the board may propose rates to be charged by the company for insurance.

(b) The board shall engage the services of an independent actuary who is a member in good standing with the Casualty Actuarial Society or the American Academy of Actuaries to develop and recommend actuarially sound rates.

(c) The company is subject to the requirements of Subchapter A, Chapter 2053, and shall include the recommendations of the independent actuary as part of the company's filing under that subchapter. (V.T.I.C. Art. 5.76-3, Sec. 7(a).)

Source Law

Sec. 7. (a) Except as otherwise provided by this subsection, the board shall have full power and authority to propose rates to be charged by the company

for insurance. The board shall engage the services of an independent actuary who is a member in good standing with the Casualty Actuarial Society or the American Academy of Actuaries to develop and recommend actuarially sound rates. The company is subject to the requirements of Article 5.55 of this code and shall include the recommendations of its independent actuary as part of its filing under that article.

Revised Law

Sec. 2054.252. AMOUNTS OF RATES. Rates charged by the company for insurance must be set in amounts sufficient, when invested, to:

(1) carry all claims to maturity;

(2) meet the reasonable expenses of conducting the company's business; and

(3) maintain a reasonable surplus. (V.T.I.C. Art. 5.76-3, Sec. 7(b).)

Source Law

(b) Rates shall be set in amounts sufficient, when invested, to:

(1) carry all claims to maturity;

(2) meet the reasonable expenses of conducting the business of the company; and

(3) maintain a reasonable surplus.

Revised Law

Sec. 2054.253. MULTITIERED PREMIUM SYSTEMS. (a) Notwithstanding any other provision of this code or another insurance law of this state, the company may establish multitiered premium systems to price workers' compensation insurance policies to:

(1) insureds in the company's competitive programs; and

(2) insureds to whom policies are offered by the company under Subchapter H.

(b) The systems may provide for a higher or lower premium payment by an insured based on:

(1) the company's evaluation of the underwriting characteristics of the individual risk; and

(2) the appropriate premium to be charged for the policy coverages.

(c) The systems must be filed in accordance with Subchapter A, Chapter 2053. (V.T.I.C. Art. 5.76-3, Sec. 7(c).)

Source Law

> (c) Notwithstanding any other provision of this code or any other insurance law of this state, the company may establish multitiered premium systems to price workers' compensation insurance policies to insureds in the company's competitive programs, as well as to insureds to whom policies are offered by the company under Article 5.76-4 of this code. Those multitiered systems shall be filed in accordance with Article 5.55 of this code. The systems may provide for higher or lower premium payments by insureds based on the company's evaluation of the underwriting characteristics of the individual risk and the appropriate premium to be charged for the policy coverages.

Revised Law

Sec. 2054.254. CASH DIVIDENDS; CREDIT ON RENEWAL PREMIUM. (a) The company may pay a cash dividend or allow a credit on the renewal premium for a policyholder insured with the company, other than a policyholder insured under Subchapter H.

(b) Payment of a cash dividend or allowance of a credit:

(1) must be made in accordance with criteria approved by the board, which may consider the policyholder's safety record and performance; and

(2) may be made only with the department's prior approval . (V.T.I.C. Art. 5.76-3, Sec. 12(d).)

Source Law

> (d) The company may pay cash dividends or allow a credit on renewal premium for policyholders insured with the company other than a policyholder insured under Article 5.76-4 of this code, in accordance with criteria approved by the board, which may consider the policyholder's safety record and performance. A dividend or credit requires prior approval of the department.

Revised Law

Sec. 2054.255. APPOINTMENT OF AGENT NOT REQUIRED. (a) Notwithstanding any other provision of this code or another insurance law of this state, the company is not required to appoint a general property and casualty agent to act as an agent for the company.

(b) An agent who transacts business with the company acts as

an agent for the applicant and not as an agent for the company, unless the company and the agent have entered into a written agreement for the agent to act on behalf of the company. (V.T.I.C. Art. 5.76-3, Sec. 5(d).)

Source Law

> (d) Notwithstanding any other provision of this code or another insurance law of this state, the company is not required to appoint a local recording agent to act as an agent for the company. An agent transacting business with the company does so as an agent for the applicant and not as an agent for the company, unless there is an express written agreement between the company and the agent that the agent acts on behalf of the company.

Revisor's Note

Section 5(d), V.T.I.C. Article 5.76-3, refers to a "local recording agent." Throughout this chapter, the revised law substitutes a reference to a "general property and casualty agent" because the category of "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 workers' compensation insurance is now regulated as a "general property and casualty agent" under Chapter 4051 of this code.

Revised Law

Sec. 2054.256. WORK PRODUCT INFORMATION. (a) Information submitted to the company by an insurance agent on behalf of an employer, including a policy expiration date, is the work product of the agent. The company may not use the information in any marketing or direct sales activity.

(b) Except as otherwise required or permitted by Chapter 552, Government Code, the company may not provide to an insurance agent information obtained from another insurance agent.

(c) This section does not prevent:

(1) an employer from designating another insurance agent or the company as the agent of record; or

(2) the company from using information submitted to the company under this section for underwriting or a fraud investigation. (V.T.I.C. Art. 5.76-3, Sec. 5(e).)

Source Law

(e) Information submitted to the company by a licensed agent on behalf of an employer, including a policy expiration date, is the work product of that agent, and the company may not use that information in any marketing or direct sales activity. Except as required or permitted by the open records law, Chapter 552, Government Code, the company may not provide information obtained from a licensed agent to any other licensed agent. This subsection does not prevent an employer from designating another licensed agent or the company as the agent of record and does not prevent the company from using the information submitted to the company under this subsection for the purpose of underwriting or fraud investigation.

Revisor's Note

Section 5(e), V.T.I.C. Article 5.76-3, refers to a "licensed agent." Throughout this chapter, the revised law omits "licensed" as unnecessary in this context because under Section 4001.101 of this code, a person may not act as an agent unless the person holds a license.

Revised Law

Sec. 2054.257. PAYMENT OF COMMISSION TO AGENT. The company shall pay an insurance agent a reasonable commission on a workers' compensation insurance policy that is written through the agent. (V.T.I.C. Art. 5.76-3, Sec. 5(c).)

Source Law

(c) If the policy is written through a licensed agent, the company shall pay the agent a reasonable commission.

[Sections 2054.258-2054.300 reserved for expansion]

SUBCHAPTER G. ISSUANCE OF COVERAGE

Revised Law

Sec. 2054.301. APPLICATION FOR COVERAGE. An application to the company for workers' compensation insurance coverage must be:

(1) made on the form prescribed by the company; and

(2) submitted directly by the applicant or by a general property and casualty agent on behalf of the applicant. (V.T.I.C. Art. 5.76-3, Sec. 5(a).)

Source Law

Sec. 5. (a) Applications to the company for workers' compensation insurance coverage shall be submitted on forms prescribed by the company and shall be made:

(1) directly by the applicant; or

(2) on behalf of the applicant by a local recording agent.

Revised Law

Sec. 2054.302. POLICY FORMS. The company shall use the uniform policy and standard policy forms prescribed by the department under Section 2052.002. (V.T.I.C. Art. 5.76-3, Sec. 14.)

Source Law

Sec. 14. The company shall use the uniform policy and standard policy forms prescribed by the department under Articles 5.56 and 5.57 of this code.

Revisor's Note

Section 14, V.T.I.C. Article 5.76-3, refers to certain policies and forms prescribed under V.T.I.C. Articles 5.56 and 5.57. The relevant provisions of those articles are revised as Section 2052.002 of this code. The revised law is drafted accordingly.

Revised Law

Sec. 2054.303. DENIAL OF COVERAGE BASED ON CREDIT RISK. The company may refuse to write insurance coverage for an applicant that the company identifies as a credit risk unless the applicant, before a policy is issued:

(1) pays the total estimated premium and related charges; or

(2) provides security for payment of the total estimated premium and related charges. (V.T.I.C. Art. 5.76-3, Sec. 5(b).)

Source Law

(b) If an applicant is identified by the company

as a credit risk, the company may refuse to write insurance coverage if the applicant does not:

(1) pay the total estimated premium and related charges before the policy is issued; or

(2) provide security for payment of the total estimated premium and related charges before the policy is issued.

Revised Law

Sec. 2054.304. CANCELLATION AND NONRENEWAL. The company may cancel or refuse to renew coverage on a policyholder as provided by Section 406.008, Labor Code. (V.T.I.C. Art. 5.76-3, Sec. 15.)

Source Law

Sec. 15. The company may cancel or refuse to renew coverage on a policyholder as provided by Section 406.008, Labor Code.

[Sections 2054.305-2054.350 reserved for expansion]

SUBCHAPTER H. COMPANY AS INSURER OF LAST RESORT

Revised Law

Sec. 2054.351. INSURER OF LAST RESORT. (a) Except as provided by Section 2054.304 and this subchapter, the company may not refuse to insure a risk that tenders:

(1) the necessary premium; and

(2) any applicable accident prevention service fee.

(b) If an applicant would be rejected for workers' compensation insurance under the company's underwriting standards, the company may not reject the risk, but shall insure the risk at a higher premium as provided by the company's requirements. The company may require the risk to meet other conditions considered necessary to protect the company's interests. (V.T.I.C. Art. 5.76-4, Secs. (a), (b).)

Source Law

Art. 5.76-4. (a) The Texas Mutual Insurance Company may not, except as otherwise provided by this article and by Section 15, Article 5.76-3 of this code, refuse to insure any risk that tenders the necessary premium and any applicable accident prevention service fees.

(b) If an applicant to the company would be rejected for workers' compensation insurance under the company's underwriting standards, the risk may not be rejected, but shall be insured at a higher premium as provided by the company's requirements. The risk may be required to meet other conditions considered necessary to protect the company's interests.

Revised Law

Sec. 2054.352. REQUIRED DECLINATION OF CERTAIN RISKS. (a) In this section, "good faith" means honesty in fact in any conduct or transaction.

(b) The company shall decline to insure a risk if:

(1) insuring the risk would cause the company to exceed the premium-to-surplus ratios established by Section 2054.156; or

(2) the risk is not, in good faith, entitled to insurance through the company. (V.T.I.C. Art. 5.76-4, Sec. (d).)

Source Law

(d) The company shall decline to insure any risk if insuring that risk would cause the company to exceed the premium-to-surplus ratios established by Article 5.76-3 of this code or if the risk is not in good faith entitled to insurance through the company. For purposes of this subsection only, "good faith" means honesty in fact in any conduct or transaction.

Revised Law

Sec. 2054.353. REQUIRED INSURANCE OF CERTAIN COMMONLY OWNED OR CONTROLLED ENTITIES. If the company suspects fraud or identifies conditions that may result in acts of fraud, the company may require an applicant for workers' compensation insurance coverage who is identified as a risk for purposes of Section 2054.351(b) to insure all business entities that are commonly owned or controlled by the applicant. (V.T.I.C. Art. 5.76-4, Sec. (g).)

Source Law

(g) If the company suspects fraud or identifies conditions that may result in acts of fraud, the company may require an applicant for workers' compensation insurance coverage who is identified as a risk for purposes of Subsection (b) of this article to insure all business entities that are commonly owned or commonly controlled by the applicant.

Revised Law

Sec. 2054.354. DEVELOPMENT AND PUBLICATION OF CERTAIN INFORMATION. (a) The company shall develop statistical and other information as necessary to allow the company to distinguish between the company's:

(1) writings in the voluntary market; and

(2) writings as the insurer of last resort.

(b) The department shall develop and publish classification relativities specifically designed for the risks insured under this subchapter.

(c) On request, the company shall report statistical or other information developed under Subsection (a) to:

(1) the department; or

(2) any successor entity for research and oversight of the workers' compensation system of this state. (V.T.I.C. Art. 5.76-4, Secs. (c), (e), (h).)

Source Law

> (c) The company shall develop statistical and other information as necessary to allow the company to distinguish between its writings in the voluntary market and its writings as the insurer of last resort.
>
> (e) The department shall develop and publish classification relativities specifically designed for the risks insured under this article.
>
> (h) The company shall report the statistical and other information developed under Subsection (c) of this article on request to the Research and Oversight Council on Workers' Compensation, or to any successor entity for research and oversight of the workers' compensation system of this state.

Revisor's Note

Section (h), V.T.I.C. Article 5.76-4, refers to "the Research and Oversight Council on Workers' Compensation." The revised law substitutes a reference to the Texas Department of Insurance because Chapter 10, Acts of the 78th Legislature, 3rd Called Session, 2003, abolished the Research and Oversight Council on Workers' Compensation, provided that a reference in law to the council means the department or the commissioner of insurance, as appropriate, and transferred the council's functions to the department.

Revisor's Note
(End of Subchapter)

The revised law omits as obsolete Section (f), V.T.I.C. Article 5.76-4, relating to the exchange of

information between the Texas Mutual Insurance Company and the Texas workers' compensation insurance facility. The Texas workers' compensation insurance facility was transferred to the Texas Property and Casualty Insurance Guaranty Association, and the facility's organic law, V.T.I.C. Article 5.76-2, was repealed by Chapter 594, Acts of the 75th Legislature, Regular Session, 1997. The omitted law reads:

> (f) The company and the Texas workers' compensation insurance facility may exchange information relating to actual or suspected fraud by any applicant, policyholder, claimant, agent, or insurer with respect to workers' compensation insurance policies issued by, or applications for coverage submitted to, the facility or the company. That information may be kept confidential and is not subject to disclosure under the open records act, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes).

[Sections 2054.355-2054.400 reserved for expansion]

SUBCHAPTER I. APPEALS

Revised Law

Sec. 2054.401. APPEAL OF CERTAIN ACTIONS AND DECISIONS. (a) An act or decision by the company to deny, cancel, or refuse to renew a policy or risk insured under Subchapter H may be appealed to the board not later than the 30th day after the date the affected party receives actual notice that the act occurred or the decision was made.

(b) The company shall:

(1) not later than the 30th day after the date the request for hearing is made, hear the appeal; and

(2) not later than the 10th day before the date of the hearing, notify the appellant in writing of the time and place of the hearing.

(c) Not later than the 30th day after the last day of the hearing, the board shall affirm, reverse, or modify the act or decision appealed to the board.

(d) Unless the board specifically orders otherwise, a hearing under this section does not suspend the operation of an act or decision of the company. (V.T.I.C. Art. 5.76-3, Sec. 2(e).)

Source Law

> (e) A decision by the company to deny, cancel, or refuse to renew a policy or risk insured under Article 5.76-4 of this code is appealable to the board not later than the 30th day after the date on which the affected party received actual notice that the act occurred or that the decision was made. The company shall hear the appeal not later than the 30th day after the date on which the request for hearing is made and shall notify the appellant in writing of the time and place of the hearing not later than the 10th day before the date of the hearing. Not later than the 30th day after the last day of the hearing, the board shall affirm, reverse, or modify the act appealed to the board. A hearing under this subsection does not suspend the operation of any act, ruling, decision, or order of the company, unless the board specifically so orders.

Revisor's Note

(1) Section 2(e), V.T.I.C. Article 5.76-3, refers to "a decision" by the Texas Mutual Insurance Company to deny, cancel, or refuse to renew certain policies or risks. The revised law adds a reference to "an act" by that company for consistency with the remainder of Section 2(e), revised as this section, which clearly applies to both an act and a decision by that company, and with Section 2(f), V.T.I.C. Article 5.76-3, revised in this chapter as Section 2054.402.

(2) Section 2(e), V.T.I.C. Article 5.76-3, refers to an "act, ruling, decision, or order" of the Texas Mutual Insurance Company. The revised law omits the references to "ruling" and "order" as included within the meaning of an "act or decision."

Revised Law

Sec. 2054.402. REVIEW OF BOARD DECISION BY COMMISSIONER. (a) A board decision under Section 2054.401 is subject to review by the commissioner in the manner provided by Chapter 2001, Government Code.

(b) The commissioner's review of a board decision does not

suspend the operation of an act or decision of the company unless the commissioner specifically orders the suspension on a showing by an aggrieved party of:

(1) immediate, irreparable injury, loss, or damage; and

(2) probable success on the merits. (V.T.I.C. Art. 5.76-3, Sec. 2(f).)

Source Law

(f) A decision of the board under this section is subject to review by the commissioner in the manner provided by the administrative procedure law, Chapter 2001, Government Code. The commissioner's review of a decision by the board does not suspend the operation of any act, ruling, decision, or order of the company unless the commissioner specifically so orders on a showing by an aggrieved party of:

(1) immediate, irreparable injury, loss, or damage; and

(2) probable success on the merits.

Revisor's Note

(1) Section 2(f), V.T.I.C. Article 5.76-3, refers to an "act, ruling, decision, or order" of the Texas Mutual Insurance Company. The revised law omits the references to "ruling" and "order" for the reason stated in Revisor's Note (2) to Section 2054.401.

(2) Section 2(f), V.T.I.C. Article 5.76-3, provides that a decision of the board of directors of the Texas Mutual Insurance Company under "this section," meaning Section 2, Article 5.76-3, is subject to review by the commissioner of insurance under Chapter 2001, Government Code. The revised law substitutes a reference to Section 2054.401 of this chapter for "this section." The only references to a decision of the board in Section 2, Article 5.76-3, are contained in Sections 2(d) and (e). Section 2(d), revised in pertinent part in Section 2054.008 of this chapter, authorizes the board to refuse to disclose certain information to the public. Section 2(e), revised as Section 2054.401 of this chapter,

authorizes certain acts or decisions of the company to be appealed to the board. It is clear from the context that the reference in Section 2(f) to a board decision is intended as a reference to a decision on appeal under Section 2(e).

Revised Law

Sec. 2054.403. APPEAL OF COMMISSIONER'S DECISION. (a) A person aggrieved by a decision of the commissioner under Section 2054.402 may appeal the decision to a district court.

(b) Judicial review under this section is governed by the substantial evidence rule. (V.T.I.C. Art. 5.76-3, Sec. 2(g).)

Source Law

(g) A person aggrieved by the decision of the commissioner may appeal that decision to the district court. Judicial review under this section is governed by the substantial evidence rule.

[Sections 2054.404-2054.450 reserved for expansion]

SUBCHAPTER J. CONTROL OF FRAUD AND OTHER VIOLATIONS

Revised Law

Sec. 2054.451. IDENTIFICATION AND INVESTIGATION PROGRAM FOR FRAUD AND OTHER VIOLATIONS. (a) The company shall develop and implement a program to identify and investigate acts of fraud and violations of this code relating to workers' compensation insurance by applicants, policyholders, claimants, agents, insurers, health care providers, or other persons.

(b) The company shall cooperate with the commission to compile and maintain information necessary to detect practices or patterns of conduct that violate this code relating to workers' compensation insurance or that violate Subtitle A, Title 5, Labor Code. (V.T.I.C. Art. 5.76-3, Sec. 9(a).)

Source Law

Sec. 9. (a) The company shall develop and implement a program to identify and investigate fraud and violations of this code relating to workers' compensation insurance by an applicant, policyholder, claimant, agent, insurer, health care provider, or other person. The company shall cooperate with the commission to compile and maintain information necessary to detect practices or patterns of conduct

that violate this code relating to the workers' compensation insurance or Subtitle A, Title 5, Labor Code (the Texas Workers' Compensation Act).

Revised Law

Sec. 2054.452. INVESTIGATIONS; COORDINATION WITH COMMISSION. (a) The company may investigate cases of suspected fraud and violations of this code relating to workers' compensation insurance.

(b) The company may:

(1) coordinate the company's investigations with those conducted by the commission to avoid duplication of efforts; and

(2) refer to the commission a case that is not otherwise resolved by the company so that the commission may:

(A) perform any further investigation necessary under the circumstances;

(B) conduct administrative violation proceedings; and

(C) assess and collect penalties and restitution. (V.T.I.C. Art. 5.76-3, Sec. 9(b).)

Source Law

(b) The company may conduct investigations of cases of suspected fraud and violations of this code relating to workers' compensation insurance. The company may:

(1) coordinate its investigations with those conducted by the commission to avoid duplication of efforts; and

(2) refer cases that are not otherwise resolved by the company to the commission to:

(A) perform any further investigations that are necessary under the circumstances;

(B) conduct administrative violation proceedings; and

(C) assess and collect penalties and restitution.

Revised Law

Sec. 2054.453. RESTITUTION PAYABLE TO COMPANY. Restitution collected under Section 2054.452(b) must be paid to the company. (V.T.I.C. Art. 5.76-3, Sec. 9(d).)

Source Law

(d) Restitution collected under Subsection (b) of this section shall be paid to the company.

Revised Law

Sec. 2054.454. DEPOSIT AND USE OF PENALTIES COLLECTED BY COMMISSION. A penalty collected under Section 2054.452(b):

(1) must be deposited in the general revenue fund to the credit of the commission; and

(2) may be appropriated only to the commission to offset the costs of the program under Section 2054.451. (V.T.I.C. Art. 5.76-3, Sec. 9(e).)

Source Law

(e) Penalties collected under Subsection (b) of this section shall be deposited in the general revenue fund to the credit of the commission and shall be appropriated to the commission to offset the costs of this program.

Revised Law

Sec. 2054.455. FUNDING AGREEMENTS FOR CRIMINAL PROSECUTIONS. The company may enter into funding agreements with local prosecutors to prosecute offenses against the company. (V.T.I.C. Art. 5.76-3, Sec. 9(c).)

Source Law

(c) The company may enter into funding agreements with local prosecutors for the prosecution of offenses against the company.

Revised Law

Sec. 2054.456. IMMUNITY FOR CERTAIN ACTIONS. The company, the board, and company employees are not liable in a civil action for an action taken in good faith in executing a duty under this subchapter, including identifying or referring a person for investigation of or prosecution for a possible administrative violation or criminal offense. (V.T.I.C. Art. 5.76-3, Sec. 9(f).)

Source Law

(f) The board, company, and employees of the company are not liable in a civil action for any action made in good faith in the execution of duties under this section including the identification and referral of a person for investigation and prosecution for a possible administrative violation or criminal offense.

[Sections 2054.457-2054.500 reserved for expansion]

SUBCHAPTER K. ACCIDENT PREVENTION

Revised Law

Sec. 2054.501. DEFINITION. In this subchapter, "division" means the commission's division of workers' health and safety. (New.)

Revisor's Note

The revised law adds the definition of "division" to avoid unnecessary repetition of the substance of the definition in this subchapter.

Revised Law

Sec. 2054.502. REQUIREMENTS FOR PREVENTION OF INJURIES. The company may make and enforce requirements for the prevention of injuries to an employee of a policyholder or applicant for insurance under this chapter. On reasonable notice, a policyholder or applicant shall grant representatives of the company, the commission, or the department free access to the premises of the policyholder or applicant during regular working hours for purposes of this section. (V.T.I.C. Art. 5.76-3, Sec. 8(a).)

Source Law

Sec. 8. (a) The company may make and enforce requirements for the prevention of injuries to employees of its policyholders or applicants for insurance under this article. For this purpose, representatives of the company, representatives of the commission, or representatives of the department on reasonable notice shall be granted free access to the premises of each policyholder or applicant during regular working hours.

Revised Law

Sec. 2054.503. GROUNDS FOR CANCELLATION OR DENIAL OF COVERAGE. A failure or refusal by a policyholder or applicant for insurance to comply with a requirement prescribed by the company under Section 2054.502, or a failure or refusal to fully disclose all information pertinent to insuring or servicing the policyholder or applicant, constitutes sufficient grounds for the company to cancel a policy or deny an application. (V.T.I.C. Art. 5.76-3, Sec. 8(b).)

Source Law

(b) Failure or refusal by any such policyholder or applicant to comply with any requirement prescribed by the company for the prevention of injuries, or failure or refusal to make full disclosure of all information pertinent to the insuring or servicing of the policyholder or applicant, constitutes sufficient grounds for the company to cancel a policy or deny an application for insurance.

Revised Law

Sec. 2054.504. SAFETY CONSULTATION FOR CERTAIN INSUREDS. (a) A policyholder who is insured under Subchapter H shall obtain a safety consultation:

(1) if the policyholder:

(A) has a Texas experience modifier greater than 1.25;

(B) has a national experience modifier greater than 1.25 and estimated premium allocable to this state of $2,500 or more; or

(C) does not have an experience modifier but has had a loss ratio greater than 0.70 in at least two of the three most recent policy years for which information is available; or

(2) as required by the company, if the policyholder:

(A) has been in business for less than three years; and

(B) meets the criteria established by the company for a safety consultation.

(b) The criteria under Subsection (a)(2)(B) may include:

(1) the number and classification of employees;

(2) the policyholder's industry; and

(3) the policyholder's previous workers' compensation experience in this state or another jurisdiction. (V.T.I.C. Art. 5.76-3, Secs. 8(c), (d).)

Source Law

(c) A policyholder in the company who is insured under Article 5.76-4 of this code shall obtain a safety consultation if the policyholder:

(1) has a Texas experience modifier greater than 1.25;

(2) has a national experience modifier greater than 1.25 and estimated premium allocable to

Texas of $2,500 or more; or

(3) does not have an experience modifier but has had a loss ratio greater than 0.70 in at least two of the three most recent policy years for which information is available.

(d) A policyholder in the company who is insured under Article 5.76-4 of this code shall obtain a safety consultation as required by the company if the policyholder:

(1) has been in business for less than three years; and

(2) meets criteria for a safety consultation established by the company, which may include the number and classification of employees, the policyholder's industry, and the policyholder's previous workers' compensation experience in this state or another jurisdiction.

Revised Law

Sec. 2054.505. SAFETY CONSULTATION PROCEDURES. Not later than the 30th day after the effective date of a policy, the policyholder shall obtain a safety consultation required under Section 2054.504 from a safety consultant. The safety consultant must be:

(1) the company;

(2) the division; or

(3) a professional source approved for that purpose by the division. (V.T.I.C. Art. 5.76-3, Sec. 8(e) (part).)

Source Law

(e) The policyholder shall obtain the safety consultation not later than the 30th day after the effective date of the policy and shall obtain the safety consultation from the division of workers' health and safety of the commission, the company, or another professional source approved for that purpose by the division of workers' health and safety. [The safety consultant] . . . .

Revised Law

Sec. 2054.506. SAFETY CONSULTANT REPORT. A safety consultant acting under this subchapter shall file a written report with the commission and the policyholder specifying any hazardous condition or practice identified in the safety consultation. (V.T.I.C. Art. 5.76-3, Sec. 8(e) (part).)

Source Law

(e) . . . The safety consultant shall file a written report with the commission and the policyholder setting out any hazardous conditions or practices identified by the safety consultation.

Revised Law

Sec. 2054.507. ACCIDENT PREVENTION PLAN. (a) If a safety consultant identifies a hazardous condition or practice, the policyholder and the safety consultant shall develop a specific accident prevention plan that addresses the condition or practice.

(b) The safety consultant may approve an existing accident prevention plan.

(c) The policyholder shall comply with the accident prevention plan. (V.T.I.C. Art. 5.76-3, Sec. 8(f).)

Source Law

> (f) The policyholder and the consultant shall develop a specific accident prevention plan that addresses the hazards identified by the consultant. The safety consultant may approve an existing accident prevention plan. The policyholder shall comply with the accident prevention plan.

Revised Law

Sec. 2054.508. ACCIDENT INVESTIGATIONS; OTHER MONITORING. The division may:

(1) investigate an accident that occurs at a work site of a policyholder for whom an accident prevention plan was developed under Section 2054.507; and

(2) otherwise monitor as the division determines necessary the implementation of the accident prevention plan. (V.T.I.C. Art. 5.76-3, Sec. 8(g).)

Source Law

> (g) The division of workers' health and safety of the commission may investigate accidents occurring at the work sites of a policyholder for whom a plan has been developed under Subsection (f) of this section, and the division may otherwise monitor the implementation of the accident prevention plan as it finds necessary.

Revised Law

Sec. 2054.509. FOLLOW-UP INSPECTION. (a) Not earlier than the 90th day after or later than the sixth month after the date an accident prevention plan is developed under Section 2054.507, the division shall conduct a follow-up inspection of the policyholder's premises in accordance with rules adopted by the commission.

(b) The commission may require the participation of the safety consultant who performed the initial consultation and developed the accident prevention plan.

(c) If the division determines that a policyholder has complied with the terms of the accident prevention plan or has implemented other accepted corrective measures, the division shall certify that determination.

(d) If the division determines that a policyholder has failed or refuses to implement the accident prevention plan or other suitable hazard abatement measures, the policyholder may elect to cancel coverage not later than the 30th day after the date of the determination. (V.T.I.C. Art. 5.76-3, Sec. 8(h) (part).)

Source Law

> (h) In accordance with rules adopted by the commission, not earlier than 90 days or later than six months after the development of an accident prevention plan under Subsection (f) of this section, the division of workers' health and safety of the commission shall conduct a follow-up inspection of the policyholder's premises. The commission may require the participation of the safety consultant who performed the initial consultation and developed the safety plan. If the division determines that the policyholder has complied with the terms of the accident prevention plan or has implemented other accepted corrective measures, the division shall so certify. If a policyholder fails or refuses to implement the accident prevention plan or other suitable hazard abatement measures, the policyholder may elect to cancel coverage not later than the 30th day after the date of the division determination. . . .

Revised Law

Sec. 2054.510. CANCELLATION OF COVERAGE BY COMPANY; IMPOSITION OF ADMINISTRATIVE PENALTY. (a) If a policyholder described by Section 2054.509(d) does not elect to cancel coverage as provided by that section:

(1) the company may cancel the coverage; or

(2) the commission may impose an administrative penalty on the policyholder.

(b) The amount of an administrative penalty under Subsection (a)(2) may not exceed $5,000. Each day of noncompliance constitutes a separate violation.

(c) In imposing an administrative penalty, the commission may consider any matter that justice may require and shall consider:

(1) the seriousness of the violation, including the nature, circumstances, consequences, extent, and gravity of the prohibited act;

(2) the history and extent of previous administrative violations;

(3) the demonstrated good faith of the violator, including actions taken to rectify the consequences of the prohibited act;

(4) any economic benefit resulting from the prohibited act; and

(5) the penalty necessary to deter future violations.

(d) A penalty collected under this section must be:

(1) deposited in the general revenue fund to the credit of the commission; or

(2) reappropriated to the commission to offset the costs of implementing and administering this subchapter. (V.T.I.C. Art. 5.76-3, Secs. 8(h) (part), (i).)

Source Law

(h) . . . If the policyholder does not elect to cancel, the company may cancel the coverage or the commission may assess an administrative penalty not to exceed $5,000. Each day of noncompliance constitutes a separate violation. Penalties collected under this section shall be deposited in the general revenue fund to the credit of the commission or reappropriated to the commission to offset the costs of implementing and administering this section.

(i) In assessing an administrative penalty, the commission may consider any matter that justice may require and shall consider:

(1) the seriousness of the violation, including the nature, circumstances, consequences, extent, and gravity of the prohibited act;

(2) the history and extent of previous administrative violations;

(3) the demonstrated good faith of the violator, including actions taken to rectify the consequences of the prohibited act;

(4) any economic benefit resulting from the prohibited act; and

(5) the penalty necessary to deter future violations.

Revised Law

Sec. 2054.511. CONTINUING COMPLIANCE WITH SUBCHAPTER. The procedures established under this subchapter must be followed each year the policyholder meets the criteria established by Section 2054.504(a)(1). (V.T.I.C. Art. 5.76-3, Sec. 8(j).)

Source Law

> (j) The procedures established under this section must be followed each year the policyholder meets the qualifications established under Subsection (c) of this section and is insured through Article 5.76-4 of this code.

Revisor's Note

Section 8(j), V.T.I.C. Article 5.76-3, includes a reference to a policyholder who meets certain criteria and "is insured through Article 5.76-4 of this code." The revised law omits the quoted language as redundant and unnecessary because a policyholder does not meet the referenced criteria unless the policyholder is insured as described by the quoted language.

Revised Law

Sec. 2054.512. FEES FOR SERVICES. The commission shall:

(1) charge a policyholder for the reasonable cost of services provided to the policyholder under Sections 2054.505, 2054.506, 2054.507, 2054.509, and 2054.510(a); and

(2) set the fees for the services at a cost-reimbursement level, including a reasonable allocation of the commission's administrative costs. (V.T.I.C. Art. 5.76-3, Sec. 8(k).)

Source Law

> (k) The commission shall charge the policyholder for the reasonable cost of services provided under Subsections (e), (f), and (h) of this section. The fees for those services shall be set at a cost-reimbursement level including a reasonable allocation of the commission's administrative costs.

Revised Law

Sec. 2054.513. ENFORCEMENT OF SUBCHAPTER. The compliance and practices division of the commission shall enforce compliance

with this subchapter through the administrative violation proceedings under Chapter 415, Labor Code. (V.T.I.C. Art. 5.76-3, Sec. 8(l).)

Source Law

> (l) The compliance and practices division of the commission shall enforce compliance with this section through the administrative violation proceedings under Chapter 415, Labor Code.

[Sections 2054.514-2054.550 reserved for expansion]

SUBCHAPTER L. PUBLIC INTEREST INFORMATION AND COMPLAINT PROCEDURES

Revised Law

Sec. 2054.551. PUBLIC INTEREST INFORMATION. (a) The company shall prepare information of public interest describing the functions of the company and the procedures by which complaints are submitted to and resolved by the company.

(b) The company shall make the information available to the public and appropriate state agencies. (V.T.I.C. Art. 5.76-3, Sec. 19(a).)

Source Law

> Sec. 19. (a) The company shall prepare information of public interest describing the functions of the company and the procedures by which complaints are filed with and resolved by the company. The company shall make the information available to the public and appropriate state agencies.

Revised Law

Sec. 2054.552. COMPLAINTS. (a) The company shall establish methods by which consumers and service recipients are notified of the name, mailing address, and telephone number of the company for the purpose of directing a complaint to the company.

(b) The company may provide for the notice:

(1) by a supplement or endorsement to a written policy;

(2) on a sign prominently displayed in the place of business of each regional office of the company; or

(3) in a bill for services provided by the company. (V.T.I.C. Art. 5.76-3, Sec. 19(b).)

Source Law

(b) The company shall establish methods by which consumers and service recipients are notified of the name, mailing address, and telephone number of the company for the purpose of directing complaints to the company. The company may provide for that notification:

(1) by a supplement or endorsement to a written policy;

(2) on a sign prominently displayed in the place of business of each regional office of the company; or

(3) in a bill for services provided by the company.

Revised Law

Sec. 2054.553. COMPLAINT RECORD. (a) The company shall keep information about each written complaint filed with the company. The information must include:

(1) the date the complaint is received;

(2) the name of the complainant;

(3) the subject matter of the complaint;

(4) a record of each person contacted in relation to the complaint;

(5) a summary of the results of the review or investigation of the complaint; and

(6) for a complaint for which the company takes no action, an explanation of the reason the complaint was closed without action.

(b) For each written complaint the company receives and has authority to resolve, the company shall:

(1) provide the company's policies and procedures relating to complaint investigation and resolution to the person filing the complaint and each person or entity that is a subject of the complaint; and

(2) at least quarterly and until final disposition of the complaint, notify the person filing the complaint and each person or entity that is a subject of the complaint of the status of the complaint unless the notification would jeopardize an undercover investigation. (V.T.I.C. Art. 5.76-3, Sec. 20.)

Source Law

Sec. 20. (a) The company shall keep information about each written complaint submitted to the company. The information shall include:

(1) the date the complaint is received;

(2) the name of the complainant;

(3) the subject matter of the complaint;

(4) a record of all persons contacted in relation to the complaint;

(5) a summary of the results of the review or investigation of the complaint; and

(6) for complaints for which the company took no action, an explanation of the reason the complaint was closed without action.

(b) For each written complaint that the company has authority to resolve, the company shall provide to the person filing the complaint and the persons or entities complained about the company's policies and procedures pertaining to complaint investigation and resolution. The company, at least quarterly and until final disposition of the complaint, shall notify the person filing the complaint and the persons or entities complained about of the status of the complaint unless the notice would jeopardize an undercover investigation.

Revisor's Note
(End of Chapter)

(1) The revised law omits as executed that part of Section 2(a), V.T.I.C. Article 5.76-3, requiring the commissioner of insurance to issue to the Texas Mutual Insurance Company a certificate of authority before September 1, 2001. The omitted provision reads as follows:

> Sec. 2. (a) . . . The commissioner shall issue a certificate of authority to the company as provided by Chapter 15 of this code to write workers' compensation insurance, not later than September 1, 2001.

(2) The revised law omits as executed V.T.I.C. Article 5.76-5, relating to the revenue bond program of the Texas Public Finance Authority to provide financing for the Texas Workers' Compensation Insurance Fund and procedures for that program. By resolution adopted December 12, 1991, the Texas Public Finance Authority authorized the issuance of the "Texas Public Finance Authority, Texas Workers' Compensation Insurance Fund Maintenance Tax Surcharge Revenue Bond Taxable Series 1991" in the principal

amount of $300 million. Those bonds were registered by the comptroller and approved by the attorney general in December 1991. The bonds had a maturity date of December 1, 2004, and on that date were fully paid. The omitted law reads:

> Art. 5.76-5
>
> Sec. 1. The legislature finds that the issuance of bonds for the purposes of providing a method to raise funds to provide workers' compensation insurance coverage through the Texas Workers' Compensation Insurance Fund and workers' compensation insurance coverage for employers in this state is for the benefit of the public and in furtherance of a public purpose.
>
> Sec. 2. In this article:
>
> (1) "Bond resolution" means the resolution or order authorizing the bonds to be issued under this article.
>
> (2) "Board" means the board of directors of the Texas Public Finance Authority.
>
> (3) "Fund" means the Texas Workers' Compensation Insurance Fund.
>
> Sec. 3. (a) On behalf of the fund, the Texas Public Finance Authority shall issue revenue bonds to:
>
> (1) establish the initial surplus of the fund;
>
> (2) establish and maintain reserves;
>
> (3) pay initial operating costs;
>
> (4) pay costs related to issuance of the bonds; and
>
> (5) pay other costs related to the bonds as may be determined by the board.
>
> (b) To the extent not inconsistent with this article, the Texas Public Finance Authority Act (Article 601d, Vernon's Texas Civil Statutes) applies to bonds issued under this article. In the event of a conflict, this article controls.
>
> Sec. 4. The following Acts apply to bonds issued under this article to the extent consistent with this article:
>
> (1) Chapter 656, Acts of the 68th Legislature, Regular Session, 1983 (Article 717q, Vernon's Texas Civil Statutes);
>
> (2) Chapter 3, Acts of the 61st Legislature, Regular Session, 1969 (Article 717k-2, Vernon's Texas Civil Statutes);
>
> (3) the Bond Procedures Act of 1981 (Article 717k-6, Vernon's Texas Civil Statutes);
>
> (4) Chapter 1078, Acts of the 70th Legislature, Regular Session, 1987 (Article 717k-7, Vernon's Texas Civil Statutes);
>
> (5) Article 3, Chapter 53, Acts of the 70th Legislature, 2nd Called

Session, 1987 (Article 717k-8, Vernon's Texas Civil Statutes);

(6) Article 717k-9, Revised Statutes; and

(7) Chapter 400, Acts of the 66th Legislature, 1979 (Article 717m-1, Vernon's Texas Civil Statutes).

Sec. 5. The Texas Public Finance Authority may issue, on behalf of the fund, bonds in a total amount not to exceed $300 million.

Sec. 6. (a) Bonds may be issued at public or private sale.

(b) Bonds may mature not more than 20 years after the date issued.

(c) Bonds must be issued in the name of the fund.

Sec. 7. In a bond resolution, the board may make additional covenants with respect to the bonds and the designated income and receipts of the fund pledged to their payment and may provide for the flow of funds and the establishment, maintenance, and investment of funds and accounts with respect to the bonds.

Sec. 8. (a) A bond resolution may establish special accounts including an interest and sinking fund account, reserve account, and other accounts.

(b) The president of the fund or the president's designee shall administer the accounts in accordance with Article 5.76-3 of this code.

Sec. 9. (a) Bonds are payable only from the maintenance tax surcharge established in Section 10 of this article or other sources the fund is authorized to levy, charge, and collect in connection with paying any portion of the bonds.

(b) Bonds are obligations solely of the fund. Bonds do not create a pledging, giving, or lending of the faith, credit, or taxing authority of this state.

(c) Each bond must include a statement that the state is not obligated to pay any amount on the bond and that the faith, credit, and taxing authority of this state are not pledged, given, or lent to those payments.

(d) Each bond issued under this article must state on its face that the bond is payable solely from the revenues pledged for that purpose and that the bond does not and may not constitute a legal or moral obligation of the state.

Sec. 10. (a) A maintenance tax surcharge is assessed against:

(1) each insurance company writing workers' compensation insurance in this state;

(2) each certified self-insurer as provided in Chapter D, Article 3, Texas Workers' Compensation Act (Article 8308-3.51 et seq., Vernon's Texas Civil Statutes); and

(3) the fund.

(b) The maintenance tax surcharge shall be set in an amount sufficient to pay

all debt service on the bonds. The maintenance tax surcharge is set by the commissioner in the same time and shall be collected by the comptroller on behalf of the fund in the same manner as provided under Article 5.68 of this code.

(c) On receiving notice of the rate of assessment set by the Texas Workers' Compensation Commission under Section 2.23, Texas Workers' Compensation Act (Article 8308-2.23, Vernon's Texas Civil Statutes), the State Board of Insurance shall increase the tax rate to a rate sufficient to pay all debt service on the bonds subject to the maximum tax rate established by Section 2.22, Texas Workers' Compensation Act (Article 8308-2.22, Vernon's Texas Civil Statutes). If the resulting tax rate is insufficient to pay all costs for the Texas Workers' Compensation Commission and all debt service on the bonds, the State Board of Insurance may assess an additional surcharge not to exceed one percent of gross workers' compensation premiums to cover all debt service on the bonds. In this code, the maintenance tax surcharge includes the additional maintenance tax assessed under this subsection and the surcharge assessed under this subsection to pay all debt service of the bonds.

(d) The fund and each insurance company may pass through the maintenance tax surcharge to each of its policyholders.

(e) As a condition of engaging in the business of insurance in this state, an insurance company writing workers' compensation insurance in this state agrees that if the company leaves the workers' compensation insurance market in this state it remains obligated to pay, until the bonds are retired, the company's share of the maintenance tax surcharge assessed under this section in an amount proportionate to that company's share of the workers' compensation insurance market in this state as of the last complete reporting period before the date on which the company ceases to engage in the insurance business in this state. The proportion assessed against the company shall be based on the company's workers' compensation insurance gross premiums for the company's last reporting period. However, a company is not required to pay the proportionate amount in any year in which the surcharge assessed against insurance companies continuing to write workers' compensation insurance in this state is sufficient to service the bond obligation. The abolition of the fund under Section 2(d), Article 5.76-3, Insurance Code, does not affect the liability of an insurance company for a maintenance tax surcharge assessed under this section.

Sec. 11. The bonds issued under this article, and any interest from the bonds, and all assets pledged to secure the payment of the bonds are free from taxation by the state or a political subdivision of this

state.

Sec. 12. The bonds issued under this article constitute authorized investments under Article 2.10 and Subpart A, Part I, Article 3.39 of this code.

Sec. 13. The state pledges to and agrees with the owners of any bonds issued in accordance with this article that the state will not limit or alter the rights vested in the fund to fulfill the terms of any agreements made with the owners of the bonds or in any way impair the rights and remedies of those owners until the bonds, any premium or interest, and all costs and expenses in connection with any action or proceeding by or on behalf of those owners are fully met and discharged. The fund may include this pledge and agreement of the state in any agreement with the owners of the bonds.

Sec. 14. A writ of mandamus and all other legal and equitable remedies are available to any party at interest to require the fund and any other party to carry out agreements and to perform functions and duties under this article, the Texas Constitution, or a bond resolution.

Sec. 15. (a) Notwithstanding any other provision of this article, effective September 1, 2001:

(1) the fund is operated as the Texas Mutual Insurance Company as provided by Article 5.76-3 of this code; and

(2) additional bonds may not be issued under this article.

(b) The Texas Mutual Insurance Company may exercise any power, and is liable to perform any duty, imposed on the fund as this article existed immediately before September 1, 2001.

[Chapters 2055-2100 reserved for expansion]

## SUBTITLE F. OTHER COVERAGE

### CHAPTER 2101. COVERAGE FOR AIRCRAFT


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Sec. 2101.002. FILING OF POLICY FORMS AND ENDORSEMENTS MAY BE REQUIRED . . . . . 1102

Sec. 2101.003. DISAPPROVAL OF POLICY FORM OR ENDORSEMENT . . . . . 1102

Sec. 2101.004. CERTAIN CONTRACTS OR OTHER AGREEMENTS VOID . . . . . 1103

Sec. 2101.005. RULES . . . . . 1104

## CHAPTER 2101. COVERAGE FOR AIRCRAFT

Revised Law

Sec. 2101.001. APPLICABILITY OF CHAPTER. This chapter applies only to aircraft hull and aircraft liability insurance. (V.T.I.C. Art. 5.90 (part).)

Source Law

> Art. 5.90. [When the State Board of Insurance finds that a public need exists for the regulation of] aircraft hull and aircraft liability insurance, . . . .

Revised Law

Sec. 2101.002. FILING OF POLICY FORMS AND ENDORSEMENTS MAY BE REQUIRED. If the commissioner finds that a public need exists to regulate the insurance subject to this chapter, the commissioner by order may require each insurer issuing that insurance in this state to file with the department each policy form and endorsement the insurer uses to write the insurance. (V.T.I.C. Art. 5.90 (part).)

Source Law

> Art. 5.90. When the State Board of Insurance finds that a public need exists for the regulation of [aircraft hull and aircraft liability insurance,] it may, by board order, require all insurers issuing any form of aircraft hull and aircraft liability insurance in Texas to file with the board all policy forms and endorsements used by each insurer in the writing of such insurance. . . .

Revisor's Note

> V.T.I.C. Article 5.90 refers to the "State Board of Insurance" and the "board." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred the 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.

Revised Law

Sec. 2101.003. DISAPPROVAL OF POLICY FORM OR ENDORSEMENT. (a) The commissioner may disapprove the use of a policy form or

endorsement filed under this chapter.

(b) After the commissioner disapproves a policy form or endorsement, an insurer may not use the form or endorsement. (V.T.I.C. Art. 5.90 (part).)

Source Law

> Art. 5.90. . . . The board may disapprove the use of any form or endorsement so filed and no insurer may thereafter use such disapproved form or endorsement. . . .

Revised Law

Sec. 2101.004. CERTAIN CONTRACTS OR OTHER AGREEMENTS VOID. (a) A contract or other agreement is void if the contract or agreement is not written into:

(1) the application for an insurance policy subject to this chapter; or

(2) the policy.

(b) A contract or other agreement that is void under Subsection (a) is:

(1) a violation of this chapter; and

(2) sufficient cause to revoke the insurer's certificate of authority to write aircraft insurance in this state. (V.T.I.C. Art. 5.90 (part).)

Source Law

> Art. 5.90. . . . Any contract or agreement not written into the application, if any, or policy shall be void and of no effect and in violation of the provisions of this subchapter and shall be sufficient cause for revocation of license of the insurer to write aircraft insurance within this state.

Revisor's Note

(1) V.T.I.C. Article 5.90 provides that certain contracts or agreements are "void and of no effect." The revised law omits "of no effect" as unnecessary. A contract or agreement that is void has no effect.

(2) V.T.I.C. Article 5.90 refers to the revocation of a "license" of an insurer. The revised law substitutes "certificate of authority" for "license" because "certificate of authority" is the

term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 2101.005. RULES. When the commissioner acts under this chapter, the commissioner may adopt any rules that are necessary to carry out the provisions of this chapter or Chapter 251 or 256. (V.T.I.C. Art. 5.92.)

Source Law

Art. 5.92. When the State Board of Insurance acts under Article 5.90, it shall have authority to make any rules that are necessary to carry out the provisions of this subchapter.

Revisor's Note

V.T.I.C. Article 5.92 authorizes the State Board of Insurance, meaning the commissioner of insurance for the reason stated in the revisor's note to Section 2101.002 of this chapter, to adopt rules necessary to carry out the provisions of "this subchapter," meaning Subchapter K, V.T.I.C. Chapter 5. Subchapter K, Chapter 5, consists of V.T.I.C. Articles 5.90 and 5.92, which are revised as this chapter, and V.T.I.C. Article 5.91, which is revised in Chapters 251 and 256 of this code. The revised law is drafted accordingly.

[Chapters 2102-2150 reserved for expansion]

SUBTITLE G. POOLS, GROUPS, PLANS, AND SELF-INSURANCE

CHAPTER 2151. TEXAS AUTOMOBILE INSURANCE PLAN ASSOCIATION

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[Sections 2151.002-2151.050 reserved for expansion]

SUBCHAPTER B. TEXAS AUTOMOBILE INSURANCE PLAN ASSOCIATION

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CHAPTER 2151. TEXAS AUTOMOBILE INSURANCE PLAN ASSOCIATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2151.001. DEFINITIONS. In this chapter:

(1) "Association" means the Texas Automobile

Insurance Plan Association.

(2) "Authorized insurer" means an insurer authorized by the department to write automobile liability coverage under this title. Except as provided by Section 2251.204, the term does not include a county mutual insurance company organized under Chapter 912.

(3) "Insurance" means an insurance policy that meets the requirements of Chapter 601, Transportation Code. (V.T.I.C. Art. 21.81, Secs. 1(1), (2), (3).)

Source Law

Art. 21.81
Sec. 1. In this article:
(1) "Association" means the Texas Automobile Insurance Plan Association established under this article.
(2) "Authorized insurer" means any insurer authorized by the Texas Department of Insurance to write motor vehicle liability coverage under the provisions of Chapter 5 of this code. Except as provided by Section 13(f), Article 5.13-2 of this code, the term does not include an insurer organized under Chapter 17 of this code.
(3) "Insurance" means an insurance policy that meets the requirements of the Texas Motor Vehicle Safety-Responsibility Act (Article 6701h, Vernon's Texas Civil Statutes).

Revisor's Note

(1) Section 1(2), V.T.I.C. Article 21.81, refers to "motor vehicle liability coverage." The revised law substitutes "automobile liability coverage" for "motor vehicle liability coverage" in this section and in similar phrases throughout this chapter for consistency in this code. "Automobile liability coverage" is the term more commonly used to describe the type of insurance that provides coverage for motor vehicles.

(2) Section 1(2), V.T.I.C. Article 21.81, refers to an insurer authorized to write automobile liability coverage under V.T.I.C. Chapter 5. That chapter has been revised in various titles of this code. The relevant provisions of Chapter 5 that

regulate the authority to write automobile liability coverage are revised in Title 10 of this code. For that reason, the revised law substitutes a reference to "this title" for the reference to "Chapter 5."

(3) Section 1(3), V.T.I.C. Article 21.81, refers to Article 6701h, Vernon's Texas Civil Statutes. That statute was codified in pertinent part in 1995 as Chapter 601, Transportation Code. Throughout this chapter, the revised law is drafted accordingly.

[Sections 2151.002-2151.050 reserved for expansion]

SUBCHAPTER B. TEXAS AUTOMOBILE INSURANCE PLAN ASSOCIATION

Revised Law

Sec. 2151.051. NATURE AND COMPOSITION OF ASSOCIATION. (a) The Texas Automobile Insurance Plan Association is a nonprofit corporate body composed of all authorized insurers.

(b) Each authorized insurer must be a member of the association as a condition of the insurer's authority to write automobile liability insurance in this state. (V.T.I.C. Art. 21.81, Sec. 2(a) (part).)

Source Law

> Sec. 2. (a) . . . The association is a nonprofit corporate body composed of all authorized insurers. Each authorized insurer shall be a member of the association and shall remain a member of the association so long as the association is in existence as a condition of its authority to write motor vehicle liability insurance in this state.

Revisor's Note

Section 2(a), V.T.I.C. Article 21.81, provides that the association is established. The revised law omits this provision as executed. The omitted law reads:

> Sec. 2. (a) The Texas Automobile Insurance Plan Association is established. . . .

Revised Law

Sec. 2151.052. AUTHORITY OF GOVERNING COMMITTEE. The

association is administered by a governing committee under a plan of operation. (V.T.I.C. Art. 21.81, Secs. 2(b) (part), 3(a) (part).)

Source Law

[Sec. 2]

(b) The association shall be administered by a governing committee . . . .

Sec. 3. (a) The governing committee has the responsibility for the administration of the association through the plan of operation. . . .

Revised Law

Sec. 2151.053. MEMBERSHIP OF GOVERNING COMMITTEE. The governing committee is composed of 15 members selected as follows:

(1) eight members who represent the interests of insurers, elected by the association members according to a method the members determine;

(2) five public members, nominated by the office of public insurance counsel and selected by the commissioner; and

(3) two members who are general property and casualty agents, as required by the plan of operation. (V.T.I.C. Art. 21.81, Sec. 2(b) (part).)

Source Law

(b) [The association shall be administered by a governing committee] composed of fifteen members selected as follows:

(1) eight members who represent the interests of insurers, elected by the members of the association according to a method determined by such members;

(2) five public members nominated by the Office of Public Insurance Counsel and selected by the commissioner; and

(3) two members who are licensed local recording agents, as defined by the plan of operation.

Revisor's Note

(1) Section 2(b)(3), V.T.I.C. Article 21.81, refers to "licensed" agents. The revised law omits "licensed" as unnecessary in this context because under Section 4001.101 of this code a person may not act as an agent unless the person holds a license.

(2) Section 2(b)(3), V.T.I.C. Article 21.81,

refers to "local recording agents." 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 automobile liability insurance is now regulated as a "general property and casualty agent" under Chapter 4051 of this code.

Revised Law

Sec. 2151.054. ELIGIBILITY TO SERVE AS INSURER REPRESENTATIVE. To be eligible to serve on the governing committee as a representative of insurers, an individual must be a full-time employee of an authorized insurer. (V.T.I.C. Art. 21.81, Sec. 2(c).)

Source Law

(c) To be eligible to serve on the governing committee as a representative of insurers, a person must be a full-time employee of an authorized insurer.

Revised Law

Sec. 2151.055. INELIGIBILITY TO SERVE AS PUBLIC MEMBER. An individual may not serve on the governing committee as a public member if the individual, another individual related to that individual within the second degree by consanguinity or affinity, or another individual residing in the same household with that individual:

(1) is required to be registered or licensed under this code or another insurance law of this state;

(2) is employed by or acts as a consultant to a person required to be registered or licensed or required to hold a certificate of authority under this code or another insurance law of this state;

(3) is the owner of, has a financial interest in, or participates in the management of an organization required to be

registered or licensed or required to hold a certificate of authority under this code or another insurance law of this state;

(4) is an officer, employer, or consultant of an association in the field of insurance; or

(5) is required to register as a lobbyist under Chapter 305, Government Code. (V.T.I.C. Art. 21.81, Sec. 2(d).)

Source Law

(d) A person may not serve on the governing committee as a public member if that person, an individual related to that person within the second degree of consanguinity or affinity, or an individual residing in the same household with that person is:

(1) required to be registered or licensed under this code or another insurance law of this state;

(2) employed by or acts as a consultant to a person required to be registered or licensed under this code or another insurance law of this state;

(3) the owner of, has a financial interest in, or participates in the management of an organization required to be registered or licensed under this code or another insurance law of this state;

(4) an officer, employer, or consultant of an association in the field of insurance; or

(5) required to register as a lobbyist under Chapter 305, Government Code.

Revisor's Note

Sections 2(d)(2) and (3), V.T.I.C. Article 21.81, refer to a person and an organization required to be "licensed" under this code or another insurance law of this state. The revised law adds a reference to a person and an organization "required to hold a certificate of authority" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 2151.056. IMMUNITY FROM LIABILITY. (a) The association, a member of the governing committee, or an employee of the association is not personally liable for:

(1) an act performed in good faith within the scope of the person's authority as determined under this chapter or the plan of operation; or

(2) damages occasioned by the person's official act or omission except an act or omission that is corrupt or malicious.

(b) The association shall provide counsel to defend an action brought against a member of the governing committee or an employee because of the person's official act or omission regardless of whether the person has terminated service with the association when the action is instituted.

(c) This section is cumulative of and does not affect or modify a common law or statutory privilege or immunity. (V.T.I.C. Art. 21.81, Sec. 6.)

Source Law

> Sec. 6. (a) The association, a member of the governing committee, and any employee of the association is not personally liable for any act performed in good faith within the scope of the person's authority as determined under this article or the plan of operation or for damages occasioned by his or her official acts or omissions except for an act or omission that is corrupt or malicious. The association shall provide counsel to defend any action brought against a member of the governing committee or an employee by reason of the person's official act or omission whether or not at the time of the institution of the action the defendant has terminated service with the association.
>
> (b) This section is cumulative with and does not affect or modify any common law or statutory privilege or immunity.

[Sections 2151.057-2151.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF ASSOCIATION

Revised Law

Sec. 2151.101. POWERS OF NONPROFIT CORPORATION. (a) The association has the powers granted to a nonprofit corporation under the Business Organizations Code.

(b) Notwithstanding Subsection (a), on or before December 31, 2009, the association has the powers granted to a nonprofit corporation under the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) or the Business Organizations Code, as applicable.

(c) This subsection and Subsection (b) expire December 31, 2009. (V.T.I.C. Art. 21.81, Sec. 3(a) (part).)

Source Law

(a) . . . The association has the powers granted to nonprofit corporations under the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes).

Revisor's Note

Section 3(a), V.T.I.C. Article 21.81, refers to the Texas Non-Profit Corporation Act. That act was codified in various chapters of the Business Organizations Code by Chapter 182, Acts of the 78th Legislature, Regular Session, 2003. The Business Organizations Code takes effect January 1, 2006, and applies only to domestic business entities formed on or after that date, to domestic business entities formed before that date that elect to have that code govern their operations, and to certain foreign business entities. On January 1, 2010, the Texas Non-Profit Corporation Act expires, and the Business Organizations Code will apply to all business entities without regard to date of formation or whether an entity is a foreign or domestic business entity. The revised law is drafted to reflect the applicability of these statutes in accordance with their effective dates or on election by a business entity.

Revised Law

Sec. 2151.102. ASSIGNMENT OF INSURANCE; ELIGIBILITY. (a) The association shall provide for the assignment of insurance to an authorized insurer for a person required by Chapter 601, Transportation Code, to show proof of financial responsibility for the future.

(b) An applicant is not eligible for insurance through the association unless the applicant and the servicing agent certify as part of the application to the association that the applicant has been rejected for insurance by at least two insurers that are authorized to engage in business in this state and that are writing

automobile insurance in this state. (V.T.I.C. Art. 21.81, Sec. 4.)

Source Law

Sec. 4. (a) The association shall provide a means by which insurance may be assigned to an authorized insurance company for a person required by the Texas Motor Vehicle Safety-Responsibility Act (Article 6701h, Vernon's Texas Civil Statutes) to show proof of financial responsibility for the future.

(b) An applicant is not eligible for insurance through the association unless the applicant and the servicing agent certify as part of the application to the association that the applicant has been rejected for insurance by at least two insurers licensed to do business in this state and actually writing automobile insurance in this state, including insurers that are not rate regulated.

Revisor's Note

(1) Section 4(a), V.T.I.C. Article 21.81, refers to an "authorized insurance company." Section 1(2), V.T.I.C. Article 21.81, revised in this chapter as Section 2151.001(2), defines "authorized insurer." For consistency of terminology in this chapter, the revised law substitutes "authorized insurer" for "authorized insurance company."

(2) Section 4(b), V.T.I.C. Article 21.81, refers to insurers that are "licensed" to do business in this state. Throughout this chapter, the revised law substitutes "authorized" for "licensed" in this context for the reason stated in the revisor's note to Section 2151.055.

(3) Section 4(b), V.T.I.C. Article 21.81, refers to insurers authorized to write and actually writing automobile insurance in this state, "including insurers that are not rate regulated." The revised law omits the quoted language as unnecessary and misleading because, following enactment of S.B. No. 14 [Chapter 206], Acts of the 78th Legislature, Regular Session, 2003, according to the Texas Department of Insurance, all authorized insurers actually writing automobile insurance in this state are rate regulated.

Revised Law

Sec. 2151.103. ASSESSMENTS. (a) The association may assess authorized insurers to provide money to operate the association.

(b) The amount assessed against an authorized insurer must be in proportion to the insurer's writing of automobile liability insurance in this state.

(c) The association may bring an action to collect an assessment against an authorized insurer that does not pay the assessment within a reasonable time. In addition, the association may report an authorized insurer's failure to pay the assessment to the commissioner. The commissioner may institute a disciplinary action against the insurer under Chapter 82. (V.T.I.C. Art. 21.81, Sec. 3(a) (part).)

Source Law

> (a) . . . The association may collect funds from the member companies to provide for the operation of the association. Assessments must be made upon member companies in proportion to their writings of motor vehicle liability insurance in this state. If an assessment made upon a member insurer is not paid within a reasonable time, the association may bring an action to collect the assessment. In addition, the association may report the failure to pay to the commissioner, who may institute a disciplinary action under Article 1.10 of this code. . . .

Revisor's Note

(1) Section 3(a), V.T.I.C. Article 21.81, refers to "member companies" of the Texas Automobile Insurance Plan Association. Section 1(2), V.T.I.C. Article 21.81, revised in this chapter as Section 2151.001(2), defines "authorized insurer," and Section 2(a), V.T.I.C. Article 21.81, revised in relevant part in this chapter as Section 2151.051, requires all authorized insurers to be members of the association. Accordingly, throughout this chapter, the revised law substitutes a reference to "authorized insurers" for the reference to "member companies" and other similar references for consistency of

terminology throughout this chapter.

(2) Section 3(a), V.T.I.C. Article 21.81, refers to disciplinary action under V.T.I.C. Article 1.10. That article has been revised in various chapters of this code. The relevant provisions were contained in Section 7, Article 1.10, revised as Chapter 82 of this code. The revised law is drafted accordingly.

[Sections 2151.104-2151.150 reserved for expansion]

SUBCHAPTER D. PLAN OF OPERATION

Revised Law

Sec. 2151.151. CONTENTS OF PLAN OF OPERATION; AMENDMENTS. (a) The plan of operation must:

(1) provide for the efficient, economical, fair, and nondiscriminatory administration of the association; and

(2) provide a means by which insurance may be provided in accordance with Section 2151.102(a).

(b) Subject to the commissioner's approval, the governing committee may amend the plan of operation. (V.T.I.C. Art. 21.81, Secs. 1(4), 3(b), (c).)

Source Law

[Sec. 1]

(4) "Plan of operation" means the plan for operating the association to provide a means by which insurance may be assigned to an eligible person who is required by law to show proof of financial responsibility for the future.

[Sec. 3]

(b) The plan of operation of the association must provide for the efficient, economical, fair, and nondiscriminatory administration of the association.

(c) Subject to the approval of the commissioner, the governing committee may make and amend the plan of operation.

Revisor's Note

(1) Section 1(4), V.T.I.C. Article 21.81, refers to a means of assigning insurance "to an eligible person who is required by law to show proof of financial responsibility for the future." The revised

law substitutes "in accordance with Section 2151.102(a)" for the quoted language because the quoted language restates the substance of the requirements of Section 4(a), V.T.I.C. Article 21.81, revised in this chapter as Section 2151.102(a).

(2) Section 3(c), V.T.I.C. Article 21.81, allows the governing committee of the Texas Automobile Insurance Plan Association to "establish" the association's plan of operation. The revised law omits the reference to "establish" as executed.

Revised Law

Sec. 2151.152. CORRECTIVE ACTION TO PLAN OF OPERATION. If the commissioner at any time believes that any part of the plan of operation is inconsistent with the purposes of Chapter 601, Transportation Code, the commissioner shall notify the governing committee in writing so that the governing committee may take corrective action. (V.T.I.C. Art. 21.81, Sec. 3(d).)

Source Law

(d) If the commissioner at any time believes that any part of the plan of operation is not in keeping with the purposes of the Texas Motor Vehicle Safety-Responsibility Act (Article 6701h, Vernon's Texas Civil Statutes), the commissioner shall notify the governing committee in writing so that the governing committee may take corrective action.

Revised Law

Sec. 2151.153. INCENTIVE PROGRAMS. (a) The plan of operation must include incentive programs to encourage authorized insurers to write insurance on a voluntary basis and to minimize the use of the association as a means to obtain insurance.

(b) One incentive program must target underserved geographic areas, which the commissioner by rule shall designate. In designating underserved areas, the commissioner shall consider with respect to an area:

(1) the availability of insurance;

(2) the number of uninsured drivers;

(3) the number of drivers insured through the

association; and

(4) any other relevant factor.

(c) The incentive programs are effective on the commissioner's approval. (V.T.I.C. Art. 21.81, Sec. 3(e).)

Source Law

> (e) Among other provisions, the plan of operation must contain incentive programs to encourage members to write insurance on a voluntary basis and to minimize the use of the association as a means to obtain insurance. The incentive programs are effective on approval of the commissioner. One of these programs shall target underserved geographic areas which shall be determined and designated by the commissioner by rule. In determining which areas will be designated as underserved, the commissioner shall consider the availability of insurance, the number of uninsured drivers, the number of drivers insured through the association, and any other relevant factor.

Revisor's Note

Section 3(e), V.T.I.C. Article 21.81, authorizes the commissioner of insurance to "determine and designate" underserved areas. The revised law omits the reference to "determine" because, in context, "determine" is included within the meaning of "designate."

Revised Law

Sec. 2151.154. ASSIGNMENT DISTRIBUTION PLAN. (a) The plan of operation must include a voluntary, competitive limited assignment distribution plan that allows an authorized insurer to contract directly with a servicing insurer to accept assignments to the servicing insurer by the association.

(b) A servicing insurer must be authorized to write automobile insurance in this state and must:

(1) have written automobile liability insurance in this state for at least five years; or

(2) be currently engaged as a servicing insurer for assigned risk automobile business in at least one other state.

(c) After notice and hearing, the commissioner may prohibit an insurer from acting as a servicing insurer.

(d) An authorized insurer and a servicing insurer shall determine through negotiation the terms of a contract described by this section, including the buy-out fee.

(e) The governing committee may:

(1) adopt reasonable rules for the conduct of business under a contract described by this section; and

(2) establish reasonable standards of eligibility for servicing insurers. (V.T.I.C. Art. 21.81, Sec. 3(f).)

Source Law

(f) The plan of operation must include a voluntary, competitive limited assignment distribution plan that allows members to contract directly with a servicing carrier to accept assignments to that carrier by the association. A servicing carrier must be an insurance company licensed to write automobile insurance in this state and is qualified if it has written automobile liability insurance in Texas for at least five years or is currently engaged as a servicing carrier for assigned risk automobile business in at least one other state. After notice and hearing, the commissioner may prohibit an insurer from acting as a servicing carrier. The terms of the contract between the servicing carrier and the insurer, including the buy-out fee, shall be determined by negotiation between the parties. The governing committee may adopt reasonable rules for the conduct of business under the contract and may establish reasonable standards of eligibility for servicing carriers.

[Sections 2151.155-2151.200 reserved for expansion]

SUBCHAPTER E. RATES FOR INSURANCE; HEARING

Revised Law

Sec. 2151.201. RATE STANDARDS. Rates for insurance provided under this chapter must be:

(1) just, reasonable, adequate, not excessive, not confiscatory, and not unfairly discriminatory for the risks to which the rates apply; and

(2) sufficient to carry all claims to maturity and meet the expenses incurred in the writing and servicing of the business. (V.T.I.C. Art. 21.81, Sec. 5(a) (part).)

Source Law

Sec. 5. (a) [The commissioner shall determine and prescribe appropriate] rates to be charged for insurance provided through the association that are just, reasonable, adequate, not excessive, not

> confiscatory, and not unfairly discriminatory for the risks to which they apply. Rates shall be set in an amount sufficient to carry all claims to maturity and to meet the expenses incurred in the writing and servicing of the business. . . .

Revised Law

Sec. 2151.202. RATE FILINGS. (a) The association shall file annually with the department rates to be charged for insurance provided through the association for approval by the commissioner.

(b) The association may not file rates under this section more than once in any 12-month period. (V.T.I.C. Art. 21.81, Sec. 5(c) (part).)

Source Law

> (c) The association shall file annually with the department for approval by the commissioner rates to be charged for insurance provided through the association. The association may not make such a filing more than once in any 12-month period. . . .

Revised Law

Sec. 2151.203. RECORDING AND REPORTING OF PREMIUM, LOSS, AND EXPENSE EXPERIENCE. (a) The commissioner shall adopt reasonable rules and statistical plans for the recording and reporting of premium, loss, and expense experience and other required data by each authorized insurer. The premium, loss, and expense experience must be reported separately for business assigned to the insurer.

(b) Each authorized insurer shall use the statistical plans adopted under this section to record and report premium, loss, and expense experience and other required data in accordance with the rules adopted by the commissioner.

(c) In approving rates under this subchapter, the commissioner shall consider the reports collected under the statistical plan regarding aggregated premiums earned and losses and expenses incurred in the writing of automobile insurance through the association. (V.T.I.C. Art. 21.81, Sec. 5(a) (part), (b).)

Source Law

> Sec. 5. (a) The commissioner shall determine and prescribe appropriate [rates to be charged for

insurance provided through the association] . . . . In making a determination, the commissioner shall consider the reports of aggregated premiums earned and losses and expenses incurred in the writing of motor vehicle insurance through the plan collected under the statistical plan provided for by Subsection (b) of this section.

(b) The commissioner shall promulgate reasonable rules and statistical plans to be used by each insurer in the recording and reporting of its premium, loss, and expense experience which must be reported separately for business assigned to it and other data required by the commissioner.

Revisor's Note

Section 5(a), V.T.I.C. Article 21.81, requires the commissioner of insurance to unilaterally "determine and prescribe" rates for insurance provided under the article. For accuracy, the revised law substitutes "approve" for "determine and prescribe" because the requirement to determine and prescribe rates was impliedly repealed by the enactment in 2001 of Sections 5(c)-(i), V.T.I.C. Article 21.81, by Section 4, Chapter 1071, Acts of the 77th Legislature, Regular Session. Sections 5(c)-(i) provide a procedure by which the Texas Automobile Insurance Plan Association files rates with the commissioner and the commissioner approves, disapproves, or modifies the filed rates.

Revised Law

Sec. 2151.204. NOTICE OF FILING. (a) The department shall file with the secretary of state for publication in the Texas Register notice that a filing has been made under Section 2151.202 not later than the seventh day after the date the filing is received by the department.

(b) The notice must include information relating to:

(1) the availability of the filing for public inspection at the department during regular business hours;

(2) the procedures for obtaining copies of the filing;

(3) procedures for making written comments related to the filing; and

(4) the time, place, and date of the hearing scheduled under Section 2151.206. (V.T.I.C. Art. 21.81, Sec. 5(f).)

Source Law

(f) The department shall file with the Texas Register notice that a filing has been made under Subsection (c) of this section not later than the seventh day after the date the filing is received by the department. The notice must include information relating to:

(1) the availability of the filing for public inspection at the department during regular business hours and the procedures for obtaining copies of the filing;

(2) procedures for making written comments related to the filing; and

(3) the time, place, and date of the hearing scheduled under Subsection (e) of this section.

Revisor's Note

Section 5(f), V.T.I.C. Article 21.81, requires the Texas Department of Insurance to file a notice "with the Texas Register." Under Section 2002.016, Government Code, material that must be filed for publication in the Texas Register is filed with the secretary of state. The revised law is drafted accordingly.

Revised Law

Sec. 2151.205. OPPORTUNITY TO REVIEW FILING. Before approving, disapproving, or modifying a filing made under Section 2151.202, the commissioner must provide to all interested persons a reasonable opportunity to:

(1) review the filing;

(2) obtain a copy of the filing on payment of any legally required copying cost; and

(3) submit to the commissioner written comments, analyses, or information related to the filing. (V.T.I.C. Art. 21.81, Sec. 5(d).)

Source Law

(d) Before approving, disapproving, or modifying a filing made under Subsection (c) of this section, the commissioner shall provide all interested persons a reasonable opportunity to:

(1) review the filing;

(2) obtain copies of the filing on payment of any legally required copying cost; and

(3) submit to the commissioner written comments, analyses, or information related to the filing.

Revised Law

Sec. 2151.206. HEARING ON FILING. (a) Not later than the 45th day after the date the department receives a filing required by Section 2151.202, the commissioner shall schedule a hearing at which interested persons may present written or oral comments relating to the filing.

(b) The association, the public insurance counsel, and any other interested person or entity that submits proposed changes or actuarial analyses may ask questions of any person testifying at the hearing.

(c) A hearing held under this section is not a contested case hearing under Chapter 2001, Government Code. (V.T.I.C. Art. 21.81, Sec. 5(e).)

Source Law

(e) Not later than the 45th day after the date on which the department receives the filing required under Subsection (c) of this section, the commissioner shall schedule a hearing at which interested persons may present written or oral comments relating to the filing. A hearing under this subsection is not a contested case hearing under Chapter 2001, Government Code. The association, the public insurance counsel, and any other interested person or entity that has submitted proposed changes or actuarial analyses may ask questions of any person testifying at the hearing.

Revised Law

Sec. 2151.207. ACTION OF COMMISSIONER ON FILING. (a) After the conclusion of the hearing under Section 2151.206, the commissioner shall approve, disapprove, or modify the filing in writing.

(b) If the commissioner disapproves a filing, the commissioner shall state in writing the reasons for the disapproval and the criteria to be met by the association to obtain approval. (V.T.I.C. Art. 21.81, Sec. 5(g) (part).)

Source Law

(g) After the conclusion of the hearing, the commissioner shall approve, disapprove, or modify the

filing in writing. If the commissioner disapproves a filing, the commissioner shall state in writing the reasons for the disapproval and the criteria to be met by the association to obtain approval. . . .

Revised Law

Sec. 2151.208. AMENDED FILING. The association may file with the commissioner an amended filing to comply with the commissioner's comments not later than the 10th day after the date the association receives the commissioner's written disapproval. (V.T.I.C. Art. 21.81, Sec. 5(g) (part).)

Source Law

(g) . . . The association may file with the commissioner, not later than the 10th day after the date on which the association receives the commissioner's written disapproval, an amended filing to comply with the commissioner's comments.

Revised Law

Sec. 2151.209. OPPORTUNITY TO REVIEW AMENDED FILING. Before approving or disapproving an amended filing, the commissioner must provide to all interested persons a reasonable opportunity, in the same manner an opportunity is provided under Section 2151.205, to:

(1) review the amended filing;

(2) obtain a copy of the amended filing on payment of any legally required copying cost; and

(3) submit to the commissioner written comments or information related to the amended filing. (V.T.I.C. Art. 21.81, Sec. 5(h) (part).)

Source Law

(h) Before approving or disapproving an amended filing, the commissioner shall provide all interested persons a reasonable opportunity to review the amended filing, obtain copies of the amended filing on payment of any legally required copying cost, and submit to the commissioner written comments or information related to the amended filing in the manner provided by Subsection (d) of this section, and . . . .

Revised Law

Sec. 2151.210. HEARING ON AMENDED FILING. (a) The commissioner may hold a hearing in the manner provided by Section 2151.206 not later than the 20th day after the date the department

receives an amended filing.

(b) Not later than the 10th day after the date the hearing on the amended filing is concluded, the commissioner shall approve or disapprove the amended filing.

(c) Not later than the 30th day after the date the amended filing is received by the department, the commissioner shall disapprove the amended filing or the filing is considered approved.

(d) The requirements provided under Sections 2151.204 and 2151.207 apply to a hearing conducted under this section. (V.T.I.C. Art. 21.81, Sec. 5(h) (part).)

Source Law

> (h) . . . the commissioner . . . may hold a hearing not later than the 20th day after the date on which the department receives the amended filing in the manner provided by Subsection (e) of this section. Not later than the 10th day after the date on which the hearing on the amended filing is concluded, the commissioner shall approve or disapprove the amended filing. Not later than the 30th day after the date on which the amended filing is received by the department, the commissioner shall disapprove the amended filing or it is considered approved. The requirements adopted under Subsections (f) and (g) of this section apply to a hearing conducted under this subsection.

Revised Law

Sec. 2151.211. APPEAL. (a) A person aggrieved by a decision of the commissioner under this subchapter may appeal the decision not later than the 30th day after the date of the decision.

(b) An appeal of a commissioner's decision under this subchapter must be made in accordance with Subchapter D, Chapter 36. (V.T.I.C. Art. 21.81, Sec. 5(i).)

Source Law

> (i) A person aggrieved by a decision of the commissioner under this section may, not later than the 30th day after the date of the commissioner's decision, appeal the decision. An appeal of a commissioner's decision under this section must be made in accordance with Subchapter D, Chapter 36, of this code.

Revised Law

Sec. 2151.212. HEARINGS BY DEPARTMENT. Subchapter B, Chapter 40, does not apply to this subchapter. (V.T.I.C. Art.

21.81, Sec. 5(c) (part).)

Source Law

(c) . . . Subchapter B, Chapter 40, of this code does not apply to:

(1) a filing made under this subsection;

(2) Subsections (d)-(h) of this section; or

(3) a department action with respect to such a filing.

Revisor's Note

Section 5(c), V.T.I.C. Article 21.81, provides that Subchapter B, Chapter 40, of this code does not apply to specified provisions of Section 5, V.T.I.C. Article 21.81, and certain actions by the Texas Department of Insurance under those provisions. Subchapter B, Chapter 40, provides for certain hearings to be conducted by the State Office of Administrative Hearings. The revised law substitutes a reference to "this subchapter" for the referenced provisions because those provisions are revised in this subchapter, and this subchapter does not contain any other provisions to which Subchapter B, Chapter 40, could apply.

CHAPTER 2152. GROUP INSURANCE IN UNDERSERVED AREAS

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Sec. 2152.004. EXCLUSION OF CERTAIN COVERAGE . . . . . 1128

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Sec. 2152.007. POLICY FORMS AND CERTIFICATES . . . . . 1128

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CHAPTER 2152. GROUP INSURANCE IN UNDERSERVED AREAS

Revised Law

Sec. 2152.001. DEFINITION. In this chapter, "residential property insurance" means insurance against loss to real or

tangible personal property at a fixed location that is provided through a homeowners policy, residential fire and allied lines policy, or farm and ranch owners policy. (V.T.I.C. Art. 21.79, 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, residential fire and allied lines policy, or farm and ranch owners policy.

Revised Law

Sec. 2152.002. DESIGNATION OF UNDERSERVED AREAS. (a) The commissioner by rule may designate an area as an underserved area for personal automobile insurance or residential property insurance.

(b) In determining which areas to designate as underserved, the commissioner shall consider:

(1) whether the insurance described by Subsection (a) is not reasonably available to a substantial number of insurable risks and the availability of insurance in general; and

(2) any other relevant factor as determined by the commissioner. (V.T.I.C. Art. 21.79, Sec. 1(a) (part).)

Source Law

> Art. 21.79
>
> Sec. 1. (a) By rule the commissioner may determine and designate areas as underserved areas for private passenger auto insurance or residential property insurance. In determining which areas will be designated as underserved, the commissioner shall consider whether such insurance is not reasonably available to a substantial number of insurable risks and the availability of insurance and any other relevant factors as determined by the commissioner. . . .

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 21.79, authorizes the commissioner of insurance to "determine and designate" underserved areas. The revised law omits the reference to "determine" because, in context, "determine" is included within the meaning of

"designate."

(2) Section 1(a), V.T.I.C. Article 21.79, refers to "private passenger auto insurance." The revised law substitutes "personal automobile insurance" for "private passenger auto insurance" in this section and throughout this chapter for consistency in this code. "Personal automobile insurance" is the term more commonly used to describe the type of insurance that provides coverage for private passenger automobiles.

Revised Law

Sec. 2152.003. AUTHORIZATION FOR ISSUANCE OF GROUP INSURANCE IN UNDERSERVED AREA. An insurer authorized to write property or casualty insurance in this state, including a Lloyd's plan and a reciprocal or interinsurance exchange, that writes personal automobile insurance or residential property insurance in this state may write the personal automobile insurance or residential property insurance on a group basis in an underserved area designated by the commissioner. (V.T.I.C. Art. 21.79, Sec. 2.)

Source Law

Sec. 2. All insurers authorized to write property or casualty insurance in this state and writing private passenger auto insurance or residential property insurance in this state, including insurers licensed under Chapters 18 and 19 of this code, are authorized to write such insurance on a group basis in underserved areas as designated by the commissioner.

Revisor's Note

Section 2, V.T.I.C. Article 21.79, refers to "insurers licensed under Chapters 18 and 19 of this code." Chapters 18 and 19 were revised in 2001 as Chapters 941 and 942 of this code, respectively. Chapter 941 of this code regulates the authority of a Lloyd's plan to engage in business in this state, and Chapter 942 of this code regulates the authority of a

reciprocal or interinsurance exchange to engage in business in this state. For the convenience of the reader, the revised law substitutes a reference to "a Lloyd's plan and a reciprocal or interinsurance exchange" for the reference to "insurers licensed under Chapters 18 and 19 of this code."

Revised Law

Sec. 2152.004. EXCLUSION OF CERTAIN COVERAGE. Group insurance provided under this chapter may not include windstorm and hail insurance coverage for a risk eligible for that coverage under Chapter 2210. (V.T.I.C. Art. 21.79, Sec. 1(b).)

Source Law

(b) Group insurance provided under this article may not include windstorm and hail insurance coverage for a risk eligible for that coverage under Article 21.49 of this code.

Revised Law

Sec. 2152.005. FORMATION OF GROUP. A group may be formed solely to purchase insurance subject to this chapter. (V.T.I.C. Art. 21.79, Sec. 3.)

Source Law

Sec. 3. A group may be formed solely for the purpose of purchasing insurance subject to this article.

Revised Law

Sec. 2152.006. RATES. Rates for coverage provided under this chapter are subject to the applicable statutes relating to the insurers providing the coverage. (V.T.I.C. Art. 21.79, Sec. 5.)

Source Law

Sec. 5. The rates for coverage shall be subject to the applicable statutory provisions relating to the respective insurers.

Revised Law

Sec. 2152.007. POLICY FORMS AND CERTIFICATES. The commissioner shall adopt policy forms and certificates for use in underserved areas designated by the commissioner under this chapter. (V.T.I.C. Art. 21.79, Sec. 4.)

Source Law

Sec. 4. All policy forms and certificates for use in underserved areas as designated by the commissioner shall be adopted by the commissioner.

Revised Law

Sec. 2152.008. RULES. In addition to other rules adopted under this chapter, the commissioner may adopt any rules that are appropriate and necessary to implement this chapter. (V.T.I.C. Art. 21.79, Sec. 6.)

Source Law

Sec. 6. The commissioner may adopt any other rules that are appropriate and necessary to implement this article.

CHAPTER 2153. GROUP MARKETING OF AUTOMOBILE INSURANCE FOR PERSONS OVER 55 YEARS OF AGE

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[Sections 2153.004-2153.050 reserved for expansion]

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[Sections 2153.060-2153.100 reserved for expansion]

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CHAPTER 2153. GROUP MARKETING OF AUTOMOBILE INSURANCE FOR PERSONS OVER 55 YEARS OF AGE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2153.001. DEFINITIONS. In this chapter:

(1) "Group automobile insurance" means automobile insurance that:

(A) covers individuals who are over 55 years of age; and

(B) is offered under a group marketing plan.

(2) "Group marketing" means the marketing of group automobile insurance to an eligible group under Section 2153.052. (V.T.I.C. Art. 21.77, Secs. 2(1) (part), (2) (part).)

Source Law

Sec. 2. As used in this article:

(1) "Group motor vehicle insurance" means all motor vehicle insurance covering persons over 55 years of age that is offered . . . on a group marketing plan to an eligible group as defined in this article.

(2) "Group marketing" means the marketing of group motor vehicle insurance . . . to an eligible group . . . .

Revisor's Note

Section 2(1), V.T.I.C. Article 21.77, defines "group motor vehicle insurance" in part as insurance "offered . . . on a group marketing plan to an eligible group as defined in this article." The revised law substitutes for the quoted language "offered under a group marketing plan" to avoid duplicating language included in Section 2(2), V.T.I.C. Article 21.77, revised in relevant part in this chapter in Section 2153.054. The revised law also substitutes "automobile insurance" for "motor vehicle insurance" in this section and throughout this chapter for consistency of terminology in this code.

Revised Law

Sec. 2153.002. APPLICABILITY OF CERTAIN PROVISIONS. Sections 4001.051 and 4001.053 do not apply to a group participating in a group marketing plan under this chapter. (V.T.I.C. Art. 21.77, Sec. 10.)

Source Law

> Sec. 10. The provisions of Article 21.02 of this code may not be construed to apply to groups participating in group plans approved under this article.

Revisor's Note

(1) Section 10, V.T.I.C. Article 21.77, refers to the provisions of "Article 21.02 of this code." Article 21.02 is revised in various sections of Chapter 4001 of this code. The relevant provisions are revised in Sections 4001.051 and 4001.053 of this code, and the revised law is drafted accordingly.

(2) Section 10, V.T.I.C. Article 21.77, refers to "group plans approved under this article." The revised law omits "approved" because the article does not grant any approval authority.

Revised Law

Sec. 2153.003. RULES. The commissioner may adopt any rules necessary to carry out the provisions of this chapter. (V.T.I.C. Art. 21.77, Sec. 9.)

Source Law

> Sec. 9. The board may make any rules necessary to carry out the provisions of this article.

Revisor's Note

Section 9, V.T.I.C. Article 21.77, authorizes the "board," meaning the State Board of Insurance, to "make" any rules that are necessary to carry out V.T.I.C. Article 21.77, revised as this chapter. 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. In addition, for consistency with terminology used in this code and the administrative procedure law, Chapter 2001, Government Code, the revised law substitutes "adopt" for "make."

Revisor's Note
(End of Subchapter)

Section 1, V.T.I.C. Article 21.77, contains a statement of the legislature's purpose in enacting that article. The revised law omits the statement of legislative purpose because that provision is nonsubstantive and because the legislature's purpose in enacting that article is clear from the substantive provisions of the article, which are revised as this chapter. The omitted law reads:

> Sec. 1. The purpose of this article is to authorize the writing of motor vehicle insurance covering persons over 55 years of age in this state on a group marketing basis subject to the conditions stated in this article and to set forth the terms and conditions under which insurance covering persons over 55 years of age on a group marketing basis may be written.

[Sections 2153.004-2153.050 reserved for expansion]

SUBCHAPTER B. CONDITIONS FOR ISSUANCE OF GROUP AUTOMOBILE INSURANCE

Revised Law

Sec. 2153.051. AUTHORIZATION FOR ISSUANCE OF GROUP AUTOMOBILE INSURANCE. An insurer may issue group automobile insurance in this state if the conditions of Sections 2153.054(b), 2153.055-2153.059, and 2153.103 are met. (V.T.I.C. Art. 21.77, Sec. 5(a).)

Source Law

> Sec. 5. (a) Group motor vehicle insurance may be issued in this state provided the conditions in this section are met.

Revised Law

Sec. 2153.052. ELIGIBILITY OF GROUP. (a) To be eligible for group marketing, a group must:

(1) have existed for at least six months before the date the group automobile insurance is purchased; and

(2) be organized for a purpose other than to become an insurance group under this chapter.

(b) The group may include any group that is actuarially credible for underwriting purposes. (V.T.I.C. Art. 21.77, Sec. 3.)

Source Law

Sec. 3. Any group, to be eligible for group marketing, must have been in existence for at least six months before the purchase of the insurance and must be a group organized for a purpose other than to become an insurance group under this Act, and the group may include any group that will be actuarially credible for underwriting purposes.

Revised Law

Sec. 2153.053. ELIGIBILITY OF GROUP MEMBER. A member of a group described by Section 2153.052 is eligible to participate in a group marketing plan if the member is:

(1) in good standing with the group;

(2) over 55 years of age; and

(3) authorized to operate a motor vehicle in this state. (V.T.I.C. Art. 21.77, Sec. 4.)

Source Law

Sec. 4. Eligible members of a group shall include all members in good standing in the group who are over 55 years of age and lawful drivers.

Revisor's Note

Section 4, V.T.I.C. Article 21.77, refers to certain group members who are "lawful drivers." The revised law substitutes "authorized to operate a motor vehicle in this state" for "lawful driver" because to be a lawful driver, a person must be authorized to operate a motor vehicle in this state.

Revised Law

Sec. 2153.054. GUARANTEED ISSUE. (a) An insurer shall

issue group automobile insurance:

(1) on a guaranteed basis under a single insurance program; and

(2) without individual underwriting selection or individual proof of insurability.

(b) An insurer that issues group automobile insurance and the insured group shall accept for participation in the group marketing plan any member of the group who is eligible under Section 2153.053 and who wants to participate. (V.T.I.C. Art. 21.77, Secs. 2(2) (part), 5(b).)

Source Law

[Sec. 2]

(2) ["Group marketing" means the marketing of group motor vehicle insurance] . . . on a guaranteed basis under a single insurance program without individual underwriting selection or individual proof of insurability.

[Sec. 5]

(b) The insurer and the group insured must accept all members who are eligible and wish to participate in the plan.

Revised Law

Sec. 2153.055. INSURER QUALIFICATIONS. To qualify to write group automobile insurance, an insurer:

(1) must be authorized to engage in the business of automobile insurance in this state;

(2) must also be engaged in the business of writing automobile insurance for independent individual risks; and

(3) may not be organized solely to provide group automobile insurance. (V.T.I.C. Art. 21.77, Secs. 2(1) (part), (2) (part), 5(c).)

Source Law

[Sec. 2]

(1) ["Group motor vehicle insurance" means all motor vehicle insurance . . . offered] by a licensed insurer in this state . . . .

(2) ["Group marketing" means the marketing of group motor vehicle insurance] by a licensed insurer otherwise engaged in insuring independent individual risks . . . .

[Sec. 5]

(c) To qualify to write the group insurance

defined in this article, an insurer must also be engaged in the business of writing the type of coverage offered for insureds other than group and may not be organized solely for the purpose of furnishing coverage to such groups.

Revisor's Note

(1) Sections 2(1) and (2), V.T.I.C. Article 21.77, refer to a "licensed insurer." The revised law substitutes "authorized" for "licensed" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

(2) Section 5(c), V.T.I.C. Article 21.77, provides that an insurer that writes group insurance must also be engaged in the business of writing "the type of coverage offered." The revised law substitutes "automobile insurance" for the quoted language because automobile insurance is the only kind of insurance the article addresses. Section 5(c), V.T.I.C. Article 21.77, also refers to "insureds other than group." The revised law substitutes "independent individual risks" for the quoted language to be consistent with similar terminology used in the definition of "group marketing" in Section 2(2), V.T.I.C. Article 21.77, revised in pertinent part as this section and Section 2153.054 of this chapter.

Revised Law

Sec. 2153.056. VEHICLES COVERED. A group marketing plan must provide that a motor vehicle is eligible for group automobile insurance coverage only if the vehicle is owned by a group member or the member's spouse jointly or severally. (V.T.I.C. Art. 21.77, Sec. 5(g).)

Source Law

(g) The plan shall provide that only those motor vehicles owned by members of the group or their spouses jointly or severally shall be eligible for coverage.

Revised Law

Sec. 2153.057. INDIVIDUAL POLICIES. An insurer shall issue an individual policy to each participating group member. (V.T.I.C. Art. 21.77, Secs. 5(d) (part), (e) (part).)

Source Law

> (d) Each member of the group shall be issued a policy [on forms prescribed for issue in this state by the State Board of Insurance].
>
> (e) Insurance must be provided by individual policies to each member of the group . . . .

Revised Law

Sec. 2153.058. GROUP PAYMENT OF PREMIUMS. An insurer shall provide group automobile insurance under an agreement under which the group periodically pays the premiums on the policies to the insurer. (V.T.I.C. Art. 21.77, Sec. 5(e) (part).)

Source Law

> (e) Insurance must be provided . . . under an agreement whereby the premiums on the policies will be paid to the insurer periodically by the group.

Revised Law

Sec. 2153.059. LIMITATIONS ON CANCELING INSURANCE. (a) An insurer may not cancel the insurance of a group member unless:

(1) the member fails to pay the premiums; or

(2) the insurance for the entire group is canceled.

(b) An insurer that cancels insurance under Subsection (a) shall provide to each group member whose insurance is canceled the same notice of cancellation the insurer provides for cancellation of individual automobile insurance policies. (V.T.I.C. Art. 21.77, Sec. 5(f).)

Source Law

> (f) An insurer may not cancel the insurance of an individual member of the group except for the nonpayment of premiums by the member or unless the insurance for the entire group is cancelled, and in such cases, notice of cancellation as provided in like nongroup policies shall be given to each member.

Revisor's Note

Section 5(f), V.T.I.C. Article 21.77, states that when a group member's insurance is canceled notice of

cancellation shall be provided as in "like nongroup policies." The revised law substitutes "individual automobile insurance policies" for the quoted language because referring to "individual" insurance rather than "nongroup" is consistent with terminology used elsewhere in this chapter.

[Sections 2153.060-2153.100 reserved for expansion]

SUBCHAPTER C. RECORDS, RATES, AND FORMS

Revised Law

Sec. 2153.101. MAINTENANCE OF RECORDS. An insurer that writes insurance under a group marketing plan shall maintain separate experience data on the group marketing plan business, including complete records of premium income, losses, and expenses, so that the experience may be fairly ascertained. (V.T.I.C. Art. 21.77, Sec. 6.)

Source Law

Sec. 6. Every insurer writing insurance under a group marketing plan shall keep and maintain separate experience data on this type of business, including complete records of premium income, losses, and expenses so that the experience may be fairly ascertained.

Revisor's Note

Section 6, V.T.I.C. Article 21.77, states that an insurer shall "keep and maintain" certain experience data. The revised law omits "keep" because "keep" is included in the meaning of "maintain."

Revised Law

Sec. 2153.102. RATES. Rates for group automobile insurance are determined in the manner provided by Chapter 2251 and Article 5.13-2, to the extent that those laws apply. (V.T.I.C. Art. 21.77, Sec. 7.)

Source Law

Sec. 7. Rates for the type of business authorized under this article shall be determined, fixed, prescribed, and promulgated in the manner provided in Article 5.01, Insurance Code, as amended, so far as it is applicable.

Revisor's Note

Section 7, V.T.I.C. Article 21.77, states that insurance rates under the article shall be "determined, fixed, prescribed, and promulgated" in the manner provided by V.T.I.C. Article 5.01, "as amended." The revised law substitutes a reference to Chapter 2251 and V.T.I.C. Article 5.13-2 for the reference to Article 5.01 because Article 5.01(f) provides that, on and after December 1, 2004, rates for "personal automobile insurance" are determined as provided by V.T.I.C. Article 5.13-2. The provisions of that article relating to rates are revised in part in this code as Chapter 2251. The kind of insurance offered under this chapter is a kind of personal automobile insurance. Although Chapter 2251 includes provisions derived from V.T.I.C. Article 5.13-2C, the revised law appropriately refers to the chapter in its entirety because the provisions that are not derived from Article 5.13-2 are inapplicable by their own terms in the context of the kind of insurance offered under this chapter.

In addition, the revised law omits the reference to "fixed, prescribed, and promulgated" because those terms do not accurately describe the procedures for determining rates under Article 5.13-2. The revised law also 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 a statute applies to all reenactments, revisions, or amendments of the statute.

Revised Law

Sec. 2153.103. POLICY FORMS. An insurer that writes group automobile insurance shall use policy forms:

(1) prescribed by the commissioner and authorized for use by Section 2301.052(b); or

(2) filed and in effect as provided by Section 2301.052(a). (V.T.I.C. Art. 21.77, Secs. 5(d) (part), 8.)

Source Law

[Sec. 5]

(d) [Each member of the group shall be issued a policy] on forms prescribed for issue in this state by the State Board of Insurance.

Sec. 8. All policy forms for insurance written under this article shall be prescribed by the commissioner as provided in Article 5.06 of this code or filed and in effect as provided in Article 5.145 of this code.

Revisor's Note

Section 5(d), V.T.I.C. Article 21.77, refers to "forms prescribed for issue . . . by the State Board of Insurance," meaning the commissioner of insurance, and Section 8 of that article refers to forms "prescribed by the commissioner as provided in Article 5.06 of this code or filed and in effect as provided in Article 5.145 of this code." Under V.T.I.C. Article 5.06, policy forms for automobile insurance were adopted or approved by the commissioner. The 78th Legislature enacted Chapter 206, Acts of the 78th Legislature, Regular Session, 2003, which took effect June 11, 2003. Section 21.07 of that act amended V.T.I.C. Article 5.06 to provide that policy forms for automobile insurance are now regulated under V.T.I.C. Article 5.13-2. However, under Section 2(b), V.T.I.C. Article 5.145, enacted by Section 2.01 of Chapter 206, an insurer may continue to use policy forms previously promulgated, approved, or adopted under Article 5.06. For clarity and to fully reflect the changes made by Chapter 206, the revised law substitutes "prescribed by the commissioner and authorized for use by Section 2301.052(b)," the revision of Section 2(b), Article

5.145, for the quoted phrases.

CHAPTER 2154. VOLUNTEER FIRE DEPARTMENT MOTOR VEHICLE SELF-INSURANCE PROGRAM

Sec. 2154.001. DEFINITIONS . . . . . 1140
Sec. 2154.002. MOTOR VEHICLE SELF-INSURANCE PROGRAM . . . . . 1141
Sec. 2154.003. SELF-INSURANCE POOL; COVERAGE . . . . . 1142
Sec. 2154.004. PARTICIPATION IN SELF-INSURANCE POOL . . . . . 1144
Sec. 2154.005. VOLUNTEER FIRE DEPARTMENT SELF-INSURANCE FUND . . . . . 1144
Sec. 2154.006. LIMITATION ON STATE'S LIABILITY . . . . . 1145
Sec. 2154.007. SELF-INSURANCE FEE . . . . . 1145
Sec. 2154.008. LEGAL REPRESENTATION . . . . . 1146

CHAPTER 2154. VOLUNTEER FIRE DEPARTMENT MOTOR VEHICLE SELF-INSURANCE PROGRAM

Revised Law

Sec. 2154.001. DEFINITIONS. In this chapter:

(1) "Fund" means the volunteer fire department self-insurance fund established under Section 2154.005.

(2) "Program" means the volunteer fire department motor vehicle self-insurance program administered under this chapter.

(3) "Service" means the Texas Forest Service of The Texas A&M University System.

(4) "Volunteer fire department" means a fire department operated by the fire department's members on a not-for-profit basis. The term includes a fire department that is exempt from federal income tax under Section 501(a), Internal Revenue Code of 1986, by being listed as an exempt organization in Section 501(c)(3) of that code. (V.T.I.C. Art. 21.61, Sec. 1.)

Source Law

Art. 21.61
Sec. 1. In this article:
(1) "Fund" means the volunteer fire department self-insurance fund established under Section 5 of this article.
(2) "Program" means the volunteer fire department motor vehicle self-insurance program

established under this article.

(3) "Service" means the Texas Forest Service of The Texas A&M University System.

(4) "Volunteer fire department" means a fire department operated by its members that is operated on a not-for-profit basis, including a department that is exempt from federal income tax under Section 501(a) of the Internal Revenue Code of 1986 (26 U.S.C. Section 501(a)) by being listed as an exempt organization in Section 501(c)(3) of that code (26 U.S.C. Section 501(c)(3)).

Revisor's Note

Section 1(2), V.T.I.C. Article 21.61, refers to the volunteer fire department motor vehicle self-insurance program "established" under the article. Section 3(a), V.T.I.C. Article 21.61, revised in this chapter in Section 2154.002, requires the Texas Forest Service of The Texas A&M University System to establish the program. Throughout this chapter, the revised law omits references to establishing the program as executed and substitutes references to administering the program because it is clear from the context of Article 21.61 that the service has a continuing duty to administer the program.

Revised Law

Sec. 2154.002. MOTOR VEHICLE SELF-INSURANCE PROGRAM. (a) The service shall administer a volunteer fire department self-insurance program that:

(1) identifies and evaluates risks arising from the use of motor vehicles by volunteer fire departments;

(2) maintains a loss-prevention and loss-control program to reduce risks arising from the use of motor vehicles by volunteer fire departments;

(3) consolidates and administers volunteer fire department risk management and self-insurance programs; and

(4) provides motor vehicle self-insurance coverage in accordance with Section 2154.003.

(b) The service may employ staff to administer the program.

(c) The director of the service may adopt rules to implement and administer the program. (V.T.I.C. Art. 21.61, Secs. 2, 3.)

Source Law

Sec. 2. (a) The Texas Forest Service shall administer the volunteer fire department motor vehicle self-insurance program established under this article.

(b) The service may employ staff to administer the program.

Sec. 3. (a) The service shall establish the program to:

(1) identify and evaluate risks arising from the use of motor vehicles by volunteer fire departments;

(2) maintain a loss-prevention and loss-control program to reduce risks arising from the use of motor vehicles by volunteer fire departments;

(3) consolidate and administer volunteer fire department risk management and self-insurance programs; and

(4) provide motor vehicle self-insurance coverage in accordance with Section 4 of this article.

(b) The director of the service may adopt rules to implement and administer the program.

Revised Law

Sec. 2154.003. SELF-INSURANCE POOL; COVERAGE. (a) The program shall administer a self-insurance pool to provide coverage for motor vehicles a volunteer fire department uses for fire fighting.

(b) The coverage may indemnify an official, employee, member, or volunteer of a volunteer fire department for liability arising from the use of a covered motor vehicle in performing the person's fire-fighting duties. The maximum limits of coverage are:

(1) for bodily injury or death:

(A) $100,000 for each person; and

(B) $300,000 for each single occurrence; and

(2) for injury to or destruction of property, $100,000 for each single occurrence.

(c) Self-insurance coverage provided under this section may be funded only from money available from the fund.

(d) The director of the service may establish:

(1) eligibility requirements for participation in coverage under this section; and

(2) equipment and safety standards for the motor

vehicles to be covered under this section.

(e) Coverage limits of self-insurance provided under this section must be based on the liquidity of the fund after deducting the cost of administering this chapter. (V.T.I.C. Art. 21.61, Secs. 4(a), (b), (c), 5(d), (e).)

Source Law

Sec. 4. (a) The program shall establish a self-insurance pool to provide coverage for motor vehicles used for fire fighting by a volunteer fire department.

(b) The coverage may indemnify an official, employee, member, or volunteer of a volunteer fire department for liability arising from the use of a covered motor vehicle in the performance of the fire fighting duties of the official, employee, member, or volunteer. The coverage must be subject to a maximum limit of $100,000 for each person and $300,000 for each single occurrence for bodily injury or death and $100,000 for each single occurrence for injury to or destruction of property.

(c) The director of the service may establish:

(1) eligibility requirements for participation in coverage under this section; and

(2) equipment and safety standards for the motor vehicle to be covered under this section.

[Sec. 5]

(d) Self-insurance coverage provided under Section 4 of this article may be funded only from money available from the fund.

(e) Coverage limits of self-insurance provided under Section 4 of this article must be based on the liquidity of the fund after deduction of the cost of administration of this article.

Revisor's Note

Section 4(a), V.T.I.C. Article 21.61, requires the volunteer fire department motor vehicle self-insurance program to "establish" a self-insurance pool to provide coverage for volunteer fire department motor vehicles. The revised law omits the requirement to "establish" the pool as executed and substitutes a requirement to "administer" the pool because it is clear from the context of Article 21.61 that the volunteer fire department motor vehicle self-insurance program has a continuing duty to administer the pool.

Revised Law

Sec. 2154.004. PARTICIPATION IN SELF-INSURANCE POOL. (a) To participate in coverage provided under Section 2154.003, a volunteer fire department must submit a written request to the program.

(b) The director of the program shall approve the request for participation if each motor vehicle to be covered meets the eligibility requirements and equipment and safety standards established under Section 2154.003(d). (V.T.I.C. Art. 21.61, Sec. 4(d).)

Source Law

(d) To participate in coverage provided under this section, a volunteer fire department must submit a written request to the program. The director of the program shall approve the request if each motor vehicle to be covered meets the eligibility requirements and equipment and safety standards established under Subsection (c) of this section.

Revised Law

Sec. 2154.005. VOLUNTEER FIRE DEPARTMENT SELF-INSURANCE FUND. (a) The fund is an account in the general revenue fund.

(b) The fund is composed of:

(1) money collected under Section 2154.007; and

(2) interest accruing on money in the fund.

(c) Money in the fund may be spent only for:

(1) funding self-insurance under the program; or

(2) administering this chapter, including paying the salaries and expenses of staff for the program and the fund. (V.T.I.C. Art. 21.61, Secs. 5(a), (b), (c).)

Source Law

Sec. 5. (a) The volunteer fire department self-insurance fund is an account in the general revenue fund.

(b) The fund is composed of:

(1) money collected under Section 6 of this article; and

(2) interest accruing on money in the fund.

(c) Money in the fund may be expended in accordance with legislative appropriation only for:

(1) administration of this article, including the salaries and expenses of staff for the program and the fund; or

(2) funding self-insurance under the program.

Revisor's Note

Section 5(c), V.T.I.C. Article 21.61, provides that money in the volunteer fire department self-insurance fund may be spent "in accordance with legislative appropriation." The revised law omits the quoted language as unnecessary 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."

Revised Law

Sec. 2154.006. LIMITATION ON STATE'S LIABILITY. The state's liability for a loss covered by self-insurance provided under this chapter is limited to the assets of the fund, and the state is not otherwise liable for that loss. (V.T.I.C. Art. 21.61, Sec. 5(f).)

Source Law

(f) The state's liability for a loss covered by self-insurance provided under this article is limited to the assets of the fund, and the state is not otherwise liable for that loss.

Revised Law

Sec. 2154.007. SELF-INSURANCE FEE. (a) The service may assess and collect a reasonable fee from participating volunteer fire departments to provide self-insurance coverage under this chapter. In establishing the amount of the fee, the service shall consider the amount that could be charged to the volunteer fire department for similar insurance coverage provided to that department in accordance with this code.

(b) Fees collected under this section shall be deposited to the credit of the fund. (V.T.I.C. Art. 21.61, Sec. 6.)

Source Law

Sec. 6. (a) The service may levy and collect a reasonable fee from participating volunteer fire departments to provide self-insurance coverage under this article. In establishing the amount of the fee, the service shall consider the amount that could be charged to the volunteer fire department for similar insurance coverage provided to the department in accordance with this code.

(b) Fees collected under this section shall be deposited to the credit of the fund.

Revised Law

Sec. 2154.008. LEGAL REPRESENTATION. (a) The service may employ an attorney to represent a volunteer fire department or an official, employee, member, or volunteer of a volunteer fire department in a liability action for which insurance coverage is provided under this chapter.

(b) The attorney general may not provide the services described by Subsection (a). (V.T.I.C. Art. 21.61, Sec. 7.)

Source Law

Sec. 7. (a) The service may employ an attorney to represent a volunteer fire department or an official, employee, member, or volunteer of a volunteer fire department in a liability action for which insurance coverage is provided under this article.

(b) The attorney general may not provide the services described by Subsection (a) of this section.

[Chapters 2155-2170 reserved for expansion]

CHAPTER 2171. COMMERCIAL GROUP PROPERTY INSURANCE

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CHAPTER 2171. COMMERCIAL GROUP PROPERTY INSURANCE

Revised Law

Sec. 2171.001. DEFINITION. In this chapter, "large risk" means an insured described by Section 2301.004. (V.T.I.C. Art. 5.41-3, Secs. (a) (part), (b) (part).)

Source Law

(a) . . . [a large risk] as that term is described by Section 8(f), Article 5.13-2, of this code . . . .

(b) . . . [a large risk] as that term is described by Section 8(f), Article 5.13-2, of this code, . . . .

Revisor's Note

Sections (a) and (b), V.T.I.C. Article 5.41-3, refer to a large risk "as that term is described by

Section 8(f), Article 5.13-2, of this code." Section 8(f), V.T.I.C. Article 5.13-2, is revised as Section 2301.004 of this code. Section 2301.004, however, does not describe a "large risk"; the section describes an insured that would be considered a large risk. Therefore, the revised law defines a "large risk" as "an insured described by Section 2301.004."

Revised Law

Sec. 2171.002. AUTHORIZATION FOR ISSUANCE. An insurer may write commercial group property insurance for:

(1) a group of businesses that constitutes a large risk if the members of the group have clearly identifiable underwriting characteristics; or

(2) an association that constitutes a large risk if the members of the association are engaged in similar undertakings. (V.T.I.C. Art. 5.41-3, Sec. (a) (part).)

Source Law

> Art. 5.41-3. (a) An insurer may write commercial group property insurance for a group of businesses or for an association that constitutes a large risk . . . if:
>
> (1) the members of a group of businesses have clearly identifiable underwriting characteristics; or
>
> (2) the members of an association are engaged in similar undertakings.

Revised Law

Sec. 2171.003. POLICY FORM FILINGS. (a) An insurer shall file a policy form with the commissioner before using the form for a group of businesses or an association described by Section 2171.002 in which each member of the group or association is not a large risk.

(b) A filing made under this section is for informational purposes only. (V.T.I.C. Art. 5.41-3, Sec. (b) (part).)

Source Law

> (b) An insurer, before using a policy form for a group of businesses or an association described by Subsection (a) of this article in which each member of the group or association is not a large risk . . . shall file the policy form with the

commissioner. A filing made under this subsection is for informational purposes only.

Revised Law

Sec. 2171.004. RATE FILINGS. An insurer shall file with the commissioner in accordance with Chapter 2251 the following information for commercial group property insurance written under this chapter in this state:

(1) rates;

(2) supplementary rating information; and

(3) pertinent supporting information. (V.T.I.C. Art. 5.41-3, Sec. (c).)

Source Law

(c) An insurer, in accordance with Sections 3 through 7, Article 5.13-2, of this code, shall file with the commissioner all rates, supplementary rating information, and pertinent supporting information for commercial group property insurance written under this article in this state.

Revisor's Note

Section (c), V.T.I.C. Article 5.41-3, requires an insurer writing commercial group property insurance to file rates, supplementary rating information, and supporting information in accordance with Sections 3-7, V.T.I.C. Article 5.13-2, which are revised in Chapter 2251 of this code. Chapter 2251 also includes provisions derived from other sections of Article 5.13-2 and from V.T.I.C. Article 5.13-2C. The revised law appropriately substitutes a reference to Chapter 2251 for the reference to Sections 3-7, Article 5.13-2, because the provisions of Chapter 2251 that are not derived from the referenced sections are either necessary to construe the provisions derived from the referenced sections or are inapplicable by their own terms in the context of commercial group property insurance.

Revised Law

Sec. 2171.005. IDENTIFICATION OF INSURED REQUIRED. An

insurer filing a policy form under Section 2171.003 or rates and related information under Section 2171.004 shall clearly identify the group of businesses or the association to be insured. (V.T.I.C. Art. 5.41-3, Sec. (d).)

Source Law

(d) An insurer filing a policy form or rates and related information under Subsection (b) or (c) of this article shall clearly identify the group of businesses or the association to be insured.

[Chapters 2172-2200 reserved for expansion]

CHAPTER 2201. RISK RETENTION GROUPS AND PURCHASING GROUPS

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CHAPTER 2201. RISK RETENTION GROUPS AND PURCHASING GROUPS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2201.001. PURPOSE OF CHAPTER. The purpose of this chapter is to:

(1) regulate the formation and operation of risk retention groups and purchasing groups in this state formed under:

(A) the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.); or

(B) the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.); and

(2) protect the public by the appropriate regulation of groups described by Subdivision (1) to the extent permitted by law. (V.T.I.C. Art. 21.54, Sec. 1.)

Source Law

Art. 21.54

Sec. 1. The purpose of this article is to regulate the formation and operation of risk retention groups and purchasing groups in this state formed pursuant to the provisions of the federal Product Liability Risk Retention Act of 1981 (Public Law 97-45) and the federal Liability Risk Retention Act of 1986 and to protect the public by the appropriate regulation of these groups to the extent permitted by law.

Revised Law

Sec. 2201.002. GENERAL DEFINITIONS. In this chapter:

(1) "Agent" includes the terms "agent" and "broker" as used in the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.).

(2) "Hazardous financial condition" means a condition in which a risk retention group, based on the group's present or reasonably anticipated financial condition and although the group is not yet financially impaired or insolvent, is unlikely to be able to:

(A) meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(B) pay other obligations in the normal course of business.

(3) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for transferring and distributing risk that is determined to be insurance under the laws of this state.

(4) "State" means any state of the United States or the District of Columbia. (V.T.I.C. Art. 21.54, Secs. 2(4), (11), (12), (13).)

Source Law

Sec. 2. In this article:

(4) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for transferring and distributing risk that is determined to be insurance under the law of this state.

(11) "State" means any state of the United States or the District of Columbia.

(12) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to:

(A) meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(B) pay other obligations in the normal course of business.

(13) "Agent" includes the terms "agent" and "broker" as used in the federal Liability Risk Retention Act of 1986.

Revisor's Note

(1) Section 2(1), V.T.I.C. Article 21.54, defines "board" as 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 board have been changed appropriately. For this reason, the revised law omits the definition of "board." The omitted law reads:

> (1) "Board" means the State Board of Insurance.

(2) Section 2(2), V.T.I.C. Article 21.54, defines "commissioner" as the "commissioner of insurance of the State of Texas or the commissioner, director, or superintendent of insurance in any other state." The revised law omits that definition 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 of this state. Throughout this chapter, a reference to "commissioner of this state" is revised as "commissioner" and any reference to a "commissioner" that includes the commissioner, director, or superintendent of insurance in another state is drafted to include those individuals. The omitted law reads:

> (2) "Commissioner" means the commissioner of insurance of the State of Texas or the commissioner, director, or superintendent of insurance in any other state.

Revised Law

Sec. 2201.003. LIABILITY DEFINED. (a) In this chapter, except as provided by Subsection (b) or as otherwise provided by

this chapter:

(1) "Completed operations liability" means liability, including liability for activities that are completed or abandoned before the date of the occurrence giving rise to the liability, arising out of the installation, maintenance, or repair of any product at a site that is not owned or controlled by:

(A) a person who performs that work; or

(B) a person who hires an independent contractor to perform that work.

(2) "Liability" means legal liability for damages, including costs of defense, legal costs, fees, and other claims expenses, incurred because of personal injury, property damage, or other damage or loss to another person resulting from or arising out of:

(A) a product, trade, or business, regardless of whether the business operates for profit;

(B) operations, premises, or services, including professional services; or

(C) any activity of:

(i) a state or local government; or

(ii) an agency or political subdivision of a state or local government.

(3) "Product liability" means liability for damages incurred because of any personal injury, death, emotional harm, consequential economic damage, or property damage, including damage resulting from the loss of use of property, arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of that person when the incident giving rise to the claim occurred.

(b) In this chapter, "liability" does not include:

(1) liability for damages incurred because of personal injury, property damage, or other damage or loss resulting from a

personal, familial, or household activity or responsibility; or

(2) an employer's liability with respect to the employer's employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. Section 51 et seq.). (V.T.I.C. Art. 21.54, Secs. 2(3), (5), (6), (7).)

Source Law

Sec. 2. In this article:

(3) "Completed operations liability" means liability, including liability for activities that are completed or abandoned before the date of the occurrence giving rise to the liability, arising out of the installation, maintenance, or repair of any product at a site that is not owned or controlled by:

(A) a person who performs that work; or

(B) a person who hires an independent contractor to perform that work.

(5) "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage, including damage resulting from the loss of use of property, arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such person when the incident giving rise to the claim occurred.

(6) "Liability":

(A) means legal liability for damages, including costs of defense, legal costs, fees, and other claims expenses, because of injuries to other persons, damage to their property, or other damage or loss to other persons resulting from or arising out of:

(i) a business, whether profit or nonprofit, a trade, a product, services, including professional services, premises, or operations; or

(ii) any activity of any state or local government or any agency or political subdivision thereof; but

(B) does not include personal risk liability or an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. 51 et seq.).

(7) "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities rather than responsibilities or activities covered by Subdivision (6) of this section.

Revisor's Note

Section 2(7), V.T.I.C. Article 21.54, defines "personal risk liability" as including certain

responsibilities or activities "rather than responsibilities or activities covered by Subdivision (6) of this section." The revised law omits the quoted language as unnecessary because it duplicates the statement in Section 2(6)(B), revised in Subsection (b), that "liability" as defined by Section 2(6)(A), revised as Subsection (a), does not include "personal risk liability."

Revised Law

Sec. 2201.004. AGENT LICENSE REQUIRED. (a) A person, firm, partnership, or corporation may not act or offer to act as an agent for, or aid in any manner in the solicitation, negotiation, or placement of insurance on behalf of, a risk retention group or purchasing group operating in this state or a group member in this state without first obtaining a license as an agent under:

(1) Chapter 4051, if a resident of this state; or

(2) Chapter 4056, if a nonresident of this state.

(b) A person, firm, partnership, or corporation must comply with Chapter 981 before the person, firm, partnership, or corporation, on behalf of a purchasing group or a group member in this state:

(1) acts or offers to act as an agent for an insurer not authorized to engage in business in this state; or

(2) aids in any manner in the solicitation, negotiation, or placement of insurance with an insurer not authorized to engage in business in this state. (V.T.I.C. Art. 21.54, Secs. 10(a), (b).)

Source Law

Sec. 10. (a) No person, firm, partnership, or corporation shall act or offer to act as an agent for a risk retention group, or aid in any manner in the solicitation, negotiation, or placement of insurance on behalf of a risk retention group operating in this state or any of its members in this state without first obtaining a license as an agent under Article 21.14 of this code in the case of a resident of this state or Article 21.11 of this code in the case of a nonresident of this state.

(b) No person, firm, partnership, or

corporation shall act or offer to act as an agent for a purchasing group or aid in any manner in the solicitation, negotiation, or placement of insurance on behalf of a purchasing group operating in this state or any of its members in this state without first obtaining a license as an agent pursuant to Article 21.14 of this code in the case of a resident of this state or Article 21.11 of this code in the case of a nonresident of this state. Furthermore, no person, firm, partnership, or corporation shall act or offer to act as an agent or aid in any manner in the solicitation, negotiation, or placement of insurance with an insurer not qualified to do business in this state on behalf of a purchasing group or its members located in this state without first complying with Article 1.14-2 of this code. No person, firm, partnership, or corporation shall solicit members of the purchasing group for coverage under the purchasing group's policy without first obtaining proper licensing to act as an insurance agent.

Revised Law

Sec. 2201.005. EXEMPTION FROM CERTAIN REQUIREMENTS. (a) A provision of Chapter 981, 4055, or 4056 does not apply to an agent described by Subsection (b) if the provision:

(1) requires residency in this state;

(2) requires countersignatures;

(3) prohibits the solicitation of insurance in this state by a nonresident or the payment of commissions to a nonresident; or

(4) prohibits a nonresident from acting as a surplus or excess lines agent.

(b) The exemption provided by Subsection (a) applies to an agent licensed under Chapter 981, 4055, or 4056 who is acting on behalf of a risk retention group or purchasing group operating in this state or a group member in this state in providing or placing liability insurance for risks located in this state. (V.T.I.C. Art. 21.54, Sec. 10(c).)

Source Law

(c) Any provision of Article 1.14-2, 21.09, or 21.11 of this code, requiring residency in this state, requiring countersignatures, prohibiting the payment of commissions to a nonresident, prohibiting the solicitation of insurance in this state by a nonresident, or prohibiting a nonresident from acting as a surplus or excess lines agent shall not apply in the case of an agent licensed pursuant to those articles when the agent acts on behalf of a risk retention group or purchasing group operating in this state or any of their members in this state in the

provision or placement of liability insurance for risks located in this state.

Revised Law

Sec. 2201.006. AUTHORITY OF COMMISSIONER. (a) To enforce the laws of this state, the commissioner may use any authority provided by this code that is not specifically preempted by the Product Liability Risk Retention Act of 1981, as amended by the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.), including the authority to investigate, issue a subpoena, conduct a deposition or hearing, issue an order, and impose a penalty.

(b) The commissioner shall rely on the procedural laws and rules of this state with regard to an investigation, an administrative proceeding, or litigation. (V.T.I.C. Art. 21.54, Secs. 12(a), (b).)

Source Law

Sec. 12. (a) The commissioner of this state is authorized to make use of any of the powers under this code to enforce the laws of this state so long as those powers are not specifically preempted by the Product Liability Risk Retention Act of 1981, as amended by the Liability Risk Retention Act of 1986. These powers include the commissioner's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, and impose penalties.

(b) With regard to any investigation, administrative proceedings, or litigation, the commissioner of this state shall rely on the procedural law and regulations of the state.

Revisor's Note

Section 12(b), V.T.I.C. Article 21.54, refers to procedural law and "regulations" of this state. Throughout this chapter, the revised law substitutes "rules" for "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, and "rule" is the more commonly used term. In addition, subsequent provisions revised in this chapter refer to both "rules" and "regulations." For the reason stated in this revisor's note, the revised law throughout this

chapter omits references to "regulations" in that context.

Revised Law

Sec. 2201.007. ANNUAL REPORT TO COMMISSIONER. An agent licensed as required by Section 2201.004 shall report to the commissioner not later than March 1 of each year the activities and scope of services being provided to a risk retention group or purchasing group. The report must be made in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.54, Sec. 10(e).)

Source Law

> (e) An agent licensed as provided by Subsection (a) or (b) of this section must report to the commissioner of this state not later than March 1 of each year the activities and scope of services being provided to the risk retention group or purchasing group in accordance with rules promulgated by the board.

Revised Law

Sec. 2201.008. RULES. The commissioner may adopt rules relating to risk retention groups and purchasing groups that are necessary to carry out this chapter. (V.T.I.C. Art. 21.54, Sec. 15.)

Source Law

> Sec. 15. The board may adopt rules relating to risk retention groups and purchasing groups that are necessary to carry out this article.

[Sections 2201.009-2201.050 reserved for expansion]

SUBCHAPTER B. RISK RETENTION GROUP QUALIFICATIONS

Revised Law

Sec. 2201.051. GENERAL QUALIFICATIONS OF RISK RETENTION GROUP. A risk retention group must be a corporation or other limited liability association that:

(1) is organized primarily to assume and spread, and engages primarily in assuming and spreading, all or any portion of the liability exposure of the group's members; and

(2) otherwise meets the qualifications of this subchapter. (V.T.I.C. Art. 21.54, Sec. 2(10) (part).)

Source Law

Sec. 2. In this article:

(10) "Risk retention group" means any corporation or other limited liability association:

(A) which is organized for the primary purpose of conducting the activity described under Paragraph (B) of this subdivision;

(B) whose primary activity consists of assuming and spreading all or any portion of the liability exposure of its group members; and

[(C) which:

(i) is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(ii) before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the commissioner of at least one state that it satisfied the capitalization requirements of that state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability as those terms were defined in the Product Liability Risk Retention Act of 1981 before the effective date of the federal Liability Risk Retention Act of 1986;

(D) which does not exclude any person from membership in the group solely to provide for members of that group a competitive advantage over such a person;

(E) which:

(i) has as its members only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

(ii) has as its sole owner an organization which has as its members only persons who comprise the membership of the risk retention group and which has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

(F) whose members are engaged in similar or related businesses or activities with respect to the liability to which those members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations;

(G) whose activities do not include the provision of insurance other than liability insurance for assuming and spreading all or any portion of the liability of its group members, and reinsurance with respect to the liability of any other risk retention group, or any members of such other group, which is engaged in businesses or activities so that the group or member meets the requirement of Subdivision (6) of this section for membership in the risk retention group which provides the reinsurance; and

(H) the name of which includes the phrase "Risk Retention Group".]

Revised Law

Sec. 2201.052. NAME OF GROUP. A risk retention group must include in its name the phrase "risk retention group." (V.T.I.C. Art. 21.54, Sec. 2(10) (part).)

Source Law

Sec. 2. In this article:

(10) ["Risk retention group" means any corporation or other limited liability association:]

. . .

(H) the name of which includes the phrase "Risk Retention Group".

Revised Law

Sec. 2201.053. STATUS AS LIABILITY INSURER REQUIRED. A corporation or other limited liability association must be chartered and authorized to engage in the business of insurance as a liability insurer under the laws of any state to act as a risk retention group. (V.T.I.C. Art. 21.54, Sec. 2(10) (part).)

Source Law

Sec. 2. In this article:

(10) ["Risk retention group" means any corporation or other limited liability association:]

. . .

(C) which:

(i) is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

. . .

Revisor's Note

Section 2(10), V.T.I.C. Article 21.54, provides that a risk retention group must be "chartered and licensed as a liability insurance company and authorized to engage in the business of insurance" in any state. The revised law omits the requirement to be "licensed" as included within the meaning of "authorized" because, in any state that requires licensure, a liability insurance company would not be authorized to engage in the business of insurance until the company obtained a license. Similar changes are made throughout this chapter.

Revised Law

Sec. 2201.054. QUALIFICATIONS REGARDING AUTHORITY OF CERTAIN ENTITIES TO ENGAGE IN BUSINESS. (a) In this section, "completed operations liability" and "product liability" have the meanings assigned by the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.) before the effective date of the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.).

(b) Notwithstanding Section 2201.053, a corporation or other limited liability association may be considered a risk retention group if:

(1) before January 1, 1985, the corporation or association:

(A) was chartered and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands; and

(B) had certified to the commissioner, director, or superintendent of insurance of at least one state that it satisfied the capitalization requirements of that state; and

(2) since January 1, 1985, the corporation or association has been continuously engaged in business solely to continue to provide insurance to cover completed operations liability or product liability. (V.T.I.C. Art. 21.54, Sec. 2(10) (part).)

Source Law

Sec. 2. In this article:

(10) ["Risk retention group" means any corporation or other limited liability association:]

. . .

(C) which:

[(i) is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or]

(ii) before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the commissioner of at least one state that it satisfied the capitalization requirements of that state, except that any such group shall be

considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability as those terms were defined in the Product Liability Risk Retention Act of 1981 before the effective date of the federal Liability Risk Retention Act of 1986;

. . .

Revisor's Note

Section 2(10)(C), V.T.I.C. Article 21.54, refers to the "commissioner" of at least one state. The revised law substitutes "commissioner, director, or superintendent of insurance" for the reason stated in Revisor's Note (2) to Section 2201.002.

Revised Law

Sec. 2201.055. QUALIFICATIONS REGARDING MEMBERSHIP. (a) A risk retention group must be composed of members who are engaged in similar or related businesses or activities with respect to the liability to which those members are exposed by virtue of any related, similar, or common product, trade, business, operations, premises, or services.

(b) A risk retention group must have:

(1) as members, only persons who are provided insurance by the group; or

(2) as the sole owner, an organization that has:

(A) as members, only persons who comprise the membership of the group; and

(B) as owners, only persons who comprise the membership of the group and are provided insurance by the group.

(c) A risk retention group may not exclude a person from membership in the group solely to provide a competitive advantage for group members over that person. (V.T.I.C. Art. 21.54, Sec. 2(10) (part).)

Source Law

Sec. 2. In this article:

(10) ["Risk retention group" means any corporation or other limited liability association:]

. . .

(D) which does not exclude any person

from membership in the group solely to provide for members of that group a competitive advantage over such a person;

(E) which:

(i) has as its members only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

(ii) has as its sole owner an organization which has as its members only persons who comprise the membership of the risk retention group and which has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

(F) whose members are engaged in similar or related businesses or activities with respect to the liability to which those members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations;

. . .

Revised Law

Sec. 2201.056. AUTHORIZED ACTIVITIES. (a) A risk retention group may provide:

(1) liability insurance for assuming and spreading all or any portion of the liability of the group's members; and

(2) reinsurance with respect to the liability of another risk retention group, or a member of that group, engaged in businesses or activities that meet the requirements of Section 2201.055(a) for membership in the group providing reinsurance.

(b) A risk retention group may not engage in activities that include providing insurance other than the insurance described by Subsection (a). (V.T.I.C. Art. 21.54, Sec. 2(10) (part).)

Source Law

Sec. 2. In this article:

(10) ["Risk retention group" means any corporation or other limited liability association:]

. . .

(G) whose activities do not include the provision of insurance other than liability insurance for assuming and spreading all or any portion of the liability of its group members, and reinsurance with respect to the liability of any other risk retention group, or any members of such other group, which is engaged in businesses or activities so that the group or member meets the requirement of Subdivision (6) of this section for membership in the risk retention group which provides the reinsurance; and

. . .

Revisor's Note

Section 2(10)(G), V.T.I.C. Article 21.54, refers to a risk retention group or group member engaged in businesses or activities of a nature that enables the group or member to meet the requirement of "Subdivision (6) of this section" for membership in another risk retention group. The revised law substitutes a reference to Section 2(10)(F), revised in this chapter as Section 2201.055(a), for the reference to Section 2(6). Section 2(6) does not provide a requirement for membership in a risk retention group; however, the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.) includes a provision parallel to Section 2(10)(G) that refers to a provision equivalent to Section 2(10)(F), which provides a requirement for membership in a risk retention group. It is clear from the circumstances that the legislature intended to refer to Section 2(10)(F) rather than Section 2(6). The revised law is drafted accordingly.

[Sections 2201.057-2201.100 reserved for expansion]

SUBCHAPTER C. RISK RETENTION GROUPS

CHARTERED IN THIS STATE

Revised Law

Sec. 2201.101. ELIGIBILITY REQUIREMENTS. Except as otherwise provided by this chapter, a risk retention group that applies to be chartered in this state must:

(1) be chartered and authorized to engage in the business of insurance under Chapter 822, 861, 883, or 942; and

(2) comply with all the laws, rules, and requirements, including Chapter 804, applicable to insurers authorized to engage in business under those chapters and with Subchapter D to the extent those requirements do not limit the laws, rules, or requirements of this state. (V.T.I.C. Art. 21.54, Secs. 3(a), (b), as amended Acts

70th Leg., R.S., Ch. 46.)

Source Law

Sec. 3. (a) Except as otherwise provided by this article, a risk retention group seeking to be chartered in this state must:

(1) be chartered and licensed as an insurance company authorized by Chapter 2, 8, 15, or 19 of this code; and

(2) comply with all of the laws, rules, regulations, and requirements applicable to insurers chartered and licensed under those chapters and with Section 4 of this article to the extent such requirements are not a limitation on laws, rules, regulations, or requirements of this state.

(b) Except as required by this article, a risk retention group seeking to be chartered in this state must be chartered and licensed as an insurance company authorized by Chapters 2 and 8 of this code and must comply with all of the laws, rules, regulations, and requirements, including Article 1.36 of this code, applicable to insurers chartered and licensed under those chapters.

Revisor's Note

(1) Section 3(a), V.T.I.C. Article 21.54, requires a risk retention group to be chartered and licensed as an insurance company authorized by "Chapter 2, 8, 15, or 19 of this code." V.T.I.C. Chapter 2 in pertinent part was revised as Chapter 822 of this code, V.T.I.C. Chapter 8 was revised as Chapters 861 and 984 of this code, V.T.I.C. Chapter 15 was revised as Chapters 826 and 883 of this code, and V.T.I.C. Chapter 19 was revised as Chapter 942 of this code. The revised law does not reference Chapter 826 of this code because that chapter governs the conversion of a mutual insurance company to a stock insurance company and does not have any provision for the charter of an insurance company. The revised law also does not reference Chapter 984 of this code because that chapter governs Mexican casualty companies that are organized under the laws of the United Mexican States or any state of that nation. Section 2201.053 of this chapter requires that an insurer be chartered under the laws of any "state" to

be a risk retention group, and Section 2201.002(4) of this chapter defines "state" to include a state of the United States or the District of Columbia. Section 2(10)(C), V.T.I.C. Article 21.54, revised in this chapter as Section 2201.054, provides an exception to that general requirement, but the exception is inapplicable in this context. Consequently, a Mexican casualty company could never meet the general requirements in Section 2201.053, and a reference in this section to Chapter 984 is unnecessary. Throughout this chapter, references to "Chapter 2, 8, 15, or 19" have been revised accordingly.

(2) Section 3(a), V.T.I.C. Article 21.54, requires a risk retention group applying for a charter in this state to be authorized to engage in business under "Chapter 2, 8, 15, or 19 of this code." However, Section 3(b), V.T.I.C. Article 21.54, as amended by Chapter 46, Acts of the 70th Legislature, Regular Session, 1987, requires the group to be authorized to engage in business under "Chapters 2 and 8 of this code."

Section 3, V.T.I.C. Article 21.54, was amended by Chapters 46 and 115, Acts of the 70th Legislature, Regular Session, 1987. Before amendment by that legislature, Section 3(b) required a risk retention group applying for a charter in this state to be authorized to engage in business under V.T.I.C. Chapters 2 and 8 and required the group to comply with all laws applicable to insurers chartered and authorized under those chapters. Chapter 46, Acts of the 70th Legislature, Regular Session, 1987, amended Section 3(b) to expressly state that V.T.I.C. Article 1.36 applies to a risk retention group applying for a charter in this state. During the same legislature,

the text of V.T.I.C. Article 21.54 was rewritten in its entirety by Chapter 115, Acts of the 70th Legislature, Regular Session, 1987, and the requirement that a group be authorized under V.T.I.C. Chapters 2 and 8 that was previously contained in Section 3(b) was moved to Section 3(a).

Following the regular session of the 70th Legislature, Section 3(a), as enacted by Chapter 115, Acts of the 70th Legislature, Regular Session, 1987, was amended by Chapter 67, Acts of the 70th Legislature, 2nd Called Session, 1987. Section 3(a), as amended by that act, required a risk retention group applying for a charter in this state to be authorized under V.T.I.C. Chapter 2, 8, 15, or 19.

It is clear from the legislative history that the requirement in Section 3(b), as amended by Chapter 46, Acts of the 70th Legislature, Regular Session, 1987, that a risk retention group applying for a charter in this state be authorized under V.T.I.C. Chapters 2 and 8 was impliedly repealed by the amendment of Section 3(a) by Chapter 67, Acts of the 70th Legislature, 2nd Called Session, 1987, which required that the group be authorized under V.T.I.C. Chapter 2, 8, 15, or 19, revised in pertinent part in this code as Chapters 822, 861, 883, and 942, respectively. The revised law is drafted accordingly.

Revised Law

Sec. 2201.102. CHARTER APPLICATION. (a) A risk retention group that applies to be chartered in this state shall provide to the commissioner with the application for charter the following in accordance with rules adopted by the commissioner:

(1) the group's name;

(2) the identity of the group's initial members;

(3) the identity of the individuals who organized the

group or who will provide administrative services or otherwise influence or control the group's activities;

(4) the amount and nature of initial capitalization;

(5) the coverages to be afforded; and

(6) the states in which the group intends to operate.

(b) Immediately on receipt of an application for charter, the commissioner shall provide summary information concerning the filing, including the information provided under Subsection (a), to the National Association of Insurance Commissioners. (V.T.I.C. Art. 21.54, Secs. 3(d), (e).)

Source Law

(d) With its application for charter, a risk retention group seeking to be chartered in this state shall provide to the commissioner of this state in accordance with rules adopted by the board, the following:

(1) the name of the risk retention group;

(2) the identity of the initial members of the group;

(3) the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group;

(4) the amount and nature of initial capitalization;

(5) the coverages to be afforded; and

(6) the states in which the group intends to operate.

(e) Immediately on receipt of an application for charter, the commissioner of this state shall provide summary information concerning the filing to the National Association of Insurance Commissioners, including the information furnished pursuant to Subsection (d) of this section.

Revised Law

Sec. 2201.103. PLAN OF OPERATION; REVISIONS. (a) Except as provided by Subsection (b), before a risk retention group chartered in this state may offer insurance in any state, the group must submit to the commissioner for approval a plan of operation as described by Section 2201.202.

(b) A risk retention group is not required to submit a plan of operation under this section with respect to any kind or classification of liability insurance that:

(1) was defined in the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.), as that Act

existed before October 27, 1986; and

(2) was offered before October 27, 1986, by any risk retention group that had been chartered and operating for at least three years before that date.

(c) The risk retention group must submit a revision of the group's plan of operation to the commissioner and the commissioner must approve the revision before the group:

(1) offers an additional line of insurance in this state or in any other state; or

(2) effects a change in the group's operations as described in the plan of operation. (V.T.I.C. Art. 21.54, Secs. 3(b), as amended Acts 70th Leg., R.S., Ch. 115, (c).)

Source Law

(b) Before it may offer insurance in any state, each risk retention group also must submit for approval to the commissioner of this state a plan of operation or a feasibility study. The risk retention group shall not offer any additional lines of insurance in this state or in any other state or effect any change in its operations as described in its plan of operation before a revision of the plan is submitted to and approved by the commissioner.

(c) The provisions of Subsection (b) of this section relating to the submission of a plan of operation or feasibility study shall not apply with respect to any kind or classification of liability insurance which:

(1) was defined in the federal Product Liability Risk Retention Act of 1981 (Public Law 97-45) before October 27, 1986; and

(2) was offered before such date by any risk retention group which had been chartered and operating for not less than three years before such date.

Revisor's Note

Section 3(b), V.T.I.C. Article 21.54, as amended by Chapter 115, Acts of the 70th Legislature, Regular Session, 1987, and Section 3(c), V.T.I.C. Article 21.54, refer to "a plan of operation or a feasibility study." Throughout this chapter, the revised law omits references to "feasibility study" and refers only to "plan of operation" for consistency of terminology and because there is no distinction made between a "feasibility study" and a "plan of

operation."

Revised Law

Sec. 2201.104. FILING FEE. (a) In addition to all other fees imposed on an insurer chartered and authorized to engage in business under Chapter 822, 861, 883, or 942, a risk retention group chartered in this state shall pay a filing fee in an amount not to exceed $1,000 as set by rules adopted by the commissioner.

(b) Fees collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account to pay expenses incurred by the commissioner under Sections 2201.102 and 2201.103. (V.T.I.C. Art. 21.54, Sec. 3(f).)

Source Law

(f) In addition to all other fees imposed on an insurance company chartered and licensed pursuant to Chapter 2, 8, 15, or 19 of this code, the risk retention group shall pay a filing fee not to exceed $1,000 as established by board regulation for expenses incurred by the board in connection with Subsections (b), (d), and (e) of this section. Fees collected under this section shall be deposited in the State Treasury to the credit of the State Board of Insurance operating fund.

Revisor's Note

(1) Section 3(f), V.T.I.C. Article 21.54, refers to an insurer that is "chartered and licensed" under specified chapters of this code. Throughout this chapter, the revised law substitutes "authorized" for "licensed" in this context because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

(2) Section 3(f), V.T.I.C. Article 21.54, refers to 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.

[Sections 2201.105-2201.150 reserved for expansion]

SUBCHAPTER D. RISK RETENTION GROUPS NOT CHARTERED IN THIS STATE

Revised Law

Sec. 2201.151. COMPLIANCE REQUIRED. A risk retention group chartered and authorized to engage in business in another state, Bermuda, or the Cayman Islands shall comply with this subchapter to engage in business as a risk retention group in this state. (V.T.I.C. Art. 21.54, Sec. 4(a).)

Source Law

> Sec. 4. (a) A risk retention group chartered and licensed in another state, Bermuda, or the Cayman Islands and seeking to do business as a risk retention group in this state must comply with this section.

Revised Law

Sec. 2201.152. PREREQUISITES TO OFFERING INSURANCE. (a) Before offering insurance in this state, a risk retention group not chartered in this state must submit to the commissioner:

(1) a statement that:

(A) identifies the state or states in which the group is chartered and authorized to engage in business as a liability insurer, the date of charter, and the group's principal place of business; and

(B) provides any other information the commissioner requires to verify that the group qualifies as a risk retention group under Subchapter B, including information on the group's membership;

(2) except as provided by Subsection (b), a copy of the group's plan of operation, as described by Section 2201.202, and revisions of that plan submitted to the state in which the group is chartered and authorized to engage in business; and

(3) a statement of registration that designates the commissioner as the group's agent for the purpose of receiving

service of legal documents or process as provided by Chapter 804.

(b) A risk retention group is not required to submit a plan of operation under this section with respect to any line or classification of liability insurance that:

(1) was defined in the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.), as that Act existed before October 27, 1986; and

(2) was offered before October 27, 1986, by any risk retention group that had been chartered and operating for at least three years before that date. (V.T.I.C. Art. 21.54, Sec. 4(b).)

Source Law

(b) Before offering insurance in this state, a risk retention group shall submit to the commissioner of this state the following:

(1) a statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, date of chartering, its principal place of business, and such other information, including information on its membership, as the commissioner of this state may require to verify that the group qualifies as a risk retention group under the definition in Subdivision (10) of Section 2 of this article;

(2) a copy of its plan of operation or a feasibility study and revisions of that plan or study submitted to the state in which it is chartered and licensed, provided, however, this provision relating to the submission of a plan of operation or feasibility study shall not apply with respect to any line or classification of liability insurance which:

(A) was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986; and

(B) was offered before such date by any risk retention group which had been chartered and operating for not less than three years before that date; and

(3) a statement of registration that designates the commissioner as its agent for the purpose of receiving service of legal documents or process as provided by Chapter 804.

Revisor's Note

(1) Section 4(b), V.T.I.C. Article 21.54, states certain requirements a risk retention group must meet before offering insurance in this state. The revised law adds "not chartered in this state" following "risk retention group" to clarify the applicability of those requirements. Section 4(a),

V.T.I.C. Article 21.54, refers to a risk retention group chartered in another state, Bermuda, or the Cayman Islands, and it is clear that the references throughout Section 4 to a "risk retention group" are referring to a group described by Section 4(a). Because Section 4, V.T.I.C. Article 21.54, applies only to risk retention groups not chartered in this state, similar clarifications are made throughout this chapter.

(2) Section 4(l), V.T.I.C. Article 21.54, imposes a requirement on certain risk retention groups to provide notice to the commissioner of insurance within 30 days of the effective date of the article as amended by Chapter 115, Acts of the 70th Legislature, Regular Session, 1987. The effective date of that act was May 19, 1987. The revised law omits the provision as executed. The omitted law reads:

> (l) Any risk retention group which was doing business in this state prior to the enactment of this article shall, within 30 days after the effective date of this article, furnish notice to the commissioner of this state pursuant to the provisions of Subsection (b) of this section and shall thereafter comply with all other provisions pertaining to risk retention groups not chartered in this state as provided by this article.

Revised Law

Sec. 2201.153. REQUIREMENTS FOR CONTINUING BUSINESS. (a) A risk retention group not chartered in this state that engages in business in this state shall submit to the commissioner:

(1) a copy of the group's financial statement submitted to the state in which the group is chartered and authorized to engage in business;

(2) a copy of each examination of the group as certified by the commissioner, director, or superintendent of insurance of another state or other public official conducting the examination;

(3) on the commissioner's request, a copy of any audit performed with respect to the group; and

(4) any other information required to verify that the group continues to qualify as a risk retention group under Subchapter B.

(b) A financial statement submitted under Subsection (a)(1) must:

(1) be certified by an independent public accountant; and

(2) contain a statement of opinion on loss and loss adjustment expense reserves made:

(A) under criteria established by the National Association of Insurance Commissioners; and

(B) by a member of the American Academy of Actuaries or a qualified loss reserve specialist. (V.T.I.C. Art. 21.54, Sec. 4(d).)

Source Law

(d) Any such risk retention group doing business in this state shall submit to the commissioner of this state:

(1) a copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist, under criteria established by the National Association of Insurance Commissioners;

(2) a copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination;

(3) on request by the commissioner of this state, a copy of any audit performed with respect to the risk retention group; and

(4) such information as may be required to verify its continuing qualification under the definition of risk retention group in Subdivision (10) of Section 2 of this article.

Revised Law

Sec. 2201.154. FILING FEES. (a) The commissioner by rule shall impose a filing fee in an amount not to exceed $500 for filing the items described by Sections 2201.152(a)(1) and (2).

(b) The commissioner by rule may impose a filing fee in an

amount not to exceed $500 for filing the financial statement under Section 2201.153(a)(1). A risk retention group shall provide to the comptroller all information the comptroller requests in connection with the reporting, collection, enforcement, and administration of the fee.

(c) Fees collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account. (V.T.I.C. Art. 21.54, Secs. 4(c), (e), (f) (part).)

Source Law

> (c) A filing fee not to exceed $500 as established by board regulation shall be imposed for filing the items under Subdivisions (1) and (2) of Subsection (b) of this section. Fees collected under Subsection (b) shall be deposited in the State Treasury to the credit of the State Board of Insurance operating fund.
>
> (e) A filing fee not to exceed $500 as established by commissioner regulation may be imposed for the filing of the financial statement under Subdivision (1) of Subsection (d) of this section. Fees collected for filing the statement 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.
>
> (f) . . . Groups shall provide to the comptroller all information the comptroller may request in connection with the reporting, collection, enforcement, and administration . . . of the fee imposed under Subsection (e) of this section.

Revised Law

Sec. 2201.155. PAYMENT OF TAXES. (a) A risk retention group not chartered in this state is liable for the payment of premium and maintenance taxes and taxes on premiums of direct business for risks located in this state and shall report to the commissioner the net premiums written for risks located in this state. The group is subject to taxation, and any fine or penalty related to that taxation, on the same basis as a foreign admitted insurer in accordance with Chapters 4, 201, 202, 203, 221, 222, 224, 227, and 251-257.

(b) A risk retention group shall provide to the comptroller all information the comptroller requests in connection with the reporting, collection, enforcement, and administration of taxes under this section. (V.T.I.C. Art. 21.54, Sec. 4(f) (part).)

Source Law

(f) Such risk retention group shall be liable for the payment of premium and maintenance taxes and taxes on premiums of direct business for risks located within this state and shall report to the commissioner of this state the net premiums written for risks located within this state. Such risk retention group shall be subject to taxation, and any applicable fines and penalties related thereto, on the same basis as a foreign admitted insurer pursuant to Chapters 4 and 5 of this code. Groups shall provide to the comptroller all information the comptroller may request in connection with the reporting, collection, enforcement, and administration of taxes due under this article and . . . .

Revisor's Note

Section 4(f), V.T.I.C. Article 21.54, provides that a risk retention group is subject to taxation on the same basis as a foreign admitted insurer pursuant to "Chapters 4 and 5 of this code." The relevant provisions of V.T.I.C. Chapters 4 and 5 that are revised are revised as Chapters 201, 202, 203, 221, 222, 224, 227, and 251-257 of this code. For that reason, the revised law substitutes a reference to "Chapters 4, 201, 202, 203, 221, 222, 224, 227, and 251-257" for the reference to "Chapters 4 and 5."

Revised Law

Sec. 2201.156. EXAMINATION OF FINANCIAL CONDITION; DISSOLUTION OR DELINQUENCY PROCEEDINGS. (a) A risk retention group not chartered in this state must submit to an examination by the commissioner to determine the group's financial condition if the commissioner of insurance of the jurisdiction in which the group is chartered and authorized to engage in business has not initiated an examination on or before the 60th day after the date the commissioner of this state requests an examination.

(b) The commissioner shall:

(1) coordinate the examination under Subsection (a) to avoid unjustified repetition; and

(2) conduct the examination in an expeditious manner under Sections 401.051, 401.052, 401.054-401.062, 401.103-401.106,

401.151, 401.152, 401.155, and 401.156 and Chapters 86 and 803 in accordance with the National Association of Insurance Commissioners Financial Condition Examiner's Handbook.

(c) A risk retention group not chartered in this state that engages in business in this state must comply with an order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by the commissioner or by a commissioner of another jurisdiction if, after an examination under this section, there is a finding that the group is financially impaired. (V.T.I.C. Art. 21.54, Secs. 4(i), (j).)

Source Law

(i) A risk retention group must submit to an examination by the commissioner of this state to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within 60 days after the date the request is made by the commissioner of this state. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner in accordance with the National Association of Insurance Commissioners Examiner Handbook and pursuant to Articles 1.15, 1.16, 1.17, 1.18, 1.19, and 1.28 of this code.

(j) A risk retention group not chartered in this state and doing business in this state must comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a commissioner if there has been a finding of financial impairment after an examination under Subsection (i) of this section.

Revisor's Note

(1) Section 4(i), V.T.I.C. Article 21.54, refers to the National Association of Insurance Commissioners "Examiner Handbook." The correct name of the handbook is the "Financial Condition Examiner's Handbook," and the revised law is drafted accordingly.

(2) Section 4(j), V.T.I.C. Article 21.54, requires compliance with a "lawful order" issued in certain proceedings. The revised law omits "lawful" as unnecessary because the word does not add to the clear meaning of the law. Compliance with an order is necessary only if the order is lawful.

Revised Law

Sec. 2201.157. APPLICABILITY OF STATE LAWS PROHIBITING CERTAIN ACTS OR PRACTICES. (a) A risk retention group not chartered in this state shall comply with the laws of this state relating to deceptive, false, or fraudulent acts or practices, including Chapters 541 and 543.

(b) A risk retention group not chartered in this state and the group's agents and representatives shall comply with Chapter 542. (V.T.I.C. Art. 21.54, Secs. 4(g), (h).)

Source Law

(g) A risk retention group and its agents and representatives shall comply with Article 21.21-2 of this code.

(h) A risk retention group shall comply with the laws of this state relating to deceptive, false, or fraudulent acts or practices, including Articles 21.21 and 21.21-A of this code.

Revised Law

Sec. 2201.158. INJUNCTIVE RELIEF. (a) A risk retention group not chartered in this state must comply with the terms of an injunction issued by a court of this state or any other state based on a finding that the group is in a hazardous financial condition or is financially impaired.

(b) Injunctive relief must be issued by a court if the commissioner seeks to enjoin a risk retention group not chartered in this state from:

(1) violating the law of this state prohibiting deceptive, false, or fraudulent acts or practices;

(2) soliciting or selling insurance to a person who is not eligible for membership in the group; or

(3) soliciting or selling insurance or operating when the group is in a hazardous financial condition or is financially impaired. (V.T.I.C. Art. 21.54, Secs. 4(k), 12(c).)

Source Law

[Sec. 4]

(k) A risk retention group not chartered in this state must comply with the terms of an injunction issued by a court of competent jurisdiction of this state or any other state based upon a finding that such

group is in hazardous financial condition or is financially impaired.

[Sec. 12]

(c) Injunctive relief must be issued by a court of competent jurisdiction when the board seeks to enjoin a risk retention group not chartered in this state from:

(1) violating the law of this state prohibiting deceptive, false, or fraudulent acts or practices;

(2) soliciting or selling insurance to a person who is not eligible for membership in the risk retention group; or

(3) soliciting or selling insurance by or operation of a risk retention group that is in hazardous financial condition or is financially impaired.

Revisor's Note

Sections 4(k) and 12(c), V.T.I.C. Article 21.54, refer 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 a matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts in this state.

[Sections 2201.159-2201.200 reserved for expansion]

SUBCHAPTER E. PROVISIONS REGULATING GENERAL OPERATION OF RISK RETENTION GROUPS

Revised Law

Sec. 2201.201. SCOPE OF AUTHORITY. A risk retention group may engage in the business of insurance in this state only:

(1) as a risk retention group; and

(2) to conduct the activities described in this chapter. (V.T.I.C. Art. 21.54, Sec. 5(d).)

Source Law

(d) A risk retention group may engage in the business of insurance in this state only as such a group and only for conducting the activities described in this article.

Revised Law

Sec. 2201.202. PLAN OF OPERATION. A plan of operation submitted to the commissioner under Section 2201.103 or 2201.152

must be in the form of an analysis that presents the expected activities and results of a risk retention group, including, at a minimum:

(1) information sufficient to verify that the group's members are engaged in businesses or activities that are similar or related with respect to the liability to which those members are exposed by virtue of any related, similar, or common product, trade, business, operations, premises, or services;

(2) for each state in which the group intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

(3) historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;

(4) pro forma financial statements and projections;

(5) appropriate opinions, including a determination of minimum premium or participation levels required to begin operations and to prevent a hazardous financial condition, by:

(A) a qualified, independent casualty actuary who is a member in good standing of the American Academy of Actuaries; or

(B) an individual who the commissioner recognizes as having comparable training and experience;

(6) identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, and investment policies; and

(7) other matters prescribed by the insurance laws of the state in which the group is chartered. (V.T.I.C. Art. 21.54, Sec. 2(8).)

Source Law

Sec. 2. In this article:

(8) "Plan of operation or feasibility study" means an analysis that presents the expected activities and results of a risk retention group

including, at a minimum:

(A) information sufficient to verify that its members are engaged in businesses or activities that are similar or related with respect to the liability to which such members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations;

(B) for each state in which it intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

(C) historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;

(D) pro forma financial statements and projections;

(E) appropriate opinions by a qualified, independent casualty actuary who is a member in good standing of the American Academy of Actuaries or an individual who is recognized by the commissioner of this state as having comparable training and experience, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

(F) identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, and investment policies; and

(G) other matters as may be prescribed by the insurance laws of the state in which the risk retention group is chartered.

Revised Law

Sec. 2201.203. AGENT TO VERIFY AUTHORITY. Before placing business with a risk retention group, each agent shall secure from the appropriate insurance regulatory authority a certified copy of the certificate of authority verifying that the insurer is authorized in the insurer's domiciliary jurisdiction to write the liability insurance policy the agent proposes to procure from the insurer. (V.T.I.C. Art. 21.54, Sec. 10(d).)

Source Law

(d) Before placing business with a risk retention group, each agent shall secure from the appropriate insurance regulatory authority a certified copy of the certificate of authority verifying that the insurer is authorized in its domiciliary jurisdiction to write the liability insurance policy proposed to be procured from it by the agent.

Revised Law

Sec. 2201.204. APPLICABILITY OF CERTAIN REQUIREMENTS FOR LIABILITY INSURERS. A risk retention group authorized to engage in

business in this state under Subchapter C or D must participate on the same basis as a liability insurer holding a certificate of authority to engage in the business of insurance in this state in:

(1) the Texas Windstorm Insurance Association;

(2) joint underwriting associations;

(3) mandatory liability and assigned risk pools; and

(4) residual market facilities. (V.T.I.C. Art. 21.54, Sec. 11(c).)

Source Law

(c) A risk retention group chartered and licensed in this state and a risk retention group qualified to do business in this state must participate in the catastrophe property insurance pool, joint underwriting associations, mandatory liability and assigned risk pools, and residual market facilities on the same basis as a liability insurer holding a certificate of authority to do the business of insurance in this state.

Revisor's Note

Section 11(c), V.T.I.C. Article 21.54, refers to the "catastrophe property insurance pool." V.T.I.C. Article 21.49, revised as Chapter 2210 of this code, was enacted by Chapter 100, Acts of the 62nd Legislature, Regular Session, 1971, which adopted the Texas Catastrophe Property Insurance Pool Act. The "pool" was administered by the Texas Catastrophe Property Insurance Association. "Pool" was never a defined term under Article 21.49, and most amendments to that article refer to the "association," rather than the "pool." In 1997, the short title of the article was changed to the "Texas Windstorm Insurance Association Act" by Chapter 438, Acts of the 75th Legislature, Regular Session. To conform to the title change, the revised law substitutes "Texas Windstorm Insurance Association" for "catastrophe property insurance pool."

Revised Law

Sec. 2201.205. RISK RETENTION GROUP PARTICIPATION IN

INSOLVENCY GUARANTY FUND PROHIBITED. A risk retention group may not be required or permitted to join or contribute financially to any insurance insolvency guaranty fund or similar mechanism in this state. A risk retention group, and any of the group's insureds or claimants against an insured, may not receive any benefit from an insurance insolvency guaranty fund or similar mechanism in this state for a claim arising under an insurance policy issued by the group. (V.T.I.C. Art. 21.54, Sec. 11(a).)

Source Law

> Sec. 11. (a) No risk retention group shall be required or permitted to join or contribute financially to any insurance insolvency guaranty fund or similar mechanism in this state, nor shall a risk retention group or its insureds or claimants against its insureds receive any benefit from such fund for claims arising under the insurance policies issued by such retention group.

Revised Law

Sec. 2201.206. REQUIRED NOTICE. (a) Any policy issued by a risk retention group must contain in 10-point type on the front page and on the declarations page the following notice:

NOTICE

> This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

(b) Each person, firm, partnership, or corporation licensed under Chapter 981, 4051, or 4056 shall inform each prospective insured on business to be placed with a risk retention group of the notice required by Subsection (a). (V.T.I.C. Art. 21.54, Secs. 5(a), 10(f) (part).)

Source Law

> Sec. 5. (a) Any policy issued by a risk retention group shall contain in 10-point type on the front page and the declaration page the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

[Sec. 10]

(f) Every person, firm, partnership, or corporation licensed pursuant to the provisions of Article 1.14-2, 21.11, or 21.14 of this code on business placed with risk retention groups or . . . shall inform each prospective insured of the provisions of the notice required by Subsection (a) of Section 5 of this article in the case of a risk retention group and . . . .

Revisor's Note

Section 10(f), V.T.I.C. Article 21.54, refers to V.T.I.C. Article 1.14-2. The relevant provisions of that article were revised as Chapter 981 of this code. The revised law is drafted accordingly.

Revised Law

Sec. 2201.207. PROHIBITED ACTIVITIES. A risk retention group may not:

(1) solicit or sell insurance to any person who is not eligible for membership in the group;

(2) solicit or sell insurance or operate if the group is in a hazardous financial condition or is financially impaired; or

(3) engage in business in this state if an insurer is directly or indirectly a member or owner of the group, unless all of the group members are insurers. (V.T.I.C. Art. 21.54, Secs. 5(b), (c).)

Source Law

(b) The following acts by a risk retention group are prohibited:

(1) the solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in the group; and

(2) the solicitation or sale of insurance by or operation of a risk retention group that is in a hazardous financial condition or is financially impaired.

(c) A risk retention group shall not do business in this state if an insurance company is directly or indirectly a member or owner of the risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

Revised Law

Sec. 2201.208. INJUNCTIVE RELIEF. An order issued by a United States district court enjoining a risk retention group from soliciting or selling insurance or operating in any state, in all states, or in any territory or possession of the United States on a finding that the group is in a hazardous financial condition, is financially impaired, or is insolvent is enforceable in the courts of this state. (V.T.I.C. Art. 21.54, Sec. 14.)

Source Law

> Sec. 14. An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance or operating in any state, in all states, or in any territory or possession of the United States on a finding that the group is in a hazardous financial condition, is financially impaired, or is insolvent is enforceable in the courts of this state.

Revised Law

Sec. 2201.209. PENALTIES. (a) A risk retention group that is authorized to engage in business in this state under Subchapter C or D and that violates this chapter is subject to all sanctions and penalties applicable to an insurer that holds a certificate of authority under Chapters 822 and 861, including revocation of the authority to engage in business in this state.

(b) A risk retention group not chartered in this state that violates this chapter is also subject to any fine or penalty applicable to a foreign admitted insurer generally, including revocation of the authority to engage in business in this state.

(c) A risk retention group engaging in business in this state that is not authorized to engage in business under Subchapter C or D is considered an unauthorized insurer and is subject to Section 823.457, Subchapters A-P, Chapter 442, and Chapters 101, 441, 804, and 801, other than Section 801.056. (V.T.I.C. Art. 21.54, Secs. 4(m), 13.)

Source Law

> [Sec. 4]
> (m) A risk retention group which violates any provision of this article shall be subject to fines and penalties applicable to foreign admitted insurers

generally, including revocation of its right to do business in this state.

Sec. 13. (a) A risk retention group that is qualified to do business in this state under Section 3 or 4 of this article and that violates this article is subject to all sanctions and penalties applicable to an insurer that holds a certificate of authority under Chapters 2 and 8 of this code including revocation of its license and the right to do business in this state.

(b) A risk retention group doing business in this state that is not qualified to do business in this state under Section 3 or 4 of this article is considered an unauthorized insurer and is subject to Articles 1.14, 1.14-1, 1.36, 21.28, and 21.28-A of this code.

[Sections 2201.210-2201.250 reserved for expansion]

SUBCHAPTER F. PURCHASING GROUPS

Revised Law

Sec. 2201.251. GENERAL QUALIFICATIONS OF PURCHASING GROUP. (a) A purchasing group must:

(1) have as one of the group's purposes the purchase of liability insurance on a group basis;

(2) be composed of members whose businesses or activities are similar or related with respect to the liability to which those members are exposed by virtue of any related, similar, or common product, trade, business, operations, premises, or services; and

(3) purchase group liability insurance only for the group's members and only to cover the members' similar or related liability exposure as described in Subdivision (2).

(b) A purchasing group may be domiciled in any state. (V.T.I.C. Art. 21.54, Sec. 2(9).)

Source Law

Sec. 2. In this article:

(9) "Purchasing group" means any group that:

(A) has as one of its purposes the purchase of liability insurance on a group basis;

(B) purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in Paragraph (C) of this subdivision;

(C) is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

(D) is domiciled in any state.

Revised Law

Sec. 2201.252. DETERMINATION OF LOCATION. (a) For purposes of this subchapter, a purchasing group is considered to be located in the state in which the highest aggregate premiums are in force on the date the group insurance policy is written or renewed. The group's location is ascertained on each placement or renewal of insurance by the group with an insurer or risk retention group.

(b) For purposes of this section, a group insurance policy is considered to be renewed annually. (V.T.I.C. Art. 21.54, Sec. 2(14).)

Source Law

Sec. 2. In this article:

> (14) "Located" or "location," for the purposes of determining the state in which a purchasing group is located, means the state in which the highest aggregate premiums are in force on the date the group policy is written or renewed and shall be ascertained upon each placement of renewal by the purchasing group of insurance with an insurer or risk retention group. For the purpose of determining the purchasing group's location, the group policy shall be deemed to be renewed annually.

Revisor's Note

Section 2(14), V.T.I.C. Article 21.54, provides that a purchasing group's location is ascertained on "each placement of renewal" of insurance by the group. The revised law substitutes "placement or renewal" because it is clear from the context that "of" in "placement of renewal" is a typographical error and that the legislature intended to use the phrase "placement or renewal."

Revised Law

Sec. 2201.253. LIMITATIONS ON AUTHORITY. (a) A purchasing group located in this state may not purchase liability insurance from a risk retention group that is not chartered in a state or from an insurer that does not hold a certificate of authority to engage in the business of insurance in this state unless the purchase is effected through a licensed agent acting under Chapter 981.

(b) A purchasing group may not offer insurance policy coverage declared unlawful by the Texas Supreme Court. (V.T.I.C. Art. 21.54, Secs. 8(a), (c).)

Source Law

> Sec. 8. (a) A purchasing group located in this state shall not purchase liability insurance from a risk retention group that is not chartered in a state or from an insurer that does not hold a certificate of authority to do the business of insurance in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent acting pursuant to Article 1.14-2 of this code.
>
> (c) No purchasing group may offer insurance policy coverage declared unlawful by the highest court of this state.

Revised Law

Sec. 2201.254. APPLICATION OF STATE LAW. (a) A purchasing group meeting the criteria established under the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.) is exempt from any law of this state that:

(1) relates to the creation of groups for the purchase of insurance;

(2) requires countersignatures;

(3) prohibits group purchasing; or

(4) discriminates against a purchasing group or the group's members.

(b) An insurer is exempt from any law of this state that prohibits providing or offering to provide to a purchasing group or the group's members advantages based on the group's or members' loss and expense experience that are not afforded to other persons with respect to rates, policy forms, coverages, or other matters.

(c) A purchasing group is subject to all other applicable laws of this state. (V.T.I.C. Art. 21.54, Sec. 6.)

Source Law

> Sec. 6. Any purchasing group meeting the criteria established under the federal Liability Risk Retention Act of 1986 shall be exempt from any law of this state relating to the creation of groups for the purchase of insurance, the requirement of countersignatures, or the prohibition of group purchasing or any law that would discriminate against a purchasing group or its members. Also, an insurer

shall be exempt from any law of this state that prohibits providing or offering to provide to a purchasing group or its members advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages, or other matters. A purchasing group shall be subject to all other applicable laws of this state.

Revised Law

Sec. 2201.255. NOTICE TO COMMISSIONER; FILING FEE. (a) Before engaging in business in this state, a purchasing group must provide notice to the commissioner. The notice must:

(1) identify the state in which the group is domiciled;

(2) specify the lines and classifications of liability insurance the group intends to purchase;

(3) specify the method by which and the persons, if any, through whom insurance will be offered to group members whose risks are located in this state;

(4) identify the insurer from which the group intends to purchase group insurance and the domicile of that insurer;

(5) identify the group's principal place of business and, if ascertainable at the time of filing, the group's location; and

(6) provide other information the commissioner requires to verify that the group qualifies as a purchasing group under Section 2201.251.

(b) The commissioner by rule shall impose a filing fee in an amount not to exceed $100 for filing notice under this section. Fees collected under this subsection shall be deposited to the credit of the Texas Department of Insurance operating account. (V.T.I.C. Art. 21.54, Sec. 7(a).)

Source Law

Sec. 7. (a) A purchasing group that intends to do business in this state shall, prior to doing such business, furnish notice to the commissioner of this state. A filing fee not to exceed $100 as established by board regulation shall be imposed for the filing of such notice. Fees collected under this subsection shall be deposited in the State Treasury to the credit of the State Board of Insurance operating fund. The notice shall:

(1) identify the state in which the group

is domiciled;

(2) specify the lines and classifications of liability insurance that the purchasing group intends to purchase;

(3) specify the method by which and the person or persons, if any, through whom insurance will be offered to its members whose risks are located in this state;

(4) identify the insurance company from which the group intends to purchase its insurance and the domicile of that company;

(5) identify the principal place of business of the group and, if ascertainable at the time of filing, the location of the group; and

(6) provide such other information as may be required by the commissioner of this state to verify that the purchasing group is qualified under Subdivision (9) of Section 2 of this article.

Revised Law

Sec. 2201.256. REGISTRATION REQUIREMENT; FEES. (a) A purchasing group shall register with and designate the commissioner or other appropriate authority as the group's agent solely for the purpose of receiving service of legal documents or process unless the group:

(1) was domiciled before April 1, 1986, in any state of the United States and is domiciled on and after October 27, 1986, in any state of the United States;

(2) before October 27, 1986, purchased the group's insurance from an insurer authorized to engage in business in any state, and after October 27, 1986, purchased the group's insurance from an insurer authorized to engage in business in any state;

(3) was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.) before October 27, 1986; and

(4) does not purchase insurance that was not authorized for purposes of an exemption under that Act as effective before October 27, 1986.

(b) The commissioner by rule may impose a fee in an amount not to exceed $50 for each document served on the commissioner and forwarded to the purchasing group. Fees collected under this subsection shall be deposited to the credit of the Texas Department of Insurance operating account. (V.T.I.C. Art. 21.54, Sec. 7(b).)

Source Law

(b) The purchasing group shall register with and designate the commissioner of this state or other appropriate authority as its agent solely for the purpose of receiving service of legal documents or process, except that these requirements do not apply in the case of a purchasing group which:

(1) was domiciled before April 1, 1986, in any state of the United States and is domiciled on and after October 27, 1986, in any state of the United States;

(2) before October 27, 1986, purchased its insurance from an insurance carrier licensed in any state and since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state;

(3) was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 before October 27, 1986; and

(4) does not purchase insurance that was not authorized for purposes of an exemption under that Act, as effective before October 27, 1986.

A fee not to exceed $50 as established by board regulation may be imposed for each document served on the commissioner of this state and forwarded to the purchasing group. Fees collected under this subsection shall be deposited in the State Treasury to the credit of the State Board of Insurance operating fund.

Revisor's Note

Section 7(c), V.T.I.C. Article 21.54, imposes a requirement on certain purchasing groups to provide notice to the commissioner of insurance within 30 days of the effective date of the article. The revised law omits the provision for the reason stated in Revisor's Note (2) to Section 2201.152. The omitted law reads:

> (c) Any purchasing group which was doing business in this state prior to the enactment of this article shall, within 30 days after the effective date of this article, furnish notice to the commissioner pursuant to the provisions of Subsection (a) of this section such information as may be required pursuant to Subsection (b) of this section.

Revised Law

Sec. 2201.257. PAYMENT OF PREMIUM TAXES. (a) Premiums paid for coverage of risks located in this state by a purchasing group or any group member are subject to taxation at the same rate and subject to the same interest, fines, and penalties for nonpayment that apply to premiums paid for similar coverage by other insureds.

(b) Title 3 is used to compute applicable tax rates for a purchasing group or any group member that pays premiums for coverage of risks located in this state to:

(1) an insurer holding a certificate of authority to engage in the business of insurance in this state; or

(2) a risk retention group authorized to engage in business in this state.

(c) To the extent that a purchasing group or group member pays premiums as described by Subsection (b), the insurer or risk retention group receiving those premiums shall remit the tax to the department.

(d) Chapter 225 is used to compute applicable tax rates for a purchasing group or any group member that pays premiums for coverage of risks located in this state to an eligible surplus lines insurer. If a purchasing group or member pays those premiums, the surplus lines agent shall report and remit the tax. If the agent does not remit the tax, the purchasing group shall remit the tax. (V.T.I.C. Art. 21.54, Sec. 9.)

Source Law

Sec. 9. (a) Premiums paid for coverage of risks located in this state by purchasing groups or any members of the purchasing group are subject to taxation at the same rate and subject to the same interest, fines, and penalties for nonpayment as that applicable to premiums paid for similar coverage by other insureds.

(b) Chapter 4 of this code shall be used to calculate applicable tax rates when the purchasing group or any members of the purchasing group pay premiums for coverage of risks located in this state to an insurance company holding a certificate of authority to do the business of insurance in this state or a risk retention group qualified to do business in this state. Article 1.14-2 of this code is to be used to calculate the applicable tax rates when the purchasing group or any members of the purchasing group pay premiums for coverage of risks located in this state to a surplus lines insurance carrier.

(c) To the extent that the purchasing group or its members pay premiums for coverage of risks located within this state to an insurance company holding a certificate of authority to do the business of insurance in this state or a risk retention group qualified to do business in this state, the insurance company or risk retention group receiving those premiums is responsible for remitting the tax to the board.

(d) To the extent that the purchasing group or

its members pay premiums for coverage of risks located within this state to a surplus lines insurance carrier, the surplus lines agent shall report and pay the taxes for premiums. To the extent the surplus lines agent does not remit the tax, the purchasing group shall pay the tax for coverage of risks located in this state.

Revisor's Note

(1) Section 9(b), V.T.I.C. Article 21.54, refers to V.T.I.C. Chapter 4. That chapter was revised in various titles of this code, but the relevant provisions were revised in Title 3 of this code. The revised law is drafted accordingly.

(2) Sections 9(b) and (d), V.T.I.C. Article 21.54, refer to a "surplus lines insurance carrier." To write surplus lines insurance in this state, an insurer must be eligible under Chapter 981 of this code. Chapter 981 defines and uses the term "eligible surplus lines insurer." For clarity and consistency of terminology within this code, the revised law substitutes "eligible surplus lines insurer" for "surplus lines insurance carrier."

Revised Law

Sec. 2201.258. PURCHASING GROUP PARTICIPATION IN INSOLVENCY GUARANTY FUND PROHIBITED; EXCEPTION. (a) A claim against a purchasing group or a group member may not be paid from any insurance insolvency guaranty fund or similar mechanism in this state.

(b) A purchasing group, a group member, or any claimant against the group or group member may not receive any benefit from an insurance insolvency guaranty fund or similar mechanism in this state for a claim arising under an insurance policy procured through the group unless the policy is underwritten by an insurer authorized to engage in business in this state that, at the time of the policy's issuance:

(1) has capital and surplus of at least $25 million; or

(2) is a member of a company group that has combined

capital and surplus of at least $25 million. (V.T.I.C. Art. 21.54, Sec. 11(b).)

Source Law

> (b) No claim against a purchasing group or its members shall be entitled to payment from any insurance insolvency guaranty fund or similar mechanism in this state, nor shall a purchasing group or its members or claimants against the group or its members receive any benefit from such fund for claims arising under the insurance policies procured through the purchasing group unless the policies are underwritten by insurance companies that are licensed in this state and have capital and surplus of at least $25 million, or insurance companies that are licensed in this state that are members of company groups with combined capital and surplus of at least $25 million, at the time of policy issuance.

Revised Law

Sec. 2201.259. REQUIRED NOTICE. (a) A purchasing group that obtains liability insurance from an insurer or a risk retention group shall provide notice to each group member that has a risk located in this state that the risk is not protected by an insurance insolvency guaranty fund in this state and that the insurer or risk retention group may not be subject to all the insurance laws and rules of this state.

(b) Each person, firm, partnership, or corporation licensed under Chapter 981, 4051, or 4056 shall inform each prospective insured on business to be written through a purchasing group of the notice required by Subsection (a). (V.T.I.C. Art. 21.54, Secs. 8(b), 10(f) (part).)

Source Law

> [Sec. 8]
> (b) A purchasing group which obtains liability insurance from an insurer or a risk retention group shall inform each of the members of such group which have a risk located in this state that such risk is not protected by an insurance insolvency guaranty fund in this state and that such risk retention group or such insurer may not be subject to all insurance laws and regulations of this state.
>
> [Sec. 10]
> (f) Every person, firm, partnership, or corporation licensed pursuant to the provisions of Article 1.14-2, 21.11, or 21.14 of this code on business . . . written through a purchasing group shall inform each prospective insured of the provisions of the notice required by . . . Subsection (b) of Section 8 of this article in the case of a

purchasing group.

Revisor's Note

Section 10(f), V.T.I.C. Article 21.54, refers to V.T.I.C. Article 1.14-2. The revised law substitutes a reference to Chapter 981 of this code for the reason stated in the revisor's note to Section 2201.206.

CHAPTER 2202. JOINT UNDERWRITING

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CHAPTER 2202. JOINT UNDERWRITING

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2202.001. DEFINITIONS. In this chapter:

(1) "Insurer" means any insurance company, corporation, reciprocal or interinsurance exchange, mutual association, county mutual insurance company, Lloyd's plan, or other insurer authorized to engage in business in this state. The term does not include an insurer that writes only life, health, or accident insurance, variable life insurance, or variable annuity contracts.

(2) "Joint underwriting association" means a voluntary unincorporated association of insurers authorized to engage in business in this state that has been authorized by the association's member insurers to act on behalf of the member insurers in joint underwriting or in issuing syndicate insurance policies on a several, but not joint, basis. (V.T.I.C. Art. 21.49-3b, Secs. 2(3), (4).)

Source Law

[Sec. 2. In this article:]

(3) "Insurer" means any insurance company, corporation, inter-insurance exchange, mutual or

reciprocal association, county mutual insurance company, Lloyd's, or other insurance carrier licensed to do business in this state. The term does not include a carrier that writes only life, health, or accident insurance, variable life insurance, or variable annuity contracts.

(4) "Joint underwriting association" means a voluntary unincorporated association of admitted insurers authorized to do business in this state that has been authorized by its member insurers to act on behalf of those insurers in joint underwriting or in the issuance of syndicate policies of insurance on a several but not joint basis.

Revisor's Note

(1) Section 2(3), V.T.I.C. Article 21.49-3b, refers to a "Lloyd's" and a "reciprocal association." For consistency of terminology within this code, the revised law substitutes references to a "Lloyd's plan" and a "reciprocal or interinsurance exchange" for the references to "Lloyd's" and "reciprocal association," respectively.

(2) Section 2(3), V.T.I.C. Article 21.49-3b, refers to an insurer "licensed" to do business in this state. Throughout this chapter, the revised law substitutes "authorized" for "licensed" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

(3) Section 2(4), V.T.I.C. Article 21.49-3b, provides that a joint underwriting association is a voluntary unincorporated association of "admitted" insurers authorized to engage in business in this state. Throughout this chapter, the revised law omits the reference to "admitted" as unnecessary because an insurer that is authorized to engage in business in this state is necessarily an "admitted" insurer.

(4) Section 2, V.T.I.C. Article 21.49-3b, defines "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 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. The omitted law reads:

> Sec. 2. In this article:
> (1) "Board" means the State Board of Insurance.
> (2) "Commissioner" means the commissioner of insurance.

Revised Law

Sec. 2202.002. INAPPLICABILITY OF CHAPTER. This chapter does not apply to the transaction of life, health, or accident insurance business. (V.T.I.C. Art. 21.49-3b, Sec. 15.)

Source Law

> Sec. 15. This article does not apply to the transaction of life, health, or accident insurance business.

Revised Law

Sec. 2202.003. DEPOSIT OF FEES. Fees collected under this chapter shall be deposited to the credit of the Texas Department of Insurance operating account. (V.T.I.C. Art. 21.49-3b, Sec. 16 (part).)

Source Law

> Sec. 16. Fees collected under this article shall be deposited in the state treasury to the credit of the State Board of Insurance operating fund. . . .

Revisor's Note

Section 16, V.T.I.C. Article 21.49-3b, requires 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. 2202.004. CERTAIN APPROPRIATIONS FROM GENERAL REVENUE FUND PROHIBITED. The legislature may not appropriate money from the general revenue fund to administer this chapter, other than fees collected under this chapter and deposited to the credit of the Texas Department of Insurance operating account. (V.T.I.C. Art. 21.49-3b, Sec. 16 (part).)

Source Law

> Sec. 16. . . . Funds may not be appropriated from the general revenue fund to administer this article.

Revisor's Note

(1) Section 16, V.T.I.C. Article 21.49-3b, refers to the appropriation of "funds." The revised law substitutes the term "money" for "funds" because, in context, the terms are synonymous and "money" is more commonly used.

(2) Section 16, V.T.I.C. Article 21.49-3b, prohibits the appropriation of funds from the general revenue fund to administer Article 21.49-3b. However, for the reason stated in the revisor's note to Section 2202.003, the State Board of Insurance operating fund, once a separate fund in the treasury, is now an account in the general revenue fund. Under Section 16, amounts in the operating fund could be appropriated to administer the article. For the purpose of preserving the intent of Section 16, the revised law is drafted to permit the appropriation of fees collected under this chapter and deposited to the credit of the Texas Department of Insurance operating account.

Revisor's Note
(End of Subchapter)

Section 1, V.T.I.C. Article 21.49-3b, provides a short title by which the article may be cited. The revised law omits this provision because Article 21.49-3b 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. 21.49-3b
> Sec. 1. This article may be cited as the Joint Underwriting Association Licensing Act.

[Sections 2202.005-2202.050 reserved for expansion]

SUBCHAPTER B. AUTHORITY TO ACT AS JOINT UNDERWRITING ASSOCIATION

Revised Law

Sec. 2202.051. CERTIFICATE OF AUTHORITY REQUIRED. An association of insurers may not act as a joint underwriting association in this state on behalf of the association's member insurers unless the association holds a certificate of authority issued under this chapter. (V.T.I.C. Art. 21.49-3b, Sec. 3.)

Source Law

> Sec. 3. An association of insurers may not act as a joint underwriting association in this state on behalf of its member insurers unless it holds a license issued under this article.

Revisor's Note

Section 3, Article 21.49-3b, states that an insurer may not act as a joint underwriting association unless the insurer holds a "license." Throughout this chapter, the revised law substitutes "certificate of authority" for "license" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 2202.052. APPLICATION FOR CERTIFICATE OF

AUTHORITY. (a) An association of insurers that applies for a certificate of authority under this chapter must file a written application on forms prescribed by the commissioner.

(b) The application must include:

(1) the names and addresses of the association's officers and directors;

(2) a copy of the association's constitution, articles of agreement or association, bylaws, rules, powers of attorney, or other agreements governing the association's activities;

(3) a list of the insurers authorized to engage in business in this state who are association members and the addresses of those insurers' principal administrative offices;

(4) the name and address of a resident of this state who will act as the association's agent for receipt of notices or orders of the commissioner and for service of process; and

(5) other information as required by the commissioner.

(c) At least one officer of the association must swear to the application. (V.T.I.C. Art. 21.49-3b, Sec. 4.)

Source Law

Sec. 4. (a) Each association of insurers that applies for a license under this article must file a written application on forms prescribed by the commissioner.

(b) The application shall include:

(1) the names and addresses of the officers and directors of the association;

(2) a copy of the association's constitution, articles of agreement or association, bylaws, rules, powers of attorney, or other agreements governing its activities;

(3) a list of the insurers licensed to do business in this state who are members of the association and the addresses of their principal administrative offices;

(4) the name and address of a resident of this state who shall act as the association's agent for receipt of notices or orders of the board and for service of process; and

(5) other information as required by the commissioner.

(c) The application shall be sworn to by at least one officer of the association.

Revised Law

Sec. 2202.053. ISSUANCE OF CERTIFICATE OF AUTHORITY. The commissioner shall issue a certificate of authority to a joint

underwriting association that complies with the requirements of this chapter. (V.T.I.C. Art. 21.49-3b, Sec. 5.)

Source Law

> Sec. 5. The commissioner shall issue a license to a voluntary unincorporated association of insurers that complies with the requirements of this article.

Revised Law

Sec. 2202.054. TERM OF CERTIFICATE OF AUTHORITY. Unless renewed, a certificate of authority issued under this chapter expires on the third anniversary of the date the certificate is issued. (V.T.I.C. Art. 21.49-3b, Sec. 11 (part).)

Source Law

> Sec. 11. Each license issued under this article expires three years from the date of issuance unless renewed. . . .

Revised Law

Sec. 2202.055. RENEWAL OF CERTIFICATE OF AUTHORITY. (a) An applicant for the renewal of a certificate of authority must file an application for renewal with the commissioner and pay the renewal fee on or before the date the certificate expires.

(b) The applicant shall file a list of the names and addresses of the association's officers and directors and a list of the association's member insurers with the application for renewal. At least one officer of the association must swear to the list.

(c) A renewed certificate of authority expires on the third anniversary of the renewal date. (V.T.I.C. Art. 21.49-3b, Secs. 8(a), 11 (part).)

Source Law

> Sec. 8. (a) Each association licensed under this article shall file a list of the names and addresses of its officers and directors and a list of its members with the application for a renewal license filed under Section 11 of this article. The list shall be sworn to by at least one officer of the association.
>
> Sec. 11. . . . To renew the license, an application for renewal must be filed with the commissioner by the renewal applicant and the renewal fee paid on or before the expiration of the license. A renewed license continues in effect for three years after the date of renewal unless otherwise revoked or suspended.

Revisor's Note

Section 11, V.T.I.C. Article 21.49-3b, states that a renewed license continues in effect "unless otherwise revoked or suspended." The revised law omits the quoted phrase as unnecessary because it is duplicative of Section 13, V.T.I.C. Article 21.49-3b, revised in pertinent part in this chapter as Sections 2202.201 and 2202.202, which provides that a license may be suspended or revoked.

Revised Law

Sec. 2202.056. FEE FOR CERTIFICATE OF AUTHORITY. (a) An applicant for the issuance or renewal of a certificate of authority must pay a nonrefundable fee in an amount set by the commissioner when the applicant files the application.

(b) The fee may not exceed $200. (V.T.I.C. Art. 21.49-3b, Sec. 12.)

Source Law

Sec. 12. An applicant for an original or renewal joint underwriting association license shall pay a nonrefundable fee when the application is filed in an amount set by the board, but not to exceed $200.

Revised Law

Sec. 2202.057. RECIPROCITY. The commissioner may waive any requirement for a certificate of authority for an applicant who holds a certificate of authority from another state if the other state has requirements for a certificate of authority that are substantially equivalent to the requirements of this state. (V.T.I.C. Art. 21.49-3b, Sec. 6.)

Source Law

Sec. 6. The board may waive any of the license requirements for an applicant with a valid license from another state that has license requirements substantially equivalent to those of this state.

Revisor's Note

Section 6, V.T.I.C. Article 21.49-3b, refers to an applicant with a "valid license" from another state. The revised law substitutes "certificate of

authority" for "license" for the reason stated in the revisor's note to Section 2202.051 and omits "valid" as unnecessary because the word does not add to the clear meaning of the law. For example, a document purporting to be a certificate of authority is no longer a certificate of authority if its is expired and is not a certificate of authority if it is a forgery.

[Sections 2202.058-2202.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF JOINT UNDERWRITING ASSOCIATION

Revised Law

Sec. 2202.101. AUTHORITY TO ACT. A joint underwriting association may:

(1) act only on behalf of association members who are authorized to engage in business in this state; and

(2) engage in only those activities the association is authorized to perform by the association members. (V.T.I.C. Art. 21.49-3b, Sec. 7.)

Source Law

Sec. 7. (a) A joint underwriting association may act only on behalf of members of the association who are admitted and licensed to do business in this state.

(b) A joint underwriting association may engage in only those activities it is authorized to perform by the members of the association.

Revised Law

Sec. 2202.102. NOTIFICATION OF CERTAIN INFORMATION REQUIRED. An association holding a certificate of authority under this chapter shall notify the commissioner of a change in the information required to be filed under Section 2202.052 not later than the 30th day after the date the change takes effect. (V.T.I.C. Art. 21.49-3b, Sec. 8(b).)

Source Law

(b) Each association licensed under this article shall notify the commissioner of any change in any of the information required to be filed under Section 4 of this article not later than the 30th day after the date on which the change takes effect.

Revised Law

Sec. 2202.103. MAINTENANCE OF INFORMATION. (a) A joint underwriting association shall maintain at the association's principal administrative office adequate records of all transactions.

(b) The association shall maintain the records in accordance with prudent recognized industry standards of recordkeeping.

(c) The commissioner or the commissioner's designated representative is entitled to access to records maintained under Subsection (a) for examination, audit, and inspection.

(d) Trade secrets, including the identity and addresses of policyholders and certificate holders, are confidential, except that the commissioner may use information otherwise confidential in proceedings instituted against an association. (V.T.I.C. Art. 21.49-3b, Sec. 9.)

Source Law

> Sec. 9. (a) Each joint underwriting association shall maintain at its principal administrative office adequate records of all transactions.
>
> (b) The association shall maintain the records in accordance with prudent recognized industry standards of recordkeeping.
>
> (c) The commissioner or the commissioner's designated representative is entitled to access to those records for examination, audit, and inspection.
>
> (d) Trade secrets, including the identity and addresses of policyholders and certificate holders, are confidential, except that the commissioner may use information otherwise confidential in proceedings instituted against an association.

[Sections 2202.104-2202.150 reserved for expansion]

SUBCHAPTER D. AUDIT AND EXAMINATION REQUIREMENTS

Revised Law

Sec. 2202.151. ANNUAL AUDIT. An independent certified public accountant shall annually audit the books of accounts of a joint underwriting association as provided by Subchapter A, Chapter 401. A copy of the audit must be filed with the commissioner. (V.T.I.C. Art. 21.49-3b, Sec. 10(a).)

Source Law

Sec. 10. (a) The books of accounts of joint underwriting associations shall be audited annually as provided by Article 1.15A of this code by an independent certified public accountant, and a copy of that audit shall be filed with the commissioner.

Revised Law

Sec. 2202.152. EXAMINATION BY COMMISSIONER. (a) The commissioner may require an examination of a joint underwriting association as often as the commissioner considers necessary. The association shall pay the reasonable costs of the examination on presentation to the association of a detailed account of the costs of the examination.

(b) The association's officers and employees may be examined under oath at any time and shall exhibit on request all books, records, accounts, documents, or agreements governing the association's operations.

(c) Instead of the examination, the commissioner may accept the report of an examination made by the insurance supervisory official of another state under the laws of that state. (V.T.I.C. Art. 21.49-3b, Sec. 10(b).)

Source Law

(b) The board may require an examination of each joint underwriting association as often as it considers necessary. The reasonable costs of the examination shall be paid by the association on presentation to the association of a detailed account of those costs. The officers and employees of the association may be examined at any time, under oath, and shall exhibit on request all books, records, accounts, documents, or agreements governing the operations of the association. Instead of the examination, the board may accept the report of an examination made by the insurance supervisory official of another state under the laws of that state.

[Sections 2202.153-2202.200 reserved for expansion]

SUBCHAPTER E. DISCIPLINARY ACTIONS AND PROCEDURES; ENFORCEMENT

Revised Law

Sec. 2202.201. GROUNDS FOR DENIAL OF CERTIFICATE OF AUTHORITY OR FOR DISCIPLINARY ACTION. The commissioner may deny an application for a certificate of authority or discipline a

certificate holder under this subchapter if the commissioner finds that the applicant or certificate holder, or an officer or director of an applicant or certificate holder:

(1) wilfully violated or participated in the violation of this chapter or any other insurance law of this state;

(2) intentionally made a material misstatement in the original or renewal application;

(3) obtained or attempted to obtain the certificate by fraud or misrepresentation;

(4) misappropriated, converted to a personal or other inappropriate use, or illegally withheld money required to be held in a fiduciary capacity;

(5) has been convicted of a felony or convicted of a misdemeanor of which criminal fraud is an essential element; or

(6) is incompetent or untrustworthy. (V.T.I.C. Art. 21.49-3b, Sec. 13 (part).)

Source Law

> Sec. 13. A license may be denied, suspended, or revoked or the renewal of the license refused if, . . . the commissioner finds that the license applicant or license holder, or an officer or director of a license applicant or license holder, has:
>
> (1) wilfully violated or participated in the violation of this article or any other insurance law of this state;
>
> (2) intentionally made a material misstatement in the original or renewal license application;
>
> (3) obtained or attempted to obtain the license by fraud or misrepresentation;
>
> (4) misappropriated or converted to a personal or other inappropriate use or illegally withheld money required to be held in a fiduciary capacity;
>
> (5) been convicted of a felony, or of any misdemeanor of which criminal fraud is an essential element; or
>
> (6) been found by the commissioner to be incompetent or untrustworthy.

Revised Law

Sec. 2202.202. DENIAL OF CERTIFICATE OF AUTHORITY OR DISCIPLINARY ACTION. If the commissioner finds that a ground for a denial of a certificate of authority or disciplinary action under Section 2202.201 exists, the commissioner may:

(1) deny the application for the certificate; or

(2) suspend, revoke, or refuse to renew the certificate of authority. (V.T.I.C. Art. 21.49-3b, Sec. 13 (part).)

Source Law

> Sec. 13. A license may be denied, suspended, or revoked or the renewal of the license refused if, . . . the commissioner finds that [the license applicant or license holder, or an officer or director of a license applicant or license holder, has:
>
> (1) wilfully violated or participated in the violation of this article or any other insurance law of this state;
>
> (2) intentionally made a material misstatement in the original or renewal license application;
>
> (3) obtained or attempted to obtain the license by fraud or misrepresentation;
>
> (4) misappropriated or converted to a personal or other inappropriate use or illegally withheld money required to be held in a fiduciary capacity;
>
> (5) been convicted of a felony, or of any misdemeanor of which criminal fraud is an essential element; or
>
> (6) been found by the commissioner to be incompetent or untrustworthy.]

Revised Law

Sec. 2202.203. NOTICE AND HEARING. (a) Before the commissioner may deny an application for a certificate of authority or discipline a certificate holder under this subchapter, the commissioner must:

(1) give notice by certified mail to the applicant or certificate holder; and

(2) set a date on which the applicant or certificate holder may appear to be heard and produce evidence.

(b) A hearing under Subsection (a) may not be set for a date that is earlier than the 20th day or later than the 30th day after the date the notice is mailed.

(c) The notice must contain specific reasons for the hearing and a list of the matters to be considered at the hearing.

(d) At the hearing, the commissioner or a department employee designated to conduct the hearing may:

(1) administer oaths, require the appearance of

witnesses, and examine any person under oath; and

(2) on the commissioner's initiative or on the request of the applicant or certificate holder, require the production of books, records, or papers relevant to the inquiry. (V.T.I.C. Art. 21.49-3b, Secs. 13 (part), 14(a).)

Source Law

> Sec. 13. [A license may be denied, suspended, or revoked or the renewal of the license refused if,] after notice and hearing as provided by Section 14 of this article, [the commissioner finds . . . .]
>
> Sec. 14. (a) Before a license may be denied, suspended, or revoked or the renewal of the license refused, the commissioner shall give notice by certified mail to the applicant or license holder and shall set a date on which the applicant or license holder may appear to be heard and to produce evidence. The hearing date must be not less than 20 days or more than 30 days after the date on which the notice is mailed. The notice must contain specific reasons for the hearing and a list of the matters to be considered at the hearing. At the hearing, the commissioner or any regular employee of the board designated to conduct the hearing may administer oaths, require the appearance of witnesses, examine any person under oath, and require the production of books, records, or papers relevant to the inquiry on the initiative of the commissioner or on the request of the applicant or license holder.

Revised Law

Sec. 2202.204. ISSUANCE OF ORDER. On the termination of the hearing, the findings shall be written and filed with the department. The commissioner shall issue an order showing the findings approved by the commissioner and shall send the order by certified mail to the applicant or certificate holder. (V.T.I.C. Art. 21.49-3b, Sec. 14(b).)

Source Law

> (b) On the termination of the hearing the findings shall be written and, on approval by the commissioner, shall be filed with the board. The commissioner shall issue an order showing the findings, and shall send the order by certified mail to the applicant or license holder. The applicant or license holder may appeal the order of the commissioner to the board.

Revisor's Note

Section 14(b), V.T.I.C. Article 21.49-3b, states: "The applicant or license holder may appeal the order of the commissioner to the board." The

revised law omits the statement as unnecessary. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred the board's functions to the commissioner of insurance or department of insurance. The process for an appeal to the board therefore no longer exists.

Revised Law

Sec. 2202.205. APPEAL. If the commissioner denies an application for a certificate of authority as provided by this chapter or suspends, revokes, or refuses to renew a certificate at a hearing as provided by this chapter, the applicant or certificate holder may appeal the commissioner's action as provided by Subchapter D, Chapter 36. (V.T.I.C. Art. 21.49-3b, Sec. 14(c).)

Source Law

(c) If the commissioner refuses an application for a license as provided by this article, or suspends, revokes, or refuses to renew a license at a hearing as provided by this article, the applicant or license holder may appeal from that action as provided by Article 1.04 of this code.

Revised Law

Sec. 2202.206. APPLICATION AFTER DENIAL, REFUSAL, OR REVOCATION. (a) Except as provided by Subsection (b), an applicant for a certificate of authority or certificate holder whose certificate of authority has been denied, refused, or revoked under this chapter may not file another application for a certificate of authority before the first anniversary of the effective date of the denial, refusal, or revocation.

(b) If an applicant or certificate holder seeks judicial review of a denial, refusal, or revocation, the applicant or certificate holder may not file another application for a certificate of authority before the first anniversary of the date of a final court order or decree affirming the denial, refusal, or revocation.

(c) If an applicant files an application after the date

specified by this section, the commissioner may refuse the application unless the applicant shows good cause why the denial of the previous application or the refusal to renew or the revocation of the original certificate of authority should not be a bar to the issuance of a new certificate. (V.T.I.C. Art. 21.49-3b, Sec. 14(d).)

Source Law

> (d) An applicant or license holder whose license has been denied, refused, or revoked under this article may not file another license application before the first anniversary of the effective date of the denial, refusal, or revocation or, if judicial review of the denial, refusal, or revocation is sought, before the first anniversary of the date of the final court order or decree affirming that action. If an application is filed after that first anniversary, the commissioner may refuse the application unless the applicant shows good cause why the denial, refusal, or revocation of the original license should not be a bar to the issuance of a new license.

Revised Law

Sec. 2202.207. ADDITIONAL SANCTIONS; INJUNCTION. (a) An association that violates this chapter or a rule or order adopted under this chapter is subject to sanctions under Chapter 82.

(b) The attorney general, a district or county attorney, or the commissioner may institute proceedings for an injunction or any other proceeding necessary to enforce this chapter. (V.T.I.C. Art. 21.49-3b, Sec. 17.)

Source Law

> Sec. 17. (a) An association that violates this article or any rule or order adopted under this article is subject to sanctions under Section 7, Article 1.10 of this code.
>
> (b) The attorney general, a district or county attorney, the commissioner, or the board may institute an injunction proceeding or any other proceeding necessary to enforce this article.

Revisor's Note
(End of Chapter)

The revised law omits Section 18, V.T.I.C. Article 21.49-3b, because Section 18 is an effective date provision that has been executed. The omitted law reads:

Sec. 18. A joint underwriting

association is not required to hold a license issued under Article 21.49-3b, Insurance Code, before January 1, 1992.

CHAPTER 2203. MEDICAL LIABILITY INSURANCE JOINT UNDERWRITING ASSOCIATION

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CHAPTER 2203. MEDICAL LIABILITY INSURANCE JOINT UNDERWRITING ASSOCIATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2203.001. SHORT TITLE. This chapter may be cited as the Texas Medical Liability Insurance Underwriting Association Act. (V.T.I.C. Art. 21.49-3, Sec. 1.)

Source Law

Art. 21.49-3
Sec. 1. This Act shall be known as the "Texas Medical Liability Insurance Underwriting Association Act."

Revised Law

Sec. 2203.002. DEFINITIONS. In this chapter:

(1) "Assisted living facility" means a for-profit or not-for-profit assisted living facility.

(2) "Association" means the joint underwriting association established under this chapter.

(3) "Board of directors" means the board of directors of the association.

(4) "Health care provider" means:

(A) a person, partnership, professional association, corporation, facility, or institution licensed or chartered by this state to provide health care, as defined in Section 74.001(a)(10), Civil Practice and Remedies Code, as:

(i) a registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist;

(ii) a hospital;

(iii) a nursing home;

(iv) a radiation therapy center that is independent of any other medical treatment facility, is licensed by the Department of State Health Services in that agency's capacity as the Texas Radiation Control Agency under Chapter 401, Health and Safety Code, and is in compliance with the regulations adopted under that chapter;

(v) a blood bank that is a nonprofit corporation chartered to operate a blood bank and is accredited by

the American Association of Blood Banks;

(vi) a nonprofit corporation that is organized for the delivery of health care to the public and is certified under Chapter 162, Occupations Code;

(vii) a health center, as defined by 42 U.S.C. Section 254b, as amended; or

(viii) an assisted living facility; or

(B) an officer, employee, or agent of an entity listed in Paragraph (A) acting in the course and scope of that person's office, employment, or agency.

(5) "Medical liability insurance" means primary and excess liability insurance coverage against:

(A) the legal liability of the insured; and

(B) loss, damage, or expense incident to a claim arising out of the death or injury of a person as the result of negligence in rendering or failing to render professional service by a health care provider or physician who is in a category eligible for coverage by the association.

(6) "Net direct premiums" means gross direct premiums written on automobile liability and other liability insurance written under this code, less:

(A) policyholder dividends;

(B) return premiums for the unused or unabsorbed portion of premium deposits; and

(C) return premiums on canceled contracts written on the liability risks.

(7) "Nursing home" means a for-profit or not-for-profit nursing home.

(8) "Physician" means a person licensed to practice medicine in this state. (V.T.I.C. Art. 21.49-3, Secs. 2(1), (2), (3), (5), (6); Art. 21.49-3d, Sec. 2(1); New.)

Source Law

[Art. 21.49-3]

Sec. 2. (1) "Medical liability insurance" means primary and excess insurance coverage against

the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence in rendering or the failure to render professional service by a health care provider or physician who is in one of the categories eligible for coverage by the association.

(2) "Association" means the joint underwriting association established pursuant to the provisions of this article.

(3) "Net direct premiums" means gross direct premiums written on automobile liability and liability other than auto insurance written pursuant to the provisions of the Insurance Code, less policyholder dividends, return premiums for the unused or unabsorbed portion of premium deposits and less return premiums upon cancelled contracts written on such liability risks.

(5) "Physician" means a person licensed to practice medicine in this state.

(6) "Health care provider" means:

(A) any person, partnership, professional association, corporation, facility, or institution duly licensed or chartered by the State of Texas to provide health care as defined in Section 1.03(a)(2), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as:

(i) a registered nurse, hospital, dentist, podiatrist, pharmacist, chiropractor, or optometrist;

(ii) a for-profit or not-for-profit nursing home;

(iii) a radiation therapy center that is independent of any other medical treatment facility and which is licensed by the Texas Department of Health in that agency's capacity as the Texas Radiation Control Agency pursuant to the provisions of Chapter 401, Health and Safety Code, and which is in compliance with the regulations promulgated under that chapter;

(iv) a blood bank that is a nonprofit corporation chartered to operate a blood bank and which is accredited by the American Association of Blood Banks;

(v) a nonprofit corporation which is organized for the delivery of health care to the public and which is certified under Chapter 162, Occupations Code;

(vi) a health center as defined by 42 U.S.C. Section 254b, as amended; or

(vii) a for-profit or not-for-profit assisted living facility; or

(B) an officer, employee, or agent of an entity listed in Paragraph (A) of this subdivision acting in the course and scope of that person's employment.

[Art. 21.49-3d]

Sec. 2. In this article:

(1) "Association" means the joint underwriting association established under Article 21.49-3 of this code.

Revisor's Note

(1) Section 2(4), V.T.I.C. Article 21.49-3,

defines "board" as 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 board have been changed appropriately. For this reason, the revised law omits the definition of "board." The omitted law reads:

> (4) "Board" means the State Board of Insurance of the State of Texas.

(2) Section 2(6), V.T.I.C. Article 21.49-3, refers to an institution that is "duly" licensed. The revised law omits the reference to "duly" as unnecessary because the word does not add to the clear meaning of the law.

(3) Section 2(6), V.T.I.C. Article 21.49-3, refers to "health care as defined in Section 1.03(a)(2), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes)." Section 10.09, Chapter 204, Acts of the 78th Legislature, Regular Session, 2003, repealed Article 4590i, and Section 10.01 of that act transferred the substance of that article's definition of "health care" to Section 74.001(a)(10), Civil Practice and Remedies Code. The revised law is drafted accordingly.

(4) Section 2(6), V.T.I.C. Article 21.49-3, refers to a medical treatment facility licensed by the "Texas Department of Health" in the department's capacity as the Texas Radiation Control Agency. The Texas Department of Health was abolished under the provisions of Section 1.26, Chapter 198, Acts of the 78th Legislature, Regular Session, 2003, and that act

transferred the department's duties and functions with respect to licensing to the Department of State Health Services, which was created under Section 1.19 of that act. In addition, any license that was issued by the former Texas Department of Health was continued in effect as a license of the Department of State Health Services. Accordingly, the revised law substitutes "Department of State Health Services" for "Texas Department of Health."

(5) The revised law adds definitions of "assisted living facility," "board of directors," and "nursing home" for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definitions.

Revised Law

Sec. 2203.003. IMMUNITY. Liability does not exist on the part of, and a cause of action does not arise against, the association, an association agent or employee, an insurer, an agent licensed under this code, the commissioner or department, or an authorized representative of the commissioner or department for a statement made in good faith by any of them:

(1) in a report or communication concerning risks insured or to be insured through the association; or

(2) at an administrative hearing conducted in connection with the report or communication. (V.T.I.C. Art. 21.49-3, Sec. 8.)

Source Law

Sec. 8. There shall be no liability on the part of, and no cause of action of any nature shall arise against the association, its agents or employees, an insurer, any licensed agent, or the board or its authorized representatives, for any statements made in good faith by them in any reports or communications, concerning risks insured or to be insured by the association, or at any administrative hearings conducted in connection therewith.

Revised Law

Sec. 2203.004. APPLICABILITY OF OTHER LAW. The association

is subject to Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156 and Subchapter A, Chapter 86. (V.T.I.C. Art. 21.49-3, Sec. 10.)

Source Law

> Sec. 10. The association is subject to Articles 1.15 and 1.16 of this code.

Revisor's Note

Section 10, V.T.I.C. Article 21.49-3, references V.T.I.C. Articles 1.15 and 1.16. Those articles are revised in various provisions of this code, including Sections 401.051 and 401.155. Section 401.051 also revises portions of V.T.I.C. Article 1.19. The revised law substitutes references to Section 401.155 and to Section 401.051 in its entirety because the provisions of Article 1.19 revised in Section 401.051 are substantively identical to provisions derived from Article 1.15 that are also revised in that section.

Revised Law

Sec. 2203.005. RELATIONSHIP TO SURPLUS LINES INSURANCE. The association is not an authorized insurer for purposes of Chapter 981 with respect to medical liability insurance for physicians. (V.T.I.C. Art. 21.49-3, Sec. 3(a) (part).)

Source Law

> (a) . . . The association shall not be a licensed insurer within the meaning of Article 1.14-2, Insurance Code, relating to medical liability insurance for physicians as defined in this article.

Revisor's Note

Section 3(a), V.T.I.C. Article 21.49-3, refers to a "licensed insurer." The revised law substitutes "authorized" for "licensed" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

[Sections 2203.006-2203.050 reserved for expansion]

SUBCHAPTER B. ASSOCIATION ADMINISTRATION AND OPERATION

Revised Law

Sec. 2203.051. PURPOSE OF ASSOCIATION. The association provides medical liability insurance on a self-supporting basis. (V.T.I.C. Art. 21.49-3, Sec. 3(a) (part).)

Source Law

> (a) . . . The purpose of the association shall be to provide medical liability insurance on a self-supporting basis. . . .

Revised Law

Sec. 2203.052. BOARD OF DIRECTORS. (a) The association is governed by a board of directors composed of the following nine members:

(1) five representatives of insurers that are required to be association members, elected by association members;

(2) one physician, appointed by the Texas Medical Association or a successor to that association;

(3) one representative of hospitals, appointed by the Texas Hospital Association or a successor to that association; and

(4) two public members, appointed by the commissioner.

(b) The board members serve one-year terms beginning on October 1 of each year. (V.T.I.C. Art. 21.49-3, Sec. 6.)

Source Law

> Sec. 6. (a) The association shall be governed by a board of nine directors, to be selected annually as follows:
>
> (1) five representatives of insurers required to be members of the association who are elected by members of the association;
>
> (2) one physician who is appointed by the Texas Medical Association or its successor;
>
> (3) one representative of hospitals appointed by the Texas Hospital Association or its successor; and
>
> (4) two members of the public to be appointed by the State Board of Insurance.
>
> (b) Members of the association's board of directors take office on October 1 each year.

Revised Law

Sec. 2203.053. PLAN OF OPERATION. (a) The association operates under a plan of operation adopted by the commissioner.

(b) The plan of operation must:

(1) provide for economic, fair, and nondiscriminatory administration;

(2) provide for the prompt and efficient provision of medical liability insurance; and

(3) contain other provisions, including provisions relating to:

(A) the establishment of necessary facilities;

(B) the association's management;

(C) the assessment of members and policyholders to defray losses and expenses;

(D) the administration of the policyholder's stabilization reserve funds;

(E) commission arrangements;

(F) reasonable and objective underwriting standards;

(G) the acceptance, assumption, and cession of reinsurance;

(H) the appointment of servicing insurers; and

(I) procedures for determining amounts of insurance to be provided by the association.

(c) The plan of operation must direct that any revenue exceeding expenditures that remains in the association's funds at the close of the association's fiscal year, after the association reimburses members' contributions in accordance with Section 2203.255(a), be added to the association's reserves. (V.T.I.C. Art. 21.49-3, Secs. 3(c)(1) (part), (2) (part), (3).)

Source Law

> (c)(1) The board shall . . . promulgate a plan of operation . . . .
>
> (2) The plan of operation shall provide for economic, fair, and nondiscriminatory administration and for the prompt and efficient provision of medical liability insurance, and shall contain other provisions including, but not limited to, . . . establishment of necessary facilities, management of the association, assessment of members and assessment of policyholders to defray losses and expenses, administration of the policyholder's stabilization reserve fund, commission arrangements, reasonable and objective underwriting standards,

acceptance, assumption, and cession of reinsurance, appointment of servicing carriers, and procedures for determining amounts of insurance to be provided by the association.

(3) The plan of operation shall provide that any balance remaining in the funds of the association at the close of its fiscal year, meaning its then excess of revenue over expenditures after reimbursement of members' contributions in accordance with Section 4(b)(5) of this article by the association shall be added to the reserves of the association.

Revisor's Note

(1) Sections 3(c)(1) and (2), V.T.I.C. Article 21.49-3, require the State Board of Insurance to adopt a plan of operation after consulting with certain persons and entities and require that the plan provide for the assessment of association members to meet the initial expenses necessary for the joint underwriting association to begin operating. The revised law omits the language as executed. The omitted law reads:

> (c)(1) [The board shall], after consultation with the joint underwriting association, representatives of the public, the Texas Medical Association, the Texas Podiatry Association, the Texas Hospital Association, and other affected individuals and organizations, [promulgate a plan of operation] consistent with the provisions of this article, to become effective and operative no later than 90 days after the effective date of this Act.
>
> (2) [The plan of operation . . . shall contain other provisions including,] . . . preliminary assessment of all members for initial expenses necessary to commence operations, . . . .

(2) Section 3(c)(2), V.T.I.C. Article 21.49-3, states that the plan of operation must contain provisions, "including, but not limited to," certain specified provisions. 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, 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 3(c)(2), V.T.I.C. Article 21.49-3, refers to the "policyholder's stabilization reserve fund." That language originally referred to the policyholder's stabilization reserve fund under Section 4A, Article 21.49-3, revised in relevant part in this chapter as Section 2203.301. However, after the enactment of Section 3(c)(2), another stabilization reserve fund was established under Section 4B, V.T.I.C. Article 21.49-3, revised in relevant part in this chapter as Section 2203.303. Section 4B established a "stabilization reserve fund," but did not expressly designate that fund to be a "policyholder's stabilization reserve fund." The revised law substitutes a reference to the "policyholder's stabilization reserve funds" for the reference to the "policyholder's stabilization reserve fund" in Section 3(c)(2) because it is clear that the reference is intended to refer to both funds created under Sections 4A and 4B. Similar changes are made throughout this chapter in this context. In addition, the revised law throughout this chapter substitutes references to the "policyholder's stabilization reserve fund" for references to the "stabilization reserve fund" established by Section 4B and similar references to that fund for consistency of terminology.

Revised Law

Sec. 2203.054. AMENDMENTS TO PLAN OF OPERATION. Amendments to the plan of operation:

(1) shall be made at the commissioner's direction; or

(2) may be made by the board of directors, subject to the commissioner's approval. (V.T.I.C. Art. 21.49-3, Sec. 3(c)(4).)

Source Law

(4) Amendments to the plan of operation may be made by the directors of the association, subject to the approval of the board, or shall be made at the direction of the board.

Revised Law

Sec. 2203.055. JOINT UNDERWRITING ASSOCIATION MEMBERSHIP. (a) The association is composed of each insurer, including a Lloyd's plan and a reciprocal or interinsurance exchange, authorized to write and writing liability insurance, including automobile liability insurance, on a direct basis in this state, other than:

(1) a farm mutual insurance company authorized under Chapter 911; and

(2) a county mutual insurance company authorized under Chapter 912.

(b) An insurer that is a member of the association must remain a member as a condition of the insurer's authority to engage in the business of the insurance described by Subsection (a).

(c) Each association member participates in the writings, expenses, and losses of the association in the proportion that the net direct premiums of the member, excluding the portion of premiums attributable to the operation of the association, written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all association members.

(d) The association shall annually determine a member's participation in the association on the basis of the net direct premiums written by the member during the preceding calendar year, as reported in the annual statements and other reports the member files as required by the department. (V.T.I.C. Art. 21.49-3, Secs. 3(a) (part), 5(b) (part).)

Source Law

Sec. 3. (a) A joint underwriting association is hereby created, consisting of all insurers authorized to write and engaged in writing, within this state, on a direct basis, automobile liability and liability other than auto insurance on or after January 1, 1975, as provided in the Insurance Code, specifically

including and applicable to Lloyds and reciprocal or interinsurance exchanges, but excluding farm mutual insurance companies as authorized by Chapter 16 of this code, and county mutual insurance companies as authorized by Chapter 17 of this code. Every such insurer shall be a member of the association and shall remain a member as a condition of its authority to continue to transact such kind of insurance in this state. . . .

[Sec. 5]

(b) All insurers which are members of the association shall participate in its writings, expenses, and losses in the proportion that the net direct premiums, as defined herein, of each such member, excluding that portion of premiums attributable to the operation of the association, written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the association. Each insurer's participation in the association shall be determined annually on the basis of such net direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the insurer that may be required by the board. . . .

Revisor's Note

(1) Section 3(a), V.T.I.C. Article 21.49-3, states that the joint underwriting association "is hereby created." The revised law omits "is hereby created" as executed.

(2) Section 3(a), V.T.I.C. Article 21.49-3, refers to an insurer authorized to write and writing insurance "as provided in the Insurance Code." The revised law omits the quoted language as unnecessary because the only authorization to write insurance in this state is provided by this code.

(3) Section 3(a), V.T.I.C. Article 21.49-3, refers to the joint underwriting association consisting of all insurers authorized to write and writing certain insurance in this state "on or after January 1, 1975." The revised law omits the quoted language as executed.

(4) Section 3(a), V.T.I.C. Article 21.49-3, refers to "Lloyds." For consistency of terminology within this code, the revised law substitutes "Lloyd's plan" for "Lloyds."

Revised Law

Sec. 2203.056. ANNUAL STATEMENT; ADDITIONAL INFORMATION. (a) Not later than March 1 of each year, the association shall file with the department a statement that contains information regarding the association's transactions, condition, operations, and affairs during the preceding calendar year.

(b) The statement must:

(1) contain the matters and information required by the department; and

(2) be in the form approved by the department.

(c) The department at any time may require the association to provide additional information regarding the association's transactions or condition, or any related matter considered to be:

(1) material; and

(2) of assistance in evaluating the scope, operation, and experience of the association. (V.T.I.C. Art. 21.49-3, Sec. 9.)

Source Law

Sec. 9. The association shall file in the office of the board, annually on or before the first day of March, a statement which shall contain information with respect to its transactions, condition, operations, and affairs during the preceding calendar year. Such statement shall contain such matters and information as are prescribed and shall be in such form as is approved by the board. The board may, at any time, require the association to furnish additional information with respect to its transactions, condition, or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation, and experience of the association.

[Sections 2203.057-2203.100 reserved for expansion]

SUBCHAPTER C. ELIGIBILITY FOR COVERAGE

Revised Law

Sec. 2203.101. GENERAL ELIGIBILITY. (a) The commissioner shall by order establish the categories of physicians and health care providers that are eligible to obtain insurance coverage from the association. The commissioner may revise the order to:

(1) include as eligible for that coverage other

categories of physicians and health care providers; or

(2) exclude from eligibility for that coverage particular categories of physicians and health care providers.

(b) If a category of physicians or health care providers is excluded from eligibility to obtain insurance coverage from the association, the commissioner may determine, after notice of at least 10 days and a hearing, that medical liability insurance is not otherwise available. On that determination, the previously excluded category is eligible to obtain insurance coverage from the association. (V.T.I.C. Art. 21.49-3, Secs. 3A(a), (b).)

Source Law

> Sec. 3A. (a) The commissioner shall establish by order the categories of physicians and health care providers who are eligible to obtain coverage from the association and may, from time to time, revise its order to include or exclude from eligibility particular categories of such physicians and health care providers.
>
> (b) If a category of physicians or health care providers has been excluded from eligibility to obtain coverage from the association, the commissioner may determine, after notice of at least 10 days and a hearing, that medical liability insurance is not available. On that determination, the category of physicians or health care providers is eligible to obtain insurance coverage from the association.

Revisor's Note

> Section 3A, V.T.I.C. Article 21.49-3, states that the commissioner of insurance may revise the order that contains categories of eligible physicians and health care providers "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."

Revised Law

Sec. 2203.102. INSURER OF LAST RESORT FOR CERTAIN NURSING HOMES AND ASSISTED LIVING FACILITIES. (a) A nursing home or assisted living facility not otherwise eligible for insurance coverage from the association under Section 2203.101 is eligible for that coverage if the home or facility demonstrates, in accordance with the requirements of the association, that the home

or facility:

(1) made a verifiable effort to obtain insurance coverage from authorized insurers and eligible surplus lines insurers; and

(2) was unable to obtain substantially equivalent insurance coverage and rates.

(b) In consultation with the Department of Aging and Disability Services, the commissioner by rule shall adopt minimum rating standards for for-profit nursing homes and for-profit assisted living facilities that must be met before a for-profit nursing home or for-profit assisted living facility may obtain insurance coverage through the association. The standards must promote the highest practical level of care for residents of the nursing homes and assisted living facilities. (V.T.I.C. Art. 21.49-3, Secs. 3A(c), (d).)

Source Law

(c) A for-profit or not-for-profit nursing home or assisted living facility not otherwise eligible under this section for coverage from the association is eligible for coverage if the nursing home or assisted living facility demonstrates, in accordance with the requirements of the association, that the nursing home or assisted living facility made a verifiable effort to obtain coverage from authorized insurers and eligible surplus lines insurers and was unable to obtain substantially equivalent coverage and rates.

(d) In consultation with the Texas Department of Human Services, the commissioner shall, by rule, adopt minimum rating standards for for-profit nursing homes and for-profit assisted living facilities that must be met before a for-profit nursing home or for-profit assisted living facility may obtain coverage through the association. The standards must promote the highest practical level of care for residents of those nursing homes and assisted living facilities.

Revisor's Note

Section 3A(d), V.T.I.C. Article 21.49-3, states that the commissioner of insurance shall consult with the "Texas Department of Human Services" to adopt rating standards for for-profit nursing homes and assisted living facilities. The Texas Department of Human Services was abolished under the provisions of

Section 1.26, Chapter 198, Acts of the 78th Legislature, Regular Session, 2003, and that act transferred the department's duties and functions to various other state agencies. That act also created the Department of Aging and Disability Services, to which the duties and functions related to the provision of services by for-profit nursing homes and assisted living facilities were transferred. Accordingly, the revised law substitutes "Department of Aging and Disability Services" for "Texas Department of Human Services."

Revised Law

Sec. 2203.103. ELIGIBILITY OF OTHER HEALTH CARE PRACTITIONERS AND FACILITIES. (a) In this section:

(1) "Health care" includes a medical or health care service, including an examination, treatment, medical diagnosis, or evaluation, and care provided in an inpatient, outpatient, or residential setting.

(2) "Health care facility" means a facility providing health care, other than a facility described by Section 2203.002(4).

(3) "Health care practitioner" means an individual, other than an individual described by Section 2203.002(4), who:

(A) is licensed to provide health care; or

(B) is not licensed to provide health care but provides health care under the direction or supervision of a licensed individual.

(b) After notice and opportunity for hearing, the commissioner may:

(1) determine that appropriate liability insurance coverage written by insurers authorized to engage in business in this state is not reasonably available to a type of health care practitioner or health care facility; and

(2) by order designate that type of health care

practitioner or health care facility to be included as a health care provider eligible to receive coverage under this chapter.

(c) A health care practitioner or facility designated under Subsection (b) is entitled to receive insurance coverage under this chapter in accordance with Chapter 1901 in the same manner as other health care providers described by Section 2203.002 and Section 1901.001.

(d) The commissioner's order may indicate whether a health care practitioner or facility designated under Subsection (b) is included under the policyholder's stabilization reserve fund established under Section 2203.301 or 2203.303 or whether a separate policyholder's stabilization reserve fund is created. A separate policyholder's stabilization reserve fund established under this subsection operates in the same manner as a policyholder's stabilization reserve fund created under Section 2203.303. (V.T.I.C. Art. 21.49-3, Sec. 3B.)

Source Law

Sec. 3B. (a) In this section:

(1) "Health care" includes any medical or health care service, including an examination, treatment, medical diagnosis, or evaluation, and care provided in an inpatient, outpatient, or residential setting.

(2) "Health care facility" means a facility providing health care, other than a facility described by Section 2(6) of this article.

(3) "Health care practitioner" means an individual, other than an individual described by Section 2(6) of this article, who:

(A) is licensed to provide health care; or

(B) is not licensed to provide health care but provides health care under the direction or supervision of a licensed individual.

(b) After notice and opportunity for hearing, the commissioner may:

(1) determine that appropriate liability insurance coverage written by insurers authorized to engage in business in this state is not reasonably available to a type of health care practitioner or health care facility; and

(2) by order designate that type of health care practitioner or health care facility to be included as a health care provider eligible to receive coverage under this article.

(c) A health care practitioner or facility designated under Subsection (b) of this section is entitled to receive coverage provided under this article in accordance with Article 5.15-1 of this code in the same manner as other health care providers

described by Section 2 of this article and Section 2, Article 5.15-1, of this code.

(d) The commissioner's order may indicate whether a health care practitioner or facility designated under Subsection (b) of this section is included under the policyholder's stabilization reserve fund established under Section 4A or 4B of this article or whether a separate policyholder's stabilization reserve fund is created. A separate policyholder's stabilization reserve fund established under this subsection operates in the same manner as a stabilization reserve fund created under Section 4B of this article.

Revisor's Note

Section 3B(c), V.T.I.C. Article 21.49-3, refers to insurance coverage provided under V.T.I.C. Article 5.15-1. The relevant provisions of that article are revised in Chapter 1901 of this code. Although Chapter 1901 contains provisions that are derived from V.T.I.C. Article 5.15-4, the revised law substitutes a reference to Chapter 1901 in its entirety for the reference to Article 5.15-1. Article 5.15-1 applies to professional liability insurance for physicians and health care providers, including the setting of rates for that kind of insurance. Section 2(2), Article 5.15-1, defines "health care provider" to include a nursing home. Article 5.15-4 in part governs the consideration of best practices for nursing homes in setting rates for professional liability insurance for nursing homes. Because both Articles 5.15-1 and 5.15-4 apply to the setting of rates for professional liability insurance for nursing homes and the articles must, therefore, be read in conjunction with respect to that kind of insurance, it is appropriate to substitute a reference to Chapter 1901 for the references to Article 5.15-1.

Revised Law

Sec. 2203.104. APPLICATION FOR COVERAGE. (a) A health care provider or physician included in a category eligible for insurance coverage by the association is entitled to apply to the

association for the coverage. An agent authorized under Chapter 4051 may apply on behalf of an applicant.

(b) The association shall issue a medical liability insurance policy to an applicant:

(1) if the association determines that:

(A) the applicant meets the underwriting standards of the association prescribed by the plan of operation; and

(B) there is no unpaid and uncontested premium, policyholder's stabilization reserve fund charge, or assessment due from the applicant for prior insurance, as shown by the insured's failure to pay or to object in writing to the charges on or before the 30th day after the date of the billing; and

(2) on receipt of the premium and the policyholder's stabilization reserve fund charge, or the portion of the premium and charge prescribed by the plan of operation. (V.T.I.C. Art. 21.49-3, Secs. 4(a)(1), (2) (part).)

Source Law

> Sec. 4. (a)(1) Any health care provider or physician included in one of the categories of health care providers eligible for coverage by the association shall, on or after the effective date of the plan of operation, be entitled to apply to the association for such coverage. Such application may be made on behalf of an applicant by an agent authorized pursuant to Article 21.14 of this code.
>
> (2) If the association determines that the applicant meets the underwriting standards of the association as prescribed in the plan of operation and there is no unpaid, uncontested premium, policyholder stabilization reserve fund charge, or assessment due from the applicant for prior insurance (as shown by the insured having failed to pay or make written objection to such charges within 30 days after billing) then the association, upon receipt of the premium and the policyholder stabilization reserve fund charge, or such portion thereof as is prescribed in the plan of operation, shall cause to be issued a policy of medical liability insurance . . . .

Revisor's Note

Section 4(a)(1), V.T.I.C. Article 21.49-3, entitles certain health care providers and physicians to apply to the joint underwriting association for insurance coverage "on or after the effective date of

the plan of operation." The revised law omits the quoted language as executed.

[Sections 2203.105-2203.150 reserved for expansion]

SUBCHAPTER D. ASSOCIATION COVERAGE

Revised Law

Sec. 2203.151. POWERS RELATING TO MEDICAL LIABILITY INSURANCE COVERAGE. (a) Under this chapter and the plan of operation, the association, on behalf of the association members, may:

(1) issue, or cause to be issued, medical liability insurance policies to applicants, including primary, excess, and incidental coverages, subject to the limits specified in the plan of operation and Section 2203.152;

(2) underwrite medical liability insurance and adjust and pay losses related to that insurance, or appoint servicing insurers to perform those functions;

(3) either or both accept and refuse the assumption of reinsurance from association members; and

(4) cede and purchase reinsurance.

(b) The association may provide general liability insurance coverage to be issued in connection with medical liability insurance issued by the association. (V.T.I.C. Art. 21.49-3, Secs. 3(b) (part), (d).)

Source Law

(b) The association shall, pursuant to the provisions of this article and the plan of operation with respect to medical liability insurance, have the power on behalf of its members:

(1) to issue, or to cause to be issued, policies of insurance to applicants, including primary, excess, and incidental coverages and subject to limits as specified in the plan of operation; . . .;

(2) to underwrite such insurance and to adjust and pay losses with respect thereto, or to appoint service companies to perform those functions;

(3) to either or both accept and refuse the assumption of reinsurance from its members; and

(4) to cede and purchase reinsurance.

(d) The association may provide general liability insurance coverage to be issued in connection with medical liability insurance issued by the association.

Revised Law

Sec. 2203.152. POLICY LIMITS. The association may not issue one or more policies insuring an individual or organization for an amount exceeding $1 million for each occurrence and $3 million in the aggregate for a year. (V.T.I.C. Art. 21.49-3, Sec. 3(b) (part).)

Source Law

> (b) . . .
>
> (1) . . . provided that no individual or organization may be insured by policies issued by the association for an amount exceeding a total of $1 million per occurrence and $3 million aggregate per annum;
>
> . . .

Revised Law

Sec. 2203.153. FOLLOWING FORM EXCESS LIABILITY COVERAGE. Excess liability insurance coverage written for a physician or health care provider by the association under this chapter must be written as following form excess liability insurance to the physician's or provider's primary insurance coverage. (V.T.I.C. Art. 21.49-3, Sec. 4(c).)

Source Law

> (c) Excess insurance coverage written for a health care provider or a physician by the association under this article shall be written on a following form basis to the primary insurance coverage of that health care provider.

Revised Law

Sec. 2203.154. PUNITIVE DAMAGES EXCLUDED. The association may not issue or renew a medical liability insurance policy for a physician or health care provider under this chapter that includes coverage for punitive damages assessed against the physician or health care provider. (V.T.I.C. Art. 21.49-3, Sec. 4(d).)

Source Law

> (d) A policy of medical liability insurance issued to or renewed for a physician or health care provider by the association under this article may not include coverage for punitive damages assessed against the physician or health care provider.

Revised Law

Sec. 2203.155. INSTALLMENT PLAN. The association may offer

an installment payment plan for insurance coverage obtained through the association. (V.T.I.C. Art. 21.49-3, Sec. 4(e).)

Source Law

> (e) The association may offer an installment payment plan for coverage obtained through the association.

Revised Law

Sec. 2203.156. TERM OF POLICY; NOTICE OF CERTAIN CHANGES. (a) A policy issued by the association must be for a term of one year or less, as determined by the association.

(b) Section 1901.253 does not apply to a medical liability insurance policy issued by the association for a term of less than one year.

(c) The association shall ensure that appropriate written notice is provided to the insured for a policy described by Subsection (b) if the association intends to:

(1) increase the premiums on the policy; or

(2) cancel or not renew the policy for a reason other than for nonpayment of premiums or because the insured is no longer licensed. (V.T.I.C. Art. 21.49-3, Secs. 4(a)(2) (part), (f).)

Source Law

> [(a)]
>
> (2) . . . [then the association] . . . shall cause to be issued a policy of medical liability insurance for a term of one year or less, as determined by the association.
>
> (f) Section 7, Article 5.15-1 of this code, does not apply to a medical liability insurance policy issued by the association for a term of less than one year. With respect to a policy subject to this subsection, the association shall ensure that appropriate written notice is provided to an insured if premiums are increased or the policy is to be canceled or is not to be renewed other than for nonpayment of premiums or because the insured is no longer licensed.

[Sections 2203.157-2203.200 reserved for expansion]

SUBCHAPTER E. RATES AND POLICY FORMS

Revised Law

Sec. 2203.201. APPLICABILITY OF OTHER LAW TO RATES AND POLICY FORMS. (a) Except as provided by Subsection (b) and subject

to Section 2203.203, the following laws govern the rates, rating plans, rating rules, rating classifications, territories, and policy forms applicable to the insurance written by the association and related statistics:

(1) Section 36.002(1);

(2) Subchapter B, Chapter 5;

(3) Subchapters A and C, Chapter 1806;

(4) Subchapter A, Chapter 2301;

(5) Chapter 251, as that chapter relates to casualty insurance and fidelity, guaranty, and surety bond insurance;

(6) Chapter 253;

(7) Chapters 2251 and 2252; and

(8) Subtitle B.

(b) If a provision of a law described by Subsections (a)(1)-(8) conflicts with a provision of this chapter, this chapter prevails. (V.T.I.C. Art. 21.49-3, Sec. 4(b)(1) (part).)

Source Law

> (b)(1) Subject to Subdivision (6) of this subsection, the rates, rating plans, rating rules, rating classification, territories, and policy forms applicable to the insurance written by the association and statistics relating thereto shall be subject to Subchapter B of Chapter 5 of the Insurance Code, as amended, . . . provided, that if any article of the above subchapter is in conflict with any provision of this Act, this Act shall prevail. . . .

Revisor's Note

Section 4(b)(1), V.T.I.C. Article 21.49-3, refers to Subchapter B, V.T.I.C. Chapter 5, "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 a statute applies to all reenactments, revisions, or amendments of the statute.

Revised Law

Sec. 2203.202. RATE STANDARDS. (a) In determining rates, rating plans, rating rules, rating classifications, territories,

and policy forms, the association shall consider:

(1) the past and prospective loss and expense experience for medical professional liability insurance, inside and outside this state, of all of the association members;

(2) trends in the frequency and severity of losses;

(3) the association's investment income; and

(4) other information the commissioner may require.

(b) Rates, rating plans, and rating rules must be based on:

(1) the association's loss and expense experience; and

(2) other information based on that experience the department considers appropriate.

(c) The resultant premium rates must be:

(1) actuarially sound; and

(2) computed to be self-supporting. (V.T.I.C. Art. 21.49-3, Secs. 4(b)(1) (part), (4) (part).)

Source Law

> (1) . . . the rates, rating plans, rating rules, rating classification, territories, and policy forms applicable to the insurance written by the association . . . [shall be subject to Subchapter B of Chapter 5] . . . giving due consideration to the past and prospective loss and expense experience for medical professional liability insurance within and without this state of all of the member companies of the association, trends in the frequency and severity of losses, the investment income of the association, and such other information as the commissioner may require; . . . .
>
> (4) After the initial year of operation, rates, rating plans, and rating rules, and . . . should be based upon the association's loss and expense experience, together with such other information based upon such experience as the department may deem appropriate. The resultant premium rates shall be on an actuarially sound basis and shall be calculated to be self-supporting.

Revisor's Note

(1) Section 4(b)(1), V.T.I.C. Article 21.49-3, states that for-profit nursing homes and assisted living facilities are subject to the same requirements under V.T.I.C. Article 5.15-1 as not-for-profit nursing homes and assisted living facilities. The revised law omits the statement because Article 5.15-1

applies by its own terms to those nursing homes and assisted living facilities. Before 2001, Article 5.15-1 applied to not-for-profit nursing homes. Section 2(2), Article 5.15-1, was amended in 2001 by Chapter 1284, Acts of the 77th Legislature, Regular Session, to apply to for-profit and not-for-profit nursing homes. That section was amended again in 2003 by Chapter 141, Acts of the 78th Legislature, Regular Session, to apply to for-profit and not-for-profit nursing homes and assisted living facilities. The omitted law reads:

> (1) . . . For purposes of this article, rates, rating plans, rating rules, rating classifications, territories, and policy forms for for-profit nursing homes and for-profit assisted living facilities are subject to the requirements of Article 5.15-1 of this code to the same extent as not-for-profit nursing homes and not-for-profit assisted living facilities.

(2) Section 4(b)(4), V.T.I.C. Article 21.49-3, refers to the information on which the joint underwriting association relies in making rates "[a]fter the initial year of operation." V.T.I.C. Article 21.49-3 was enacted by Chapter 331, Acts of the 64th Legislature, Regular Session, 1975, and the joint underwriting association was established by that act on the act's effective date of June 3, 1975. Accordingly, the revised law omits the reference as executed.

Revised Law

Sec. 2203.203. DISCOUNT FOR CERTAIN HEALTH CARE PROVIDERS. (a) The rates applicable to professional liability insurance coverage provided by the association for not-for-profit nursing homes and not-for-profit assisted living facilities must reflect a discount of 30 percent from the rates for the same coverage provided to others in the same category of insureds.

(b) The commissioner shall ensure compliance with this

section. (V.T.I.C. Art. 21.49-3, Sec. 4(b)(6).)

Source Law

(6) The rates applicable to professional liability insurance provided by the association that cover nursing homes and assisted living facilities that are not for profit must reflect a discount of 30 percent from the rates for the same coverage provided to others in the same category of insureds. The commissioner shall ensure compliance with this subdivision.

[Sections 2203.204-2203.250 reserved for expansion]

SUBCHAPTER F. FINANCIAL PARTICIPATION BY MEMBERS AND POLICYHOLDERS

Revised Law

Sec. 2203.251. DEFICIT RECOUPMENT. (a) This section applies to a deficit sustained in a single year by the association with respect to:

(1) physicians and health care providers, other than nursing homes and assisted living facilities; or

(2) a nursing home or assisted living facility.

(b) The deficit must be recouped in accordance with the plan of operation and the rating plan in effect when the deficit is sustained under one or more of the following procedures, in this sequence:

(1) a contribution from the policyholder's stabilization reserve fund established under Section 2203.301 or the policyholder's stabilization reserve fund established under Section 2203.303, as appropriate, until the respective fund is exhausted;

(2) an assessment on the policyholders in accordance with Section 2203.252; or

(3) an assessment on the members in accordance with Sections 2203.055(c) and (d) and 2203.253. (V.T.I.C. Art. 21.49-3, Sec. 4(b)(3) (part).)

Source Law

(3) Any deficit sustained by the association with respect to physicians and health care providers, other than for-profit and not-for-profit nursing homes and assisted living facilities, or by for-profit and not-for-profit nursing homes and assisted living facilities in any one year shall be

recouped, pursuant to the plan of operation and the rating plan then in effect, by one or more of the following procedures in this sequence:

First, a contribution from the policyholder's stabilization reserve fund for physicians and health care providers, other than for-profit and not-for-profit nursing homes and assisted living facilities, established under Section 4A of this article or from the stabilization reserve fund for for-profit and not-for-profit nursing homes and assisted living facilities, established under Section 4B of this article, as appropriate, until the respective fund is exhausted;

Second, an assessment upon the policyholders pursuant to Section 5(a) of this article;

Third, an assessment upon the members pursuant to Section 5(b) of this article. . . .

Revised Law

Sec. 2203.252. ASSESSMENT OF POLICYHOLDERS FOR DEFICIT RECOUPMENT. (a) Each policyholder within the group of physicians and health care providers, other than nursing homes and assisted living facilities, or within the group of nursing homes and assisted living facilities, has contingent liability for a proportionate share of an assessment made under this chapter of policyholders in the applicable group.

(b) If a deficit, as computed under the plan of operation, is sustained with respect to a group described by Subsection (a) in a single year, the board of directors shall levy an assessment only on the policyholders in the applicable group who held policies in force at any time during the two most recently completed calendar years:

(1) before the date the assessment is levied; and

(2) in which the association was issuing policies.

(c) The aggregate amount of an assessment under Subsection (b) must be equal to the amount of the deficit not recouped under Section 2203.251(b)(1) from the applicable policyholder's stabilization reserve fund. Subject to Subsection (d), each policyholder in the applicable group shall be assessed for a portion of the deficit that reflects the proportion that the earned premium on the policies of that policyholder bears to the total earned premium for all policies of the association in the applicable group in the two most recently completed calendar years.

(d) The maximum aggregate assessment on each policyholder in the applicable group may not exceed the annual premium for the liability insurance policy most recently in effect. (V.T.I.C. Art. 21.49-3, Sec. 5(a).)

Source Law

> Sec. 5. (a) Each policyholder within the group of physicians and health care providers, other than for-profit and not-for-profit nursing homes and assisted living facilities, or within the group of for-profit and not-for-profit nursing homes and assisted living facilities shall have contingent liability for a proportionate share of any assessment of policyholders in the applicable group made under the authority of this article. Whenever a deficit, as calculated pursuant to the plan of operation, is sustained with respect to the group of physicians and health care providers, other than for-profit and not-for-profit nursing homes and assisted living facilities, or the group of for-profit and not-for-profit nursing homes and assisted living facilities in any one year, its directors shall levy an assessment only upon those policyholders in the applicable group who held policies in force at any time within the two most recently completed calendar years in which the association was issuing policies preceding the date on which the assessment was levied. The aggregate amount of the assessment shall be equal to that part of the deficit not recouped from the applicable stabilization reserve fund. The maximum aggregate assessment per policyholder in the applicable group shall not exceed the annual premium for the liability policy most recently in effect. Subject to such maximum limitation, each policyholder in the applicable group shall be assessed for that portion of the deficit reflecting the proportion which the earned premium on the policies of such policyholder bears to the total earned premium for all policies of the association in the applicable group in the two most recently completed calendar years.

Revisor's Note

Section 5(a), V.T.I.C. Article 21.49-3, refers to deficit recoupment from the policyholder's stabilization reserve fund. Section 4(b)(3), V.T.I.C. Article 21.49-3, the relevant part of which is revised in this chapter as Section 2203.251(b)(1), provides for the recoupment of a deficit from the policyholder's stabilization reserve fund. The revised law adds a cross-reference to Section 2203.251(b)(1) for the convenience of the reader.

Revised Law

Sec. 2203.253. LIMITATION ON REIMBURSEMENT BY MEMBER FOR DEFICIT RECOUPMENT. (a) An association member is not obligated in a single year to reimburse the association for the member's proportionate share of the deficits from the association's operations in that year in an amount that exceeds one percent of the member's policyholder surplus. The aggregate amount not reimbursed in accordance with this subsection shall be reallocated among the other association members. The association shall reallocate that amount in accordance with the method of determining a member's participation under Sections 2203.055(c) and (d), after excluding the total net direct premiums of all members not sharing in the excess deficits.

(b) If the deficits from the association's operations allocated to all association members in a calendar year exceed one percent of all members' respective policyholder surplus, the association shall allocate to each member the amount of the deficits in accordance with the method of determining a member's participation under Sections 2203.055(c) and (d). (V.T.I.C. Art. 21.49-3, Sec. 5(b) (part).)

Source Law

> (b) . . . No member shall be obligated in any one year to reimburse the association on account of its proportionate share in the deficits from operations of the association in that year in excess of one percent of its surplus to policyholders and the aggregate amount not so reimbursed shall be reallocated among the remaining members in accordance with the method of determining participation prescribed in this subdivision, after excluding from the computation the total net direct premiums of all members not sharing in such excess deficits. In the event that the deficits from operations allocated to all members of the association in any calendar year shall exceed one percent of their respective surplus to policyholders, the amount of such deficits shall be allocated to each member in accordance with the method of determining participation prescribed in this subdivision.

Revised Law

Sec. 2203.254. CONTRIBUTION BY MEMBERS FOR SOUND FINANCIAL OPERATION. If sufficient funds are not available for the sound financial operation of the association, each association member

shall contribute to the financial requirements of the association in accordance with Sections 2203.055(c) and (d), 2203.252, and 2203.253, as authorized and considered necessary by the department. A contribution under this section is in addition to:

(1) an assessment paid in accordance with the plan of operation under Section 2203.053(b); and

(2) a contribution from a policyholder's stabilization reserve fund. (V.T.I.C. Art. 21.49-3, Sec. 4(b)(5) (part).)

Source Law

> (5) In the event that sufficient funds are not available for the sound financial operation of the association, in addition to assessments paid pursuant to the plan of operation in accordance with Section 3(c)(2) of this article and contributions from the policyholder's stabilization reserve fund, all members shall, on a basis authorized by the department, as long as the department deems it necessary, contribute to the financial requirements of the association in the manner provided for in Section 5. . . .

Revised Law

Sec. 2203.255. REIMBURSEMENT OF ASSESSMENT OR CONTRIBUTION; PREMIUM TAX CREDIT. (a) Subject to commissioner approval, the association shall reimburse an assessment or contribution, with interest at a rate approved by the commissioner, to:

(1) the association members; or

(2) the state, to the extent that the members have recouped their assessments using premium tax credits as provided by Subsection (c).

(b) Pending recoupment or reimbursement of an assessment or contribution paid by a member to the association, the unrepaid balance of the assessment or contribution may be reflected in the member's books and records as an admitted asset of the member for all purposes, including exhibition in an annual statement under Section 862.001.

(c) To the extent a member has paid one or more assessments and has not received reimbursement from the association in accordance with Subsection (a), a credit against premium taxes

under Chapter 221 is allowed at a rate of 20 percent a year for five successive years following the year in which the deficit was sustained. At the member's option, the tax credit may be taken over an additional number of years. (V.T.I.C. Art. 21.49-3, Secs. 4(b)(3) (part), (5) (part).)

Source Law

> (3) . . . To the extent a member has paid one or more assessments and has not received reimbursement from the association in accordance with Subdivision (5) of this subsection, a credit against premium taxes under Article 4.10 of this code, as amended, shall be allowed. The tax credit shall be allowed at a rate of 20 percent per year for five successive years following the year in which said deficit was sustained and at the option of the insurer may be taken over an additional number of years.
>
> (5) . . . Any assessment or contribution shall be reimbursed to the members, or to the state to the extent that the members have recouped their assessments using premium tax credits as provided under Subsection (b)(3) of this section, with interest at a rate to be approved by the commissioner, subject to the approval of the commissioner. Pending recoupment or reimbursement of assessments or contributions paid to the association by a member, the unrepaid balance of such assessments and contributions 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 pursuant to Section 862.001 of this code.

Revisor's Note

Section 4(b)(3), V.T.I.C. Article 21.49-3, refers to "Article 4.10 of this code, as amended." The revised law omits "as amended" for the reason stated in the revisor's note to Section 2203.201.

Revised Law

Sec. 2203.256. STANDARDS FOR RECOUPMENT PROVISIONS. A provision for recoupment must be based on:

(1) the association's loss and expense experience; and

(2) other information based on that experience the department considers appropriate. (V.T.I.C. Art. 21.49-3, Sec. 4(b)(4) (part).)

Source Law

> (4) . . . any provision for recoupment should be based upon the association's loss and expense experience, together with such other information based

upon such experience as the department may deem appropriate. . . .

[Sections 2203.257-2203.300 reserved for expansion]

SUBCHAPTER G. POLICYHOLDER'S STABILIZATION RESERVE FUNDS

Revised Law

Sec. 2203.301. POLICYHOLDER'S STABILIZATION RESERVE FUND FOR PHYSICIANS AND CERTAIN HEALTH CARE PROVIDERS. (a) The policyholder's stabilization reserve fund for physicians and health care providers other than nursing homes and assisted living facilities is collected and administered by the association as provided by this section, Section 2203.302, and the plan of operation.

(b) The policyholder's stabilization reserve fund shall be:

(1) credited with all policyholder's stabilization reserve fund charges collected under Section 2203.302;

(2) charged with any deficit sustained by physicians and health care providers, other than nursing homes and assisted living facilities, from the association's operation during the previous year;

(3) treated as a liability of the association along with, and in the same manner as, premium and loss reserves; and

(4) valued annually by the board of directors as of the close of the preceding year. (V.T.I.C. Art. 21.49-3, Secs. 4A(a) (part), (c), (e).)

Source Law

Sec. 4A. (a) There is hereby created a policyholder's stabilization reserve fund for physicians and health care providers, other than for-profit and not-for-profit nursing homes and assisted living facilities, which shall be administered as provided herein and in the plan of operation of the association. . . .

(c) The stabilization reserve fund shall be collected and administered by the association and shall be treated as a liability of the association along with and in the same manner as premium and loss reserves. The fund shall be valued annually by the board of directors as of the close of the last preceding year.

(e) The stabilization reserve fund shall be credited with all stabilization reserve fund charges collected from physicians and health care providers,

other than for-profit and not-for-profit nursing homes and assisted living facilities, and shall be charged with any deficit sustained by physicians and health care providers, other than for-profit and not-for-profit nursing homes and assisted living facilities, from the prior year's operation of the association.

Revisor's Note

(1) Section 4A(a), V.T.I.C. Article 21.49-3, states that "[t]here is hereby created a policyholder's stabilization reserve fund." The revised law omits the language as executed.

(2) Section 4A(c), V.T.I.C. Article 21.49-3, refers to the "last preceding year." The revised law omits "last" as unnecessary. "The preceding" means "the last preceding."

Revised Law

Sec. 2203.302. POLICYHOLDER'S STABILIZATION RESERVE FUND CHARGE FOR PHYSICIANS AND CERTAIN HEALTH CARE PROVIDERS. (a) Each policyholder other than a nursing home or assisted living facility shall pay annually into the policyholder's stabilization reserve fund under Section 2203.301 a charge that:

(1) is in an amount established annually by advisory directors chosen by physicians and health care providers, other than nursing homes and assisted living facilities, eligible for insurance through the association in accordance with the plan of operation;

(2) is in proportion to each premium payment due for liability insurance through the association; and

(3) is separately stated in the policy.

(b) A charge stated in a policy as required by Subsection (a)(3) is not:

(1) a part of premiums; or

(2) subject to premium taxation or a servicing fee, acquisition cost, or any other similar charge.

(c) If the association offers an installment payment plan for coverage obtained through the association, the association may:

(1) permit payment of the policyholder's stabilization reserve fund charge under this section on an installment basis; or

(2) require the policyholder to pay the charge as an annual lump sum.

(d) Collections of the policyholder's stabilization reserve fund charge under this section shall continue until the net balance of the policyholder's stabilization reserve fund under Section 2203.301 is not less than the projected sum of premiums for physicians and health care providers, other than nursing homes and assisted living facilities, to be written in the year following the valuation date. (V.T.I.C. Art. 21.49-3, Secs. 4A(b), as amended Acts 78th Leg., R.S., Chs. 56, 141, (d).)

Source Law

(b) [as amended Acts 78th Leg., R.S., Ch. 56] Each policyholder shall pay annually into the stabilization reserve fund a charge, the amount of which shall be established annually by advisory directors chosen by health care providers, other than for-profit and not-for-profit nursing homes, and physicians eligible for insurance in the association in accordance with the plan of operation. The charge shall be in proportion to each premium payment due for liability insurance through the association. Such charge shall be separately stated in the policy, but shall not constitute a part of premiums or be subject to premium taxation, servicing fees, acquisition costs, or any other such charges. If the association offers an installment payment plan for coverage obtained through the association, the association may permit payment of the stabilization reserve fund charge on an installment basis or may require the policyholder to pay the charge as an annual lump sum.

(b) [as amended Acts 78th Leg., R.S., Ch. 141] Each policyholder shall pay annually into the stabilization reserve fund a charge, the amount of which shall be established annually by advisory directors chosen by health care providers, other than for-profit and not-for-profit nursing homes and assisted living facilities, and physicians eligible for insurance in the association in accordance with the plan of operation. The charge shall be in proportion to each premium payment due for liability insurance through the association. Such charge shall be separately stated in the policy, but shall not constitute a part of premiums or be subject to premium taxation, servicing fees, acquisition costs, or any other such charges.

(d) Collections of the stabilization reserve fund charge shall continue until such time as the net balance of the stabilization reserve fund is not less than the projected sum of premiums for physicians and health care providers, other than for-profit and

not-for-profit nursing homes and assisted living facilities, to be written in the year following valuation date.

Revised Law

Sec. 2203.303. POLICYHOLDER'S STABILIZATION RESERVE FUND FOR NURSING HOMES AND ASSISTED LIVING FACILITIES. (a) The policyholder's stabilization reserve fund for nursing homes and assisted living facilities is collected and administered by the association as provided by this section, Section 2203.304, and the plan of operation.

(b) The policyholder's stabilization reserve fund shall be:

(1) credited with:

(A) all policyholder's stabilization reserve fund charges collected under Section 2203.304; and

(B) the net earnings on liability insurance policies issued to nursing homes and assisted living facilities;

(2) charged with any deficit sustained by nursing homes and assisted living facilities from the association's operation during the previous year;

(3) treated as a liability of the association along with, and in the same manner as, premium and loss reserves; and

(4) valued annually by the board of directors as of the close of the preceding year.

(c) The policyholder's stabilization reserve fund under this section, and any earnings of the fund, are state funds and shall be held by the comptroller outside the state treasury on behalf of, and with legal title in, the department. No part of the fund or the earnings of the fund may inure to the benefit of an association member, a policyholder, or another individual. The fund assets may be used in accordance with the association's plan of operation only to implement this chapter and for the purposes of the association, including to make payment to satisfy, wholly or partly, the liability of the association regarding a claim made on a policy written by the association.

(d) Notwithstanding Sections 11, 12, and 13, Article

21.49-3, the policyholder's stabilization reserve fund under this section may be terminated only by law.

(e) Notwithstanding Section 11, Article 21.49-3, on termination of the policyholder's stabilization reserve fund under this section, all assets of the fund shall be transferred to the general revenue fund to be appropriated for purposes related to ensuring the provision of the kinds of liability insurance coverage that the association may provide under this chapter to nursing homes and assisted living facilities. (V.T.I.C. Art. 21.49-3, Secs. 4B(a) (part), (c), (e), (f), (g), (h).)

Source Law

> Sec. 4B. (a) There is hereby created a stabilization reserve fund for for-profit and not-for-profit nursing homes and assisted living facilities that shall be administered as provided in this section and in the plan of operation of the association. . . .
>
> (c) The stabilization reserve fund shall be collected and administered by the association and shall be treated as a liability of the association along with and in the same manner as premium and loss reserves. The fund shall be valued annually by the board of directors as of the close of the last preceding year.
>
> (e) The stabilization reserve fund shall be credited with all stabilization reserve fund charges collected from for-profit and not-for-profit nursing homes and assisted living facilities and the net earnings on liability insurance policies issued to for-profit and not-for-profit nursing homes and assisted living facilities and shall be charged with any deficit sustained by for-profit and not-for-profit nursing homes and assisted living facilities from the prior year's operation of the association.
>
> (f) The stabilization reserve fund established under this section, and any earnings of the fund, are state funds and shall be held by the comptroller outside the state treasury on behalf of, and with legal title in, the department. No part of the fund, or the earnings of the fund, may inure to the benefit of a member of the association, a policyholder, or any other individual, and the assets of the fund may be used in accordance with the association's plan of operation only to implement this article and for the purposes of the association, including making payment to satisfy, in whole or in part, the liability of the association regarding a claim made on a policy written by the association.
>
> (g) Notwithstanding Sections 11, 12, and 13 of this article, the stabilization reserve fund established under this section may be terminated only by law.
>
> (h) Notwithstanding Section 11 of this article, on termination of the stabilization reserve fund

established under this section, all assets of the fund shall be transferred to the general revenue fund to be appropriated for purposes related to ensuring the kinds of liability insurance coverage that may be provided by the association under this article for for-profit and not-for-profit nursing homes and assisted living facilities.

Revisor's Note

(1) Section 4B(a), V.T.I.C. Article 21.49-3, states that "[t]here is hereby created a stabilization reserve fund" for for-profit and not-for-profit nursing homes and assisted living facilities. The revised law omits the language as executed.

(2) Section 4B(c), V.T.I.C. Article 21.49-3, refers to the "last preceding year." The revised law omits "last" for the reason stated in Revisor's Note (2) to Section 2203.301.

Revised Law

Sec. 2203.304. POLICYHOLDER'S STABILIZATION RESERVE FUND CHARGE FOR NURSING HOMES AND ASSISTED LIVING FACILITIES. (a) Each policyholder that is a nursing home or assisted living facility shall pay annually into the policyholder's stabilization reserve fund under Section 2203.303 a charge that:

(1) is in an amount established annually by advisory directors chosen by nursing homes and assisted living facilities eligible for insurance through the association in accordance with the plan of operation;

(2) is in proportion to each premium payment due for liability insurance through the association; and

(3) is separately stated in the policy.

(b) A charge stated in a policy as required by Subsection (a)(3) is not:

(1) a part of premiums; or

(2) subject to premium taxation or a servicing fee, acquisition cost, or any other similar charge.

(c) If the association offers an installment payment plan for coverage obtained through the association, the association may:

(1) permit payment of the policyholder's stabilization reserve fund charge under this section on an installment basis; or

(2) require the policyholder to pay the charge as an annual lump sum.

(d) Collections of the policyholder's stabilization reserve fund charge under this section shall continue only until the net balance of the policyholder's stabilization reserve fund under Section 2203.303 is not less than the projected sum of premiums for nursing homes and assisted living facilities to be written in the year following the valuation date. (V.T.I.C. Art. 21.49-3, Secs. 4B(b), as amended Acts 78th Leg., R.S., Chs. 56, 141, (d).)

Source Law

(b) [as amended Acts 78th Leg., R.S., Ch. 56] Each policyholder shall pay annually into the stabilization reserve fund a charge, the amount of which shall be established annually by advisory directors chosen by for-profit and not-for-profit nursing homes eligible for insurance in the association in accordance with the plan of operation. The charge shall be in proportion to each premium payment due for liability insurance through the association. The charge shall be separately stated in the policy, but shall not constitute a part of premiums or be subject to premium taxation, servicing fees, acquisition costs, or any other similar charges. If the association offers an installment payment plan for coverage obtained through the association, the association may permit payment of the stabilization reserve fund charge on an installment basis or may require the policyholder to pay the charge as an annual lump sum.

(b) [as amended Acts 78th Leg., R.S., Ch. 141] Each policyholder shall pay annually into the stabilization reserve fund a charge, the amount of which shall be established annually by advisory directors chosen by for-profit and not-for-profit nursing homes and assisted living facilities eligible for insurance in the association in accordance with the plan of operation. The charge shall be in proportion to each premium payment due for liability insurance through the association. The charge shall be separately stated in the policy, but shall not constitute a part of premiums or be subject to premium taxation, servicing fees, acquisition costs, or any other similar charges.

(d) Collections of the stabilization reserve fund charge shall continue only until such time as the net balance of the stabilization reserve fund is not less than the projected sum of premiums for for-profit and not-for-profit nursing homes and assisted living facilities to be written in the year following the valuation date.

Revised Law

Sec. 2203.305. SEPARATE FUNDS. The policyholder's stabilization reserve fund for physicians and health care providers other than nursing homes and assisted living facilities described by Section 2203.301 is separate from the policyholder's stabilization reserve fund for nursing homes and assisted living facilities described by Section 2203.303. (V.T.I.C. Art. 21.49-3, Secs. 4A(a) (part), 4B(a) (part).)

Source Law

> Sec. 4A. (a) . . . The stabilization reserve fund created by this section is separate and distinct from the stabilization reserve fund for for-profit and not-for-profit nursing homes and assisted living facilities created by Section 4B of this article.
>
> Sec. 4B. (a) . . . The stabilization reserve fund created by this section is separate and distinct from the policyholder's stabilization reserve fund for physicians and health care providers, other than for-profit and not-for-profit nursing homes and assisted living facilities, created by Section 4A of this article.

Revisor's Note

Sections 4A(a) and 4B(a), V.T.I.C. Article 21.49-3, refer to "separate and distinct" funds. The revised law omits the references to "distinct" because "distinct" is included in the meaning of "separate."

[Sections 2203.306-2203.350 reserved for expansion]

SUBCHAPTER H. REVENUE BOND PROGRAM

Revised Law

Sec. 2203.351. PURPOSE. The legislature finds that the issuance of bonds to provide a method to raise funds to provide professional liability insurance for nursing homes and assisted living facilities in this state through the association is to benefit the public and to further a public purpose. (V.T.I.C. Art. 21.49-3d, Sec. 1.)

Source Law

> Art. 21.49-3d
>
> Sec. 1. The legislature finds that the issuance of bonds to provide a method to raise funds to provide professional liability insurance through the association for nursing homes and assisted living

facilities in this state is for the benefit of the public and in furtherance of a public purpose.

Revised Law

Sec. 2203.352. DEFINITIONS. In this subchapter:

(1) "Board" means the board of directors of the Texas Public Finance Authority.

(2) "Bond resolution" means the resolution or order authorizing bonds to be issued under this subchapter. (V.T.I.C. Art. 21.49-3d, Secs. 2(2), (3).)

Source Law

Sec. 2. In this article:

(2) "Bond resolution" means the resolution or order authorizing the bonds to be issued under this article.

(3) "Board" means the board of directors of the Texas Public Finance Authority.

Revisor's Note

Section 2(4), V.T.I.C. Article 21.49-3d, defines "insurer" to mean an insurer required to be a member of the joint underwriting association under Section 3, V.T.I.C. Article 21.49-3, revised in relevant part in this chapter in Section 2203.055. For consistency with the terminology used in Subchapters A-G and I of this chapter, the revised law omits the definition of "insurer" and throughout this subchapter substitutes "association member" for references to "insurer." The omitted law reads:

(4) "Insurer" means any insurer required to be a member of the association under Section 3, Article 21.49-3 of this code.

Revised Law

Sec. 2203.353. APPLICABILITY OF OTHER LAWS. The following laws apply to bonds issued under this subchapter to the extent consistent with this subchapter:

(1) Chapters 1201, 1202, 1204, 1205, 1231, 1232, and 1371, Government Code; and

(2) Subchapter A, Chapter 1206, Government Code.

(V.T.I.C. Art. 21.49-3d, Secs. 3(b), 4.)

Source Law

[Sec. 3]

(b) To the extent not inconsistent with this article, Chapter 1232, Government Code, applies to bonds issued under this article. In the event of a conflict, this article controls.

Sec. 4. The following laws apply to bonds issued under this article to the extent consistent with this article:

(1) Chapters 1201, 1202, 1204, 1205, 1231, and 1371, Government Code; and

(2) Subchapter A, Chapter 1206, Government Code.

Revisor's Note

Section 3(b), V.T.I.C. Article 21.49-3d, provides that, to the extent not inconsistent with that article, Chapter 1232, Government Code, applies to bonds issued under that article but that, in the event of a conflict, that article controls. The revised law omits the statement that in the event of a conflict V.T.I.C. Article 21.49-3d controls over Chapter 1232, Government Code, because that is implied by the statement that Chapter 1232, Government Code, applies to bonds issued under V.T.I.C. Article 21.49-3d to the extent not inconsistent with that article.

Revised Law

Sec. 2203.354. ISSUANCE OF BONDS AUTHORIZED. On behalf of the association and subject to Section 2203.355, the Texas Public Finance Authority shall issue revenue bonds to:

(1) fund the policyholder's stabilization reserve fund for nursing homes and assisted living facilities under Section 2203.303;

(2) pay costs related to issuing the bonds; and

(3) pay other costs related to the bonds as determined by the board. (V.T.I.C. Art. 21.49-3d, Sec. 3(a).)

Source Law

Sec. 3. (a) On behalf of the association, the Texas Public Finance Authority shall issue revenue

bonds to:

(1) fund the stabilization reserve fund for for-profit and not-for-profit nursing homes and assisted living facilities established under Section 4B, Article 21.49-3 of this code;

(2) pay costs related to issuance of the bonds; and

(3) pay other costs related to the bonds as may be determined by the board.

Revisor's Note

Section 3(a), V.T.I.C. Article 21.49-3d, provides that the Texas Public Finance Authority shall issue revenue bonds for the joint underwriting association for certain purposes. Section 5, V.T.I.C. Article 21.49-3d, revised in this chapter as Section 2203.355, limits the total amount of bonds the authority may issue on behalf of the association. For the convenience of the reader, the revised law adds a cross-reference to Section 2203.355.

Revised Law

Sec. 2203.355. LIMITATION ON AMOUNT OF BONDS. The Texas Public Finance Authority may issue on behalf of the association bonds in a total amount not to exceed $75 million. (V.T.I.C. Art. 21.49-3d, Sec. 5.)

Source Law

Sec. 5. The Texas Public Finance Authority may issue, on behalf of the association, bonds in a total amount not to exceed $75 million.

Revised Law

Sec. 2203.356. TERMS OF ISSUANCE. (a) Bonds issued under this subchapter may be issued at a public or private sale.

(b) Bonds must:

(1) be issued in the name of the association; and

(2) mature not more than 10 years after the date issued. (V.T.I.C. Art. 21.49-3d, Sec. 6.)

Source Law

Sec. 6. (a) Bonds may be issued at public or private sale.

(b) Bonds may mature not more than 10 years after the date issued.

(c) Bonds must be issued in the name of the association.

Revised Law

Sec. 2203.357. CONTENTS OF BOND RESOLUTION; ADMINISTRATION OF ACCOUNTS. (a) In a bond resolution, the board may:

(1) provide for the flow of funds and the establishment, maintenance, and investment of funds and special accounts with regard to the bonds, including an interest and sinking fund account, a reserve account, and other accounts; and

(2) make additional covenants with regard to the bonds and the designated income and receipts of the association pledged to the payment of the bonds.

(b) The association shall administer the accounts in accordance with this chapter. (V.T.I.C. Art. 21.49-3d, Secs. 7, 8.)

Source Law

Sec. 7. In a bond resolution, the board may make additional covenants with respect to the bonds and the designated income and receipts of the association pledged to their payment and may provide for the flow of funds and the establishment, maintenance, and investment of funds and accounts with respect to the bonds.

Sec. 8. (a) A bond resolution may establish special accounts, including an interest and sinking fund account, reserve account, and other accounts.

(b) The association shall administer the accounts in accordance with Article 21.49-3 of this code.

Revised Law

Sec. 2203.358. SOURCE OF PAYMENT. (a) Bonds issued under this subchapter are payable only from:

(1) the surcharge fee established under Section 2203.359; or

(2) other sources the association is authorized to levy and charge and from which the association is authorized to collect in connection with paying any portion of the bonds.

(b) The bonds are obligations solely of the association and do not create a pledge, gift, or loan of the faith, credit, or taxing authority of this state.

(c) Each bond must:

(1) include a statement that the state is not

obligated to pay any amount on the bond and that the faith, credit, and taxing authority of this state are not pledged, given, or loaned to those payments; and

(2) state on the bond's face that the bond:

(A) is payable solely from the revenue pledged for that purpose; and

(B) is not a legal or moral obligation of the state. (V.T.I.C. Art. 21.49-3d, Sec. 9.)

Source Law

> Sec. 9. (a) Bonds are payable only from the surcharge fee established in Section 10 of this article or other sources the association is authorized to levy, charge, and collect in connection with paying any portion of the bonds.
>
> (b) Bonds are obligations solely of the association. Bonds do not create a pledging, giving, or lending of the faith, credit, or taxing authority of this state.
>
> (c) Each bond must include a statement that the state is not obligated to pay any amount on the bond and that the faith, credit, and taxing authority of this state are not pledged, given, or lent to those payments.
>
> (d) Each bond issued under this article must state on its face that the bond is payable solely from the revenues pledged for that purpose and that the bond does not and may not constitute a legal or moral obligation of the state.

Revised Law

Sec. 2203.359. SURCHARGE FEE. (a) A surcharge fee is assessed against:

(1) each association member; and

(2) the association.

(b) The commissioner shall set the surcharge fee in an amount sufficient to pay all debt service on the bonds issued under this subchapter. Each association member and the association shall pay the surcharge fee as required by the commissioner by rule.

(c) The comptroller shall collect the surcharge fee and the department shall reimburse the comptroller in the manner described by Section 201.052.

(d) The commissioner, in consultation with the comptroller, may coordinate payment and collection of the surcharge fee with other payments made by association members and collected by the

comptroller.

(e) Except as provided by Subsection (f), as a condition of engaging in the business of insurance in this state, an association member agrees that, if the member leaves the liability insurance market in this state, the member remains obligated to pay the member's share of the surcharge fee assessed under this section until the bonds are retired. The amount assessed against a member under this subsection must be:

(1) proportionate to the member's share of the liability insurance market, including automobile liability insurance, in this state as of the last complete reporting period before the date the member ceases to engage in the liability insurance business in this state; and

(2) based on the member's gross premiums for liability insurance, including automobile liability insurance, for the member's last reporting period.

(f) An association member is not required to pay the proportionate amount under Subsection (e) in any year in which the surcharge fee assessed against association members continuing to write liability insurance in this state is sufficient to service the bond obligation. (V.T.I.C. Art. 21.49-3d, Sec. 10.)

Source Law

Sec. 10. (a) A surcharge fee is assessed against:

(1) each insurer; and

(2) the association.

(b) The surcharge fee shall be set by the commissioner in an amount sufficient to pay all debt service on the bonds. The surcharge shall be paid by each insurer and the association as required by commissioner rule.

(c) The comptroller shall collect the surcharge fee and the department shall reimburse the comptroller in the manner described by Article 4.19 of this code.

(d) The commissioner, in consultation with the comptroller, may coordinate payment and collection of the surcharge fee with other payments made by insurers and collected by the comptroller.

(e) As a condition of engaging in the business of insurance in this state, an insurer agrees that if the company leaves the market for liability insurance in this state the insurer remains obligated to pay, until the bonds are retired, the insurer's share of the surcharge fee assessed under this section in an amount proportionate to that insurer's share of the market for

liability insurance, including motor vehicle liability insurance, in this state as of the last complete reporting period before the date on which the insurer ceases to engage in that insurance business in this state. The proportion assessed against the insurer shall be based on the insurer's gross premiums for liability insurance, including motor vehicle liability insurance, for the insurer's last reporting period. However, an insurer is not required to pay the proportionate amount in any year in which the surcharge fee assessed against insurers continuing to write liability insurance in this state is sufficient to service the bond obligation.

Revisor's Note

Section 10(e), V.T.I.C. Article 21.49-3d, refers to "motor vehicle liability insurance." The revised law substitutes "automobile liability insurance" for the reference to "motor vehicle liability insurance" for consistency with terminology used in this code and because "automobile" insurance is the term more commonly used to describe the kind of insurance that provides coverage for motor vehicles.

Revised Law

Sec. 2203.360. EXEMPTION FROM TAXATION. Bonds issued under this subchapter, any interest from the bonds, and all assets pledged to secure the payment of the bonds are exempt from taxation by the state or a political subdivision of this state. (V.T.I.C. Art. 21.49-3d, Sec. 11.)

Source Law

Sec. 11. The bonds issued under this article, and any interest from the bonds, and all assets pledged to secure the payment of the bonds are free from taxation by the state or a political subdivision of this state.

Revised Law

Sec. 2203.361. AUTHORIZED INVESTMENTS. Bonds issued under this subchapter are authorized investments under Subchapter B, Chapter 424, and Subchapter D, Chapter 425. (V.T.I.C. Art. 21.49-3d, Sec. 12.)

Source Law

Sec. 12. The bonds issued under this article constitute authorized investments under Article 2.10 and Subpart A, Part I, Article 3.39, of this code.

Revisor's Note

Section 12, V.T.I.C. Article 21.49-3, provides that bonds issued under that article are authorized investments under V.T.I.C. Article 2.10 and under Subpart A, Part I, V.T.I.C. Article 3.39. Those articles are revised in pertinent part in Subchapter B, Chapter 424, and Subchapter D, Chapter 425, respectively. While these subchapters contain provisions derived from laws other than Article 2.10 and Subpart A, Part I, V.T.I.C. Article 3.39, it is appropriate to refer to the subchapters in their entirety because inclusion of the additional provisions in the reference does not change the substantive effect of the reference.

Revised Law

Sec. 2203.362. STATE PLEDGE REGARDING BOND OWNER RIGHTS AND REMEDIES. (a) The state pledges to and agrees with the owners of bonds issued in accordance with this subchapter that the state will not limit or alter the rights vested in the association to fulfill the terms of agreements made with the owners or impair the rights and remedies of the owners until the following obligations are fully discharged:

(1) the bonds;

(2) any bond premium;

(3) interest; and

(4) all costs and expenses related to an action or proceeding by or on behalf of the owners.

(b) The association may include the state's pledge and agreement under Subsection (a) in an agreement with the owners of the bonds. (V.T.I.C. Art. 21.49-3d, Sec. 13.)

Source Law

Sec. 13. The state pledges to and agrees with the owners of any bonds issued in accordance with this article that the state will not limit or alter the rights vested in the association to fulfill the terms of any agreements made with the owners of the bonds or

in any way impair the rights and remedies of those owners until the bonds, any premium or interest, and all costs and expenses in connection with any action or proceeding by or on behalf of those owners are fully met and discharged. The association may include this pledge and agreement of the state in any agreement with the owners of the bonds.

Revised Law

Sec. 2203.363. PAYMENT ENFORCEABLE BY MANDAMUS. A writ of mandamus and any other legal or equitable remedy are available to a party in interest to require the association or another party to fulfill an agreement or perform a function or duty under:

(1) this subchapter;

(2) the Texas Constitution; or

(3) a bond resolution. (V.T.I.C. Art. 21.49-3d, Sec. 14.)

Source Law

Sec. 14. A writ of mandamus and all other legal and equitable remedies are available to any party at interest to require the association and any other party to carry out agreements and to perform functions and duties under this article, the Texas Constitution, or a bond resolution.

[Sections 2203.364-2203.400 reserved for expansion]

SUBCHAPTER I. APPEALS

Revised Law

Sec. 2203.401. DEFINITION. In this subchapter, "act" includes a ruling or decision. (New.)

Revisor's Note

The revised law adds a definition of "act" for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 2203.402. APPEAL TO BOARD OF DIRECTORS; HEARING. (a) A person insured or applying for insurance under this chapter, the person's authorized representative, or an affected insurer that may be aggrieved by an act of the association may appeal to the board of directors not later than the 30th day after the date the act occurs. At the time the person is notified of the act, the association shall

provide to the person written notice of the person's right to appeal under this subsection.

(b) The board of directors shall:

(1) hear an appeal brought under Subsection (a) not later than the 30th day after the date the board of directors receives the appeal; and

(2) give not less than 10 days' written notice of the time and place of the hearing to the person bringing the appeal or the person's authorized representative. (V.T.I.C. Art. 21.49-3, Secs. 7(a), (b) (part).)

Source Law

> Sec. 7. (a) Any person insured or applying for insurance pursuant to this Act, or his duly authorized representative, or any affected insurer who may be aggrieved by an act, ruling, or decision of the association, may, within 30 days after such act, ruling, or decision, appeal to the board of directors of the association. At the time the person is notified of the act, ruling, or decision of the association, the association shall provide to the person written notice of the person's right to appeal under this subsection.
>
> (b) The board of directors of the association shall hear said appeal within 30 days after receipt of such request or appeal and shall give not less than 10 days' written notice of the time and place of hearing to the person making such request or the duly authorized representative. . . .

Revisor's Note

(1) Sections 7(a) and (b), V.T.I.C. Article 21.49-3, refer to a person's "duly authorized representative." The revised law omits the references to "duly" for the reason stated in Revisor's Note (2) to Section 2203.002.

(2) Section 7(b), V.T.I.C. Article 21.49-3, prescribes the time during which the joint underwriting association's board of directors must hear a "request or appeal," meaning an appeal brought under Section 7(a) of that article, and refers to the person making that "request." Section 7(c) of that article, revised in relevant part in this chapter as Section 2203.404, refers to a "request or appeal,"

meaning an appeal brought by making a written request to the commissioner of insurance for a hearing. For consistency of terminology within this subchapter, the revised law substitutes "appeal" for the quoted language.

Revised Law

Sec. 2203.403. DECISION OF BOARD OF DIRECTORS. (a) Not later than the 10th day after the date of the hearing under Section 2203.402(b), the board of directors shall affirm, reverse, or modify the board's previous action or the appealed act.

(b) At the time the person is notified of the final action of the board of directors, the association shall provide to the person written notice of the person's right to appeal under Section 2203.404. (V.T.I.C. Art. 21.49-3, Sec. 7(b) (part).)

Source Law

> (b) . . . Within 10 days after such hearing, the board of directors of the association shall affirm, reverse, or modify its previous action or the act, ruling, or decision appealed to the board of directors of the association. At the time the person is notified of the final action of the board of directors of the association, the association shall provide to the person written notice of the person's right to appeal under Subsection (c) of this section.

Revised Law

Sec. 2203.404. APPEAL TO COMMISSIONER; HEARING. (a) Not later than the 30th day after the date of the final action of the board of directors under Section 2203.403, a person insured or applying for insurance aggrieved by that final action may appeal to the commissioner by making a written request for a hearing.

(b) The appeal shall be heard not later than the 30th day after the date the appeal is received. The person bringing the appeal or the person's authorized representative must be given written notice of the time and place of the hearing on or before the 10th day before the date of the hearing. (V.T.I.C. Art. 21.49-3, Sec. 7(c) (part).)

Source Law

(c) In the event any person insured or applying

for insurance is aggrieved by the final action of the board of directors of the association, the aggrieved party may, within 30 days after such action, make a written request to the commissioner for a hearing thereon. The commissioner shall hear the appeal from an act, ruling, or decision of the association, within 30 days after receipt of such request or appeal and shall give not less than 10 days' written notice of the time and place of hearing to the person, or his duly authorized representative, appealing from the act, ruling, or decision of the board of directors of the association. . . .

Revisor's Note

Section 7(c), V.T.I.C. Article 21.49-3, refers to a person's "duly authorized representative." The revised law omits the reference to "duly" for the reason stated in Revisor's Note (2) to Section 2203.002.

Revised Law

Sec. 2203.405. COMMISSIONER'S DECISION. (a) Not later than the 30th day after the date of the hearing under Section 2203.404, the commissioner shall affirm, reverse, or modify the appealed act.

(b) Pending the hearing and decision, the commissioner may suspend or postpone the effective date of a rule or of the act appealed. (V.T.I.C. Art. 21.49-3, Sec. 7(c) (part).)

Source Law

(c) . . . Within 30 days after such hearing, the commissioner shall affirm, reverse, or modify the act, ruling, or decision appealed to the commissioner. Pending such hearing and decision thereon, the commissioner may suspend or postpone the effective date of the rule or of the act, ruling, or decision appealed.

Revised Law

Sec. 2203.406. APPEAL OF COMMISSIONER'S DECISION. (a) The association or a person aggrieved by an order or decision of the commissioner may appeal in accordance with Subchapter D, Chapter 36.

(b) At the time the person is notified of the commissioner's order or decision, the commissioner shall provide to the person written notice of the person's right to appeal under this section. (V.T.I.C. Art. 21.49-3, Sec. 7(d).)

Source Law

(d) The association, or the person aggrieved by any order or decision of the commissioner, may thereafter appeal in accordance with Article 1.04 of this code. At the time the person is notified of the decision of the commissioner, the commissioner shall provide to the person written notice of the person's right to appeal under this subsection.

CHAPTER 2204. TEXAS INSURANCE EXCHANGE

SUBCHAPTER A. GENERAL PROVISIONS

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CHAPTER 2204. TEXAS INSURANCE EXCHANGE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2204.001. DEFINITIONS. In this chapter:

(1) "Directors" means the board of directors of the exchange.

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

(3) "Member" means a person, firm, corporation, or underwriting syndicate authorized by the directors to insure or reinsure risks through the exchange. (V.T.I.C. Art. 1.14-3, Secs. 1(1), (3), (4).)

Source Law

Sec. 1. In this article:

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

(3) "Directors" means the board of directors of the exchange.

(4) "Member" means a person, firm, corporation, or underwriting syndicate authorized by the directors of the exchange to insure or reinsure risks through the exchange.

Revisor's Note

Section 1(2), V.T.I.C. Article 1.14-3, 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 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. The omitted law reads:

(2) "Board" means the State Board of Insurance.

Revised Law

Sec. 2204.002. EXEMPTION. (a) This chapter, Chapters 251 and 261, and rules adopted by the commissioner or comptroller, as applicable, apply to the exchange, a member, and insurance and reinsurance written through the exchange, except to the extent exempted by rules adopted by the commissioner or comptroller, as applicable.

(b) An exemption may not be:

(1) unfairly discriminatory; or

(2) detrimental to the solvency of an insurer authorized to engage in the business of insurance in this state. (V.T.I.C. Art. 1.14-3, Sec. 9.)

Source Law

Sec. 9. This article and regulations promulgated by the commissioner or the comptroller, as applicable, apply to the exchange, its members, and the insurance and reinsurance written through the exchange, except to the extent exempt by regulations of the commissioner or the comptroller, as applicable.

An exemption may not be unfairly discriminatory or detrimental to the solvency of licensed insurers.

Revisor's Note

(1) Section 9, V.T.I.C. Article 1.14-3, refers to the applicability of Article 1.14-3 to the Texas Insurance Exchange and members of the exchange. With the exception of Section 8, Article 1.14-3, the article is revised as this chapter. Section 8 was revised in 2003 in Chapters 251 and 261 of this code, which took effect April 1, 2005. The revised law is drafted accordingly.

(2) Section 9, V.T.I.C. Article 1.14-3, refers to "regulations promulgated" by and "regulations of" the commissioner of insurance or the comptroller. Throughout this chapter, the revised law substitutes "rules adopted" for "regulations promulgated" or "regulations of," as applicable. Under Section 311.005(5), Government Code (Code Construction Act), applicable to the revised law, a rule is defined to include a regulation, and "rule" is the more commonly used term. In addition, "adopted" and "promulgated" are synonymous in context, and the former is more commonly used.

(3) Section 9, V.T.I.C. Article 1.14-3, refers to "licensed" insurers. Throughout this chapter, the revised law substitutes "authorized" for "licensed" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 2204.003. RULES. The commissioner shall adopt rules for the operation and management of the exchange. (V.T.I.C. Art. 1.14-3, Sec. 4 (part).)

Source Law

Sec. 4. The board shall promulgate regulations

under which the exchange shall be operated and managed, and . . . .

[Sections 2204.004-2204.050 reserved for expansion]

SUBCHAPTER B. OPERATION AND MANAGEMENT

Revised Law

Sec. 2204.051. PURPOSE OF EXCHANGE; SPECIFIC AUTHORIZATION FOR CERTAIN INSURANCE. (a) The exchange shall provide a facility for underwriting:

(1) reinsurance of any kind of insurance;

(2) direct insurance of any kind of risk located entirely outside the United States;

(3) direct insurance of any kind of risk that:

(A) is located in another state; and

(B) qualifies for placement under the excess and surplus lines requirements of the jurisdiction in which the risk is located; and

(4) a risk located in this state that has been submitted to and certified as rejected by a committee representing at least three and not more than seven insurers authorized to engage in the business of insurance in this state and subject to conditions imposed by rules adopted by the commissioner.

(b) For purposes of Chapter 101, insurance or reinsurance a member writes to cover a risk described by Subsection (a)(4) is considered to be specifically authorized by the laws of this state. (V.T.I.C. Art. 1.14-3, Secs. 3, 11.)

Source Law

Sec. 3. The purpose of the exchange is to provide a facility for underwriting the following:

(1) reinsurance of any kind of insurance;

(2) direct insurance of any kind of risk located entirely outside the United States;

(3) direct insurance of any kind of risk located in a state of the United States other than this state if the risk qualifies for placement under the excess and surplus lines requirements of the jurisdiction in which the risk is located; and

(4) a risk located in this state that is submitted to and certified as having been rejected by a committee representative of not fewer than three and not more than seven insurers licensed to do an insurance business in this state and subject to conditions imposed by regulations promulgated by the board.

Sec. 11. For purposes of Article 1.14-1 of this code, insurance and reinsurance written under Subdivision (4) of Section 3 of this article written by members of the exchange are deemed to have been written in accordance with specific authorization of the laws of this state.

Revised Law

Sec. 2204.052. OPERATION OF EXCHANGE. The exchange shall operate under:

(1) a constitution and bylaws adopted by the exchange and approved by the department; and

(2) rules adopted by the commissioner under Section 2204.003. (V.T.I.C. Art. 1.14-3, Secs. 2, 5(a).)

Source Law

Sec. 2. The Texas Insurance Exchange is created and shall operate under a constitution and bylaws and under regulations promulgated by the board.

Sec. 5. (a) The exchange shall function under a constitution and bylaws adopted by it and approved by the board.

Revisor's Note

Section 2, V.T.I.C. Article 1.14-3, provides that the Texas Insurance Exchange "is created." The revised law omits as executed the reference to the creation of the exchange.

Revised Law

Sec. 2204.053. CONSTITUTION AND BYLAWS. (a) In this section:

(1) "Principal office" means an office at which officers and personnel who are engaged in administration, underwriting, claims adjustment, policyholders' service, marketing, accounting, recordkeeping, and support services are located.

(2) "Subscriber" means a person, firm, corporation, or other organization that, on payment of fees or dues required by the constitution and bylaws, the directors designate as a subscriber.

(b) The constitution and bylaws of the exchange must provide for:

(1) the election of nine directors, four of whom represent the public interest and are not members, subscribers, or agents of the exchange;

(2) the locations of the principal offices of the exchange and the members in this state for transacting business described by Section 2204.051(a);

(3) the submission by the exchange, members, and applicants for membership in the exchange of financial information required by rules adopted by the commissioner;

(4) the establishment and maintenance by the exchange of a security fund in a form and amount specified by rules adopted by the commissioner;

(5) the voting power of members; and

(6) members' rights and duties, including the manner of conducting business, financial stability, dues, membership fees, mandatory arbitration, and any other matter necessary or appropriate to conduct business authorized by this chapter.

(c) For an agent transacting business on the exchange to participate in the operation and management of the exchange, the constitution and bylaws of the exchange must provide for the voting power and other rights granted to a nonprofit corporation under the Business Organizations Code.

(c-1) Notwithstanding Subsection (c), on or before December 31, 2009, for an agent transacting business on the exchange to participate in the operation and management of the exchange, the constitution and bylaws of the exchange must provide for the voting power and other rights granted to a nonprofit corporation under the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) or the Business Organizations Code, as applicable.

(c-2) This subsection and Subsection (c-1) expire January 1, 2010.

(d) In a manner that complies with the requirements adopted under this section, the exchange may, with the department's

approval, amend the exchange's constitution or bylaws in accordance with the terms of the constitution and bylaws.

(e) The constitution, a bylaw, or an amendment to the constitution or a bylaw is invalid without the department's approval. (V.T.I.C. Art. 1.14-3, Secs. 1(5), 5(b), (c), (d), (e).)

Source Law

[Sec. 1]

[In this article:] . . .

(5) "Subscriber" means a person, firm, corporation, or other organization designated by the directors of the exchange as a subscriber on payment of fees or dues required by the constitution and bylaws.

[Sec. 5]

(b) The exchange may amend its constitution and bylaws in accordance with their terms and with the approval of the board.

(c) The constitution and bylaws and amendments to the constitution and bylaws are invalid without the approval of the board.

(d) Notwithstanding any authority under this article to adopt or amend the constitution and bylaws, the constitution and bylaws must provide for:

(1) the election of nine directors, four of whom represent the public interest and are not members, subscribers, or agents of the exchange;

(2) the location of the principal offices of the exchange and its members within this state for the purpose of the transaction of the types of business described in Section 3 of this article;

(3) the submission by the exchange, its members, and applicants for membership in the exchange of financial information required by regulations promulgated by the board;

(4) the exchange to establish and maintain a security fund in a form and amount specified by regulations promulgated by the board;

(5) the voting power of members;

(6) the voting power and other rights granted under the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) to participate in the conduct and management of the affairs of the exchange by agents transacting business on the exchange; and

(7) the rights and duties of members, including the manner and form for conducting business, financial stability, dues, membership fees, mandatory arbitration, and other matters necessary or appropriate to conduct business authorized by this article.

(e) For the purposes of this section, a principal office is an office at which officers and personnel who are engaged in administration, underwriting, claims adjustment, policyholders' service, marketing, accounting, record-keeping, and support services are located.

Revisor's Note

(1) Section 5(d)(6), V.T.I.C. Article 1.14-3,

refers to the Texas Non-Profit Corporation Act. That Act was codified in various chapters of the Business Organizations Code by Chapter 182, Acts of the 78th Legislature, Regular Session, 2003. The Business Organizations Code takes effect January 1, 2006, and applies only to domestic business entities formed on or after that date, to domestic business entities formed before that date that elect to have that code govern their operations, and to certain foreign business entities. On January 1, 2010, the Texas Non-Profit Corporation Act expires, and the Business Organizations Code will apply to all business entities without regard to date of formation or whether an entity is a foreign or domestic business entity. The revised law is drafted to reflect the applicability of these statutes in accordance with their effective dates or on election by a business entity.

(2) Section 5(d)(7), V.T.I.C. Article 1.14-3, refers to the "manner and form" for conducting business. The revised law omits "form" as included within the meaning of "manner."

Revised Law

Sec. 2204.054. DIRECTORS. (a) The directors shall operate and manage the exchange in accordance with rules adopted under Section 2204.003.

(b) The directors shall be elected by the members and any other person authorized by the exchange's constitution and bylaws to vote in an election of directors.

(c) At least two-thirds of the directors must be citizens of the United States. (V.T.I.C. Art. 1.14-3, Secs. 4 (part), 6.)

Source Law

Sec. 4. . . . the directors shall operate and manage the exchange in accordance with those regulations.

Sec. 6. (a) The directors for the exchange

shall be elected by the members of the exchange and by any other persons authorized by the constitution and bylaws of the exchange to vote for election of directors.

(b) At least two-thirds of the directors must be citizens of the United States.

[Sections 2204.055-2204.100 reserved for expansion]

SUBCHAPTER C. FINANCES

Revised Law

Sec. 2204.101. TAXES. (a) Except as provided by this section and Chapters 251 and 261, the exchange is not subject to state or local taxes that are measured by income, premiums, or gross receipts.

(b) A direct premium written, procured, or received by a member through the exchange on a risk located in this state is:

(1) considered written, procured, or received by the exchange; and

(2) subject to the premium taxes imposed under Subtitle B, Title 3.

(c) Premium taxes shall be reported, paid, and administered as provided by Subtitle B, Title 3.

(d) The exchange and the members are considered insurers for purposes of:

(1) Sections 201.052, 201.053, and 201.054;

(2) Chapters 4, 202, 203, 221, 222, 224, 227, 251, 257, and 1109; and

(3) Section 171.0525, Tax Code. (V.T.I.C. Art. 1.14-3, Sec. 7.)

Source Law

Sec. 7. (a) Except as provided by this section and Section 8 of this article, the exchange is not subject to any state or local taxes measured by income, premiums, or gross receipts.

(b) Direct premiums written, procured, or received by any member through the exchange on risks located in this state are deemed written, procured, or received by the exchange, and those premiums are subject to the premium taxes imposed under Chapter 4 of this code. Those taxes shall be reported, paid, and administered as provided by Chapter 4 of this code.

(c) For purposes of Chapter 4 of this code, the exchange and its members are considered insurance carriers.

Revisor's Note

(1) Section 7(a), V.T.I.C. Article 1.14-3, refers to "Section 8 of this article." Section 8, V.T.I.C. Article 1.14-3, was revised in 2003 in Chapters 251 and 261 of this code, which took effect April 1, 2005. The revised law provides the references to those chapters.

(2) Section 7(b), V.T.I.C. Article 1.14-3, refers to V.T.I.C. Chapter 4. That chapter is codified in various titles in this code. The relevant provisions of that chapter in the context of Section 7(b), revised as Sections 2204.101(b) and (c), were revised in 2003 as Subtitle B, Title 3, of this code, which took effect April 1, 2005.

Revised Law

Sec. 2204.102. INVESTMENTS IN MEMBER OR AGENT. (a) The commissioner by rule may establish limitations on investments in a member.

(b) An investment, directly or indirectly, in a member by an agent transacting business on the exchange or in an agent transacting business on the exchange by a member is limited in the aggregate to:

(1) less than 20 percent of the total investment in the member or agent; or

(2) a lesser amount provided by a rule adopted by the commissioner. (V.T.I.C. Art. 1.14-3, Sec. 10.)

Source Law

Sec. 10. (a) The board by regulation may establish limitations on investments in members of the exchange.

(b) The investment in a member by agents transacting business on the exchange and the investment in an agent transacting business on the exchange by a member, either directly or indirectly, in each case is limited in the aggregate to less than 20 percent of the total investment in the member or agent or to a lesser amount provided by board regulation.

Revised Law

Sec. 2204.103. COVERAGE BY GUARANTY FUNDS. (a) The performance of a contractual obligation of the exchange or a member entered into under this chapter is not covered by an insurance guaranty fund provided by the laws of this state.

(b) This section does not apply to the security fund established under Section 2204.053(b)(4). (V.T.I.C. Art. 1.14-3, Sec. 12.)

Source Law

> Sec. 12. Performance of the contractual obligations of the exchange or its members entered into under this article is not covered by any of the Texas insurance guaranty funds provided by the laws of this state. This section does not apply to the security fund provided by Subdivision (4) of Subsection (d) of Section 5 of this article.

CHAPTER 2205. TEXAS CHILD-CARE FACILITY LIABILITY POOL

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CHAPTER 2205. TEXAS CHILD-CARE FACILITY LIABILITY POOL

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2205.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of trustees of the pool.

(2) "Child-care facility" has the meaning assigned by Section 42.002, Human Resources Code.

(3) "Fund" means the Texas child-care facility liability fund.

(4) "Pool" means the Texas Child-Care Facility Liability Pool. (V.T.I.C. Art. 21.49-18, Sec. 1.)

Source Law

Art. 21.49-18
Sec. 1. In this article:
(1) "Board" means the board of trustees of the pool.
(2) "Child-care facility" has the meaning assigned to that term by Section 42.002, Human Resources Code.
(3) "Fund" means the Texas child-care facility liability fund.
(4) "Pool" means the Texas child-care facility liability pool.

Revised Law

Sec. 2205.002. POOL NOT ENGAGED IN BUSINESS OF INSURANCE. (a) Except as provided by this section and Section 2205.003(b), the pool is not engaged in the business of insurance under this code or other state law, and this code and other state insurance laws do not apply to the pool.

(b) The pool is subject to:

(1) this chapter;

(2) the requirements of this code or commissioner rules relating to reporting liability claims information; and

(3) the requirements of Chapter 2251 and Article 5.13-2 relating to making, filing, and approving rates. (V.T.I.C. Art. 21.49-18, Secs. 20(a), (b) (part).)

Source Law

Sec. 20. (a) Except as provided by Subsection (c) of this section, the pool is not engaged in the business of insurance under this code and other state

laws, and this code and other state insurance laws do not apply to the pool.

(b) In addition to this article, the pool is subject to:

(1) the requirements under this code and State Board of Insurance rules relating to the reporting of liability claims information;

(2) the requirements of Subchapter B, Chapter 5 of this code relating to the making, filing, and approval of rates; and . . . .

Revisor's Note

(1) Section 20(b)(1), V.T.I.C. Article 21.49-18, 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. Throughout this chapter, references to the board have been changed appropriately.

(2) Section 20(b)(2), V.T.I.C. Article 21.49-18, refers to the requirements of Subchapter B, V.T.I.C. Chapter 5, relating to making, filing, and approving rates. That subchapter has been revised in part in various titles of this code. The relevant provisions of Subchapter B, Chapter 5, that regulate making, filing, and approving rates are in V.T.I.C. Article 5.13-2, revised in part in Chapter 2251 of this code. For that reason, the revised law substitutes a reference to "Chapter 2251 and Article 5.13-2" for the reference to "Subchapter B, Chapter 5."

Revised Law

Sec. 2205.003. DEPARTMENT AND COMMISSIONER SUPERVISION. (a) The pool is subject to the department's continuing supervision relating to the pool's solvency.

(b) The commissioner may set minimum requirements to ensure the capability of the pool to satisfy the pool's obligations. (V.T.I.C. Art. 21.49-18, Secs. 20(b) (part), (c).)

Source Law

(b) . . . the pool is subject to:

. . .

(3) continuing supervision by the State Board of Insurance relating to the pool's solvency.

(c) The State Board of Insurance may set minimum requirements to assure the capability of the pool to satisfy its obligations.

[Sections 2205.004-2205.050 reserved for expansion]

SUBCHAPTER B. CREATION OF POOL

Revised Law

Sec. 2205.051. CREATION OF POOL. (a) The Texas Child-Care Facility Liability Pool is created when the governing bodies of 10 or more child-care facilities agree in writing to participate in the pool.

(b) The pool provides liability insurance coverage for child-care facilities as provided by this chapter. (V.T.I.C. Art. 21.49-18, Secs. 2, 3(a) (part).)

Source Law

Sec. 2. The Texas Child-Care Facility Liability Pool is created when the governing bodies of at least 10 child-care facilities have entered into a written agreement for participation in the pool.

Sec. 3. (a) The pool shall insure a child-care facility and [its officers and employees] against liability [for acts and omissions under the laws of this state in their official or employment capacities and shall provide primary and excess liability coverage to child-care facilities that qualify under this article and under the pool's plan of operation].

Revised Law

Sec. 2205.052. PARTICIPATION IN POOL. A child-care facility is entitled to coverage from the pool if the facility:

(1) submits a complete application;

(2) provides other information required by the pool;

(3) meets the underwriting standards established by the pool; and

(4) pays the premiums required for the coverage. (V.T.I.C. Art. 21.49-18, Sec. 4.)

Source Law

Sec. 4. A child-care facility is entitled to coverage from the pool if it:

(1) submits a complete application;

(2) provides other information required by the pool;

(3) meets the underwriting standards established by the pool; and

(4) pays the premiums required for the coverage.

Revised Law

Sec. 2205.053. SELECTION OF TEMPORARY BOARD. At the time the governing bodies of the child-care facilities enter into the written agreement under Section 2205.051, the governing bodies shall select nine individuals to:

(1) serve as the temporary board; and

(2) draft the plan of operation for the pool. (V.T.I.C. Art. 21.49-18, Sec. 5(a).)

Source Law

Sec. 5. (a) The governing bodies of the child-care facilities that create the pool under Section 2 of this article shall, when the agreement is executed, appoint nine persons to serve as a temporary board to draft the plan of operation of the pool.

[Sections 2205.054-2205.100 reserved for expansion]

SUBCHAPTER C. PLAN OF OPERATION

Revised Law

Sec. 2205.101. TIME FOR CREATION OF PLAN OF OPERATION. (a) Not later than the 30th day after the date the last member of the temporary board is selected, the temporary board shall meet to prepare a plan of operation for the pool.

(b) The temporary board shall complete and adopt the plan of operation not later than the 90th day after the date the last member of the temporary board is selected. (V.T.I.C. Art. 21.49-18, Secs. 5(b), (d).)

Source Law

(b) Not later than the 30th day after the selection of the last member of the temporary board, the temporary board shall meet to prepare a plan of operation for the pool.

(d) The temporary board shall complete and adopt the plan of operation not later than the 90th day after the date of the appointment of the last member of the temporary board.

Revised Law

Sec. 2205.102. CONTENTS OF PLAN OF OPERATION. (a) Subject to the requirements of this chapter, the plan of operation must include:

(1) the organizational structure of the pool, including:

(A) the method of selecting the board;

(B) the board's methods of procedure and operation; and

(C) a summary of the methods for managing and operating the pool;

(2) a description of the contributions and other financial arrangements necessary to cover the initial expenses of the pool and estimates, supported by statistical information, of the amounts of those contributions or other financial arrangements;

(3) underwriting standards and procedures for evaluating risks;

(4) a requirement that each participant in the pool receive continuing training in the methods of controlling liability losses;

(5) procedures for purchasing reinsurance;

(6) procedures and guidelines for:

(A) establishing premium rates for and maximum limits of excess liability coverage available from the pool;

(B) negotiating and paying settlements, defending claims, and paying judgments; and

(C) managing and investing the fund;

(7) procedures for:

(A) processing and paying claims; and

(B) defraying losses or expenses of the pool;

(8) guidelines for nonrenewal of coverage;

(9) the minimum capital and surplus to be maintained by the pool; and

(10) the minimum standards for reserve requirements for the pool.

(b) The plan of operation may include any matter relating to the organization and operation of the pool or to the pool's finances. (V.T.I.C. Art. 21.49-18, Sec. 5(c).)

Source Law

(c) The plan of operation may include any matters relating to the organization and operation of the pool and the pool's finances. The plan must include:

(1) the organizational structure of the pool, including the method of selection of the board, the methods of procedure and operation of the board, and a summary of the methods of management and operation of the pool;

(2) a description of the contributions and other financial arrangements necessary to cover the initial expenses of the pool and estimates supported by statistical information of the amounts of those contributions or other financial arrangements;

(3) underwriting standards and procedures for the evaluation of risks;

(4) a requirement that each participant in the pool receive continuing training in methods of controlling liability losses;

(5) procedures for the purchase of reinsurance;

(6) procedures and guidelines for establishing premium rates and maximum limits of excess liability coverage available from the pool;

(7) procedures and guidelines for negotiation and payment of settlements, defense of claims, and payments of judgments;

(8) procedures for the processing and payment of claims;

(9) procedures for defraying any losses or expenses of the pool;

(10) procedures and guidelines for the management and investment of the fund;

(11) guidelines for nonrenewal of coverage;

(12) minimum limits of capital and surplus to be maintained by the pool; and

(13) minimum standards for reserve requirements for the pool.

Revisor's Note

Section 5(c), V.T.I.C. Article 21.49-18, specifies certain provisions that the Texas Child-Care Facility Liability Pool must include in the plan of operation. For the convenience of the reader, the revised law adds a reference to "the requirements of this chapter" because other provisions of V.T.I.C. Article 21.49-18, revised in this chapter, specify additional requirements applicable to the provisions of the plan of operation.

Revised Law

Sec. 2205.103. APPROVAL OF PLAN OF OPERATION. (a) On completion of the plan of operation, the temporary board shall

submit the plan to the department for examination, suggested changes, and final approval.

(b) The department shall approve the plan of operation on the determination that the pool is able and will continue to be able to pay valid claims made against the pool. (V.T.I.C. Art. 21.49-18, Sec. 5(e).)

Source Law

(e) On completion of the plan of operation, the temporary board shall submit the plan to the State Board of Insurance for examination, suggested changes, and final approval. The State Board of Insurance shall approve the plan of operation on the determination that the pool has and will continue to have the ability to pay valid claims made against it.

[Sections 2205.104-2205.150 reserved for expansion]

SUBCHAPTER D. BOARD OF TRUSTEES

Revised Law

Sec. 2205.151. GOVERNANCE OF POOL. (a) The pool is governed by a board of trustees composed of nine members selected as provided by the plan of operation.

(b) Not later than the 15th day after the date the department approves the plan of operation, the initial regular board must be selected as provided by the plan of operation. The members of the initial regular board shall take office not later than the 30th day after the date the plan of operation is adopted. (V.T.I.C. Art. 21.49-18, Secs. 5(g), 6(a).)

Source Law

[Sec. 5]

(g) The first board shall be selected as provided by the plan of operation not later than the 15th day after the date on which the plan of operation is approved by the State Board of Insurance. The members of the first board shall take office not later than the 30th day after the date of the adoption of the plan of operation.

Sec. 6. (a) The pool is governed by a nine-member board of trustees. The trustees shall be selected as provided by the plan of operation.

Revisor's Note

Section 6(a), V.T.I.C. Article 21.49-18, refers to the selection of "trustees" for the Texas Child-Care Facility Liability Pool. Throughout this

chapter, the revised law substitutes "members" for "trustees" for consistency and because "member" is more commonly used in this chapter to describe a person serving on the board of trustees.

Revised Law

Sec. 2205.152. TERMS; VACANCY. (a) Board members serve two-year terms. The terms expire as provided by the plan of operation.

(b) A vacancy on the board shall be filled as provided by the plan of operation. (V.T.I.C. Art. 21.49-18, Secs. 6(b), (c).)

Source Law

(b) Members of the board serve for two-year terms, with the terms expiring as provided by the plan of operation.

(c) A vacancy on the board shall be filled as provided by the plan of operation.

Revised Law

Sec. 2205.153. PERFORMANCE BOND REQUIRED. (a) Each board member shall execute a bond in the amount required by the plan of operation. The bond must be payable to the pool and conditioned on the faithful performance of the member's duties.

(b) The pool shall pay the cost of the bond executed under this section. (V.T.I.C. Art. 21.49-18, Sec. 6(d).)

Source Law

(d) Each member of the board shall execute a bond payable to the pool and conditioned on the faithful performance of the member's duties. The bond shall be executed in the amount required by the plan of operation. The pool shall pay the cost of the bond.

Revised Law

Sec. 2205.154. COMPENSATION. A board member is not entitled to compensation for the member's service on the board. (V.T.I.C. Art. 21.49-18, Sec. 6(e).)

Source Law

(e) A member of the board is not entitled to compensation for the member's service on the board.

Revised Law

Sec. 2205.155. OFFICERS; MEETINGS. (a) The board shall

elect from the board's membership a presiding officer and other officers as provided by the plan of operation.

(b) Each officer serves a one-year term that expires as provided by the plan of operation.

(c) The board shall meet at the call of the presiding officer and at times established by the board's rules. (V.T.I.C. Art. 21.49-18, Secs. 6(f), (g).)

Source Law

> (f) The board shall elect a presiding officer and other officers from its membership as provided by the plan of operation. Each officer shall serve a one-year term that expires as provided by the plan of operation.
>
> (g) The board shall meet at the call of the presiding officer and at times established by its rules.

Revised Law

Sec. 2205.156. GENERAL POWERS AND DUTIES OF BOARD. (a) The board shall:

(1) approve contracts, other than liability insurance contracts issued by the pool to child-care facilities; and

(2) adopt premium rate schedules and policy forms for the pool.

(b) The board may:

(1) adopt rules as necessary for the operation of the pool;

(2) delegate specific responsibilities to the pool manager; and

(3) with the department's approval, amend the plan of operation as necessary to ensure the orderly management and operation of the pool. (V.T.I.C. Art. 21.49-18, Secs. 5(f) (part); 7(a) (part), (b).)

Source Law

> [Sec. 5]
>
> (f) The plan of operation may be amended by the board with the approval of the State Board of Insurance. . . .
>
> Sec. 7. (a) The board shall:
>
> (1) approve contracts, other than liability insurance contracts issued to child-care

facilities by the pool;

(2) adopt policy forms and premium rate schedules for the pool; and . . . .

(b) The board may:

(1) adopt rules as necessary for the operation of the pool;

(2) delegate specific responsibilities to the pool manager; and

(3) amend the plan of operation as necessary to assure the orderly management and operation of the pool.

Revisor's Note

Section 5(f), V.T.I.C. Article 21.49-18, requires the amended plan of operation to require participants in the Texas Child-Care Facility Liability Pool to receive certain training. The revised law omits this provision as duplicative of Section 5(c)(4), V.T.I.C. Article 21.49-18, revised as Section 2205.102(a)(4). The omitted law reads:

> (f) . . . The amended plan must maintain the requirement that each participant receive continuing training in methods of controlling liability losses.

Revised Law

Sec. 2205.157. IMMUNITY OF BOARD MEMBERS FROM CERTAIN LIABILITIES. A board member is not liable:

(1) with respect to a claim or judgment for which coverage is provided by the pool; or

(2) for a claim or judgment against a child-care facility covered by the pool. (V.T.I.C. Art. 21.49-18, Sec. 6(h).)

Source Law

> (h) A member of the board is not liable with respect to any claim of judgment for which coverage is provided by the pool, or for a claim or judgment against a child-care facility covered by the pool against which a claim is made.

Revisor's Note

Section 6(h), V.T.I.C. Article 21.49-18, provides that a member of the board of trustees of the Texas Child-Care Facility Liability Pool is not liable for a "claim of judgment for which coverage is provided by the pool." The revised law substitutes "or" for "of" in the quoted language because it is clear from

the context that "of" is a typographical error and that the legislature intended to use the phrase "claim or judgment."

[Sections 2205.158-2205.200 reserved for expansion]

SUBCHAPTER E. OPERATION OF POOL

Revised Law

Sec. 2205.201. GENERAL POWERS AND DUTIES OF POOL. (a) The pool shall:

(1) issue primary and excess liability coverage to each child-care facility entitled to coverage under this chapter;

(2) collect premiums for coverage issued or renewed by the pool;

(3) process and pay valid claims;

(4) maintain detailed information regarding the pool; and

(5) establish a plan to conduct loss control training or contract with an outside entity to establish continuing training and inspections programs designed to reduce the potential liability losses of pool participants.

(b) The pool may:

(1) enter into contracts;

(2) purchase reinsurance;

(3) cancel or refuse to renew coverage; and

(4) perform any other act necessary to implement this chapter, the plan of operation, or a rule adopted by the board. (V.T.I.C. Art. 21.49-18, Sec. 11.)

Source Law

Sec. 11. (a) The pool shall:

(1) issue primary and excess liability coverage to each child-care facility entitled to coverage under this article;

(2) collect premiums for coverage issued or renewed by the pool;

(3) process and pay valid claims;

(4) maintain detailed information regarding the pool; and

(5) establish a plan to conduct loss control training or contract with an outside entity to establish continuing training and inspections programs designed to reduce the potential liability

losses of participants in the pool.

(b) The pool may:

(1) contract;

(2) purchase reinsurance;

(3) cancel or refuse to renew coverage; and

(4) perform other acts necessary to implement this article, the plan of operation, and the rules adopted by the board.

Revised Law

Sec. 2205.202. POOL MANAGER; PERFORMANCE BOND REQUIRED. (a) The board shall appoint a pool manager who serves at the pleasure of the board, and the board shall supervise the pool manager's activities.

(b) The pool manager shall execute a bond in the amount determined by the board. The bond must be payable to the pool and conditioned on the faithful performance of the pool manager's duties. (V.T.I.C. Art. 21.49-18, Secs. 7(a) (part); 8(a) (part), (b).)

Source Law

Sec. 7. (a) The board shall:

. . .

(3) supervise the activities of the pool manager.

Sec. 8. (a) The board shall appoint a pool manager who serves at the pleasure of the board. . . .

(b) The pool manager shall execute a bond in the amount determined by the board, payable to the pool, and conditioned on the faithful performance of the manager's duties.

Revised Law

Sec. 2205.203. GENERAL POWERS AND DUTIES OF POOL MANAGER. (a) The pool manager shall direct the general operation of the pool and perform other duties as directed by the board.

(b) The pool manager shall:

(1) receive and approve applications for liability coverage from the pool;

(2) negotiate contracts for the pool; and

(3) prepare proposed policy forms for board approval.

(c) The pool manager may refuse to renew the coverage of a child-care facility insured by the pool that fails to meet the guidelines included in the plan of operation. (V.T.I.C. Art.

21.49-18, Secs. 8(a) (part), (c) (part), (d).)

Source Law

Sec. 8. (a) [The board shall appoint a pool manager who serves at the pleasure of the board.] The pool manager shall direct the general operation of the pool and shall perform other duties as directed by the board.

(c) The pool manager shall:

(1) receive and approve applications received from child-care facilities for liability coverage from the pool;

(2) negotiate contracts for the pool;

(3) prepare . . . proposed policy forms for board approval; and . . . .

(d) The pool manager may refuse to renew the coverage of any child-care facility insured by the pool that fails to meet the guidelines provided by the plan of operation.

Revised Law

Sec. 2205.204. PERSONNEL. (a) The pool manager may employ or contract with persons as necessary to assist the board and the pool manager in implementing the powers and duties of the pool.

(b) The board must approve:

(1) the compensation paid to a pool employee; and

(2) a contract made with a person under this section.

(V.T.I.C. Art. 21.49-18, Secs. 9(a), (b).)

Source Law

Sec. 9. (a) The pool manager may employ or contract with persons as necessary to assist the board and pool manager in implementing the powers and duties of the pool.

(b) The board must approve compensation paid to pool employees and contracts made with other persons.

Revised Law

Sec. 2205.205. PERFORMANCE BOND AUTHORIZED. The board may require an employee or a person with whom the pool manager contracts under Section 2205.204 to execute a bond in an amount determined by the board. The bond must be payable to the board and conditioned on the faithful performance of the employee's or other person's duties to the pool. (V.T.I.C. Art. 21.49-18, Sec. 9(c).)

Source Law

(c) The board may require any employee or person with whom it contracts under this section to execute a bond in an amount determined by the board, payable to the board, and conditioned on the faithful performance

of the employee's or person's duties to the pool.

Revised Law

Sec. 2205.206. IMMUNITY OF EMPLOYEES AND CONTRACTORS FROM CERTAIN LIABILITIES. An employee or a person with whom the pool manager contracts under Section 2205.204 is not liable with respect to a claim or judgment against a child-care facility covered by the pool. (V.T.I.C. Art. 21.49-18, Sec. 9(d).)

Source Law

(d) An employee or person with whom the pool has contracted is not liable with respect to any claim or judgment against a child-care facility covered by the pool against whom a claim is made.

Revised Law

Sec. 2205.207. OFFICE; RECORDS. (a) The pool shall maintain the pool's principal office in Austin, Texas.

(b) Records and other information relating to the operation of the pool must be maintained in the pool's principal office. (V.T.I.C. Art. 21.49-18, Sec. 10.)

Source Law

Sec. 10. (a) The pool shall maintain its principal office in Austin, Texas.

(b) The records and other information relating to the operation of the pool shall be maintained in the pool's principal office.

Revised Law

Sec. 2205.208. ANNUAL AUDIT. The board shall require an annual audit of the pool's capital, surplus, and reserves. The audit must be conducted by an actuary who is a member of the American Academy of Actuaries or a similar national organization of actuaries recognized by the board. (V.T.I.C. Art. 21.49-18, Sec. 12(h).)

Source Law

(h) The board shall require an annual audit of the capital, surplus, and reserves of the pool to be conducted by an actuary who is a member of the American Academy of Actuaries or a similar national organization of actuaries recognized by the board.

[Sections 2205.209-2205.250 reserved for expansion]

SUBCHAPTER F. TEXAS CHILD-CARE FACILITY LIABILITY FUND

Revised Law

Sec. 2205.251. FUND CREATION; MANAGEMENT. (a) The Texas child-care facility liability fund is established on the creation of the pool.

(b) The fund is composed of:

(1) premiums paid by child-care facilities for coverage provided by the pool;

(2) contributions and other money received by the pool to cover the initial expenses of the fund;

(3) investments of the fund and money earned from those investments; and

(4) any other money received by the pool.

(c) The pool manager, under the general supervision of the board, shall manage and invest the money in the fund in the manner provided by the plan of operation.

(d) Money earned by the investment of money in the fund must be deposited in the fund or reinvested for the fund. (V.T.I.C. Art. 21.49-18, Secs. 12(a), (b), (c); 13.)

Source Law

Sec. 12. (a) The Texas child-care facility liability fund is created on the creation of the pool.

(b) The fund is composed of:

(1) premiums paid by child-care facilities for coverage by the pool;

(2) contributions and other money received by the pool to cover the initial expenses of the fund;

(3) investments and money earned from investments of the fund; and

(4) any other money received by the pool.

(c) The pool manager shall manage the fund under the general supervision of the board.

Sec. 13. (a) The pool manager shall manage and invest the fund in the manner provided by the plan of operation.

(b) Money earned by the investment of the fund shall be deposited in the fund or reinvested for the fund.

Revised Law

Sec. 2205.252. CONTRIBUTIONS. The board shall determine the amount of contributions necessary to meet the initial expenses of the pool. The board shall make this determination based on the

information provided by the plan of operation. (V.T.I.C. Art. 21.49-18, Sec. 14.)

Source Law

> Sec. 14. From information provided in the plan of operation, the board shall determine the amount of contributions necessary to meet the initial expenses of the pool.

Revised Law

Sec. 2205.253. USES OF FUND. (a) Administrative expenses of the pool may be paid from the fund. Payments for administrative expenses during a fiscal year may not exceed 10 percent of the total amount of the money in the fund during that fiscal year.

(b) Money in the fund may not be used to pay:

(1) punitive damages; or

(2) a fine or penalty imposed for a violation of:

(A) a statute;

(B) a rule of a state agency; or

(C) an ordinance or order of a local government.

(c) A claim or judgment may be paid from the fund under excess liability insurance coverage only if all benefits payable under any other underlying liability insurance policy covering that claim or judgment are exhausted. (V.T.I.C. Art. 21.49-18, Secs. 12(d), (e), (f).)

Source Law

> (d) Administrative expenses of the pool may be paid from the fund. Payments for administrative expenses in any fiscal year may not exceed 10 percent of the total amount of money in the fund during that fiscal year.
>
> (e) The fund may not be used to pay punitive damages, fines or penalties for violation of a civil or criminal statute, or fines or penalties imposed for the violation of a rule of a state agency or an ordinance or order of a local government.
>
> (f) A claim or judgment may not be paid from the fund under excess liability insurance coverage unless and until all benefits payable under any other underlying liability insurance policy covering that claim or judgment are exhausted.

Revisor's Note

Section 12(e), V.T.I.C. Article 21.49-18, refers to "punitive damages, fines or penalties for violation

of a civil or criminal statute." The revised law omits the reference to "civil or criminal" as unnecessary because all statutes are either "civil" or "criminal."

Revised Law

Sec. 2205.254. DEPOSITORY BANK. (a) The board may select one or more banks to serve as a depository for the fund.

(b) A depository bank must provide security before money in the fund may be deposited in the bank in an amount that exceeds the maximum amount secured by the Federal Deposit Insurance Corporation. The security must be in an amount sufficient to secure the excess amount of the deposit. (V.T.I.C. Art. 21.49-18, Sec. 12(g).)

Source Law

> (g) The board may select one or more banks to serve as depository for the fund. Before the deposit of fund money in a depository bank in an amount that exceeds the maximum secured by the Federal Deposit Insurance Corporation, the bank must provide security in an amount sufficient to secure from loss the fund money that exceeds the amount secured by the Federal Deposit Insurance Corporation.

[Sections 2205.255-2205.300 reserved for expansion]

SUBCHAPTER G. POOL COVERAGE

Revised Law

Sec. 2205.301. SCOPE OF COVERAGE. (a) The pool shall insure a child-care facility and the facility's officers and employees against liability for acts and omissions under the laws of this state by the officers and employees in their official or employment capacities.

(b) The pool shall provide to a child-care facility that qualifies under this chapter and the plan of operation:

(1) primary liability insurance coverage in an amount not to exceed $300,000; and

(2) excess liability insurance coverage in an amount that the board determines is actuarially sound.

(c) The pool may participate in evaluating, settling, and defending a claim against a child-care facility insured by the

pool.

(d) The pool is liable in an amount not to exceed the limit of coverage provided to a child-care facility on a claim made against the facility. (V.T.I.C. Art. 21.49-18, Sec. 3.)

Source Law

> Sec. 3. (a) The pool shall insure a child-care facility and its officers and employees against liability for acts and omissions under the laws of this state in their official or employment capacities and shall provide primary and excess liability coverage to child-care facilities that qualify under this article and under the pool's plan of operation.
>
> (b) The pool may provide primary liability coverage to a child-care facility in an amount not to exceed $300,000. The pool may provide excess liability coverage to a child-care facility only in an amount determined by the board to be actuarially sound. The pool is liable on any claim only to the limit provided by the coverage of the child-care facility against which the claim is made.
>
> (c) The pool may participate in the evaluation, settlement, and defense of a claim against a child-care facility insured by the pool.

Revised Law

Sec. 2205.302. BASIS OF COVERAGE. The pool may provide liability insurance coverage on a claims-made basis or an occurrence basis. (V.T.I.C. Art. 21.49-18, Sec. 17.)

Source Law

> Sec. 17. Liability insurance coverage provided by the pool may be provided on a claims-made basis or on an occurrence basis.

Revised Law

Sec. 2205.303. RATES AND LIMITS OF COVERAGE. (a) To ensure that the pool is actuarially sound, the board shall:

(1) set the premium rates charged; and

(2) determine the maximum limits of coverage provided.

(b) The pool manager, for the board's consideration, shall:

(1) collect and compile statistical information relating to the liability coverage provided by the pool, including relevant loss, expense, and premium information, and other necessary information;

(2) prepare the proposed premium rate schedules for the approval of the board; and

(3) prepare the maximum limits of coverage.

(c) The board shall periodically reexamine the rate schedules and the maximum limits of coverage.

(d) The pool manager shall make available to the public the information described by Subsection (b)(1). (V.T.I.C. Art. 21.49-18, Secs. 8(c) (part), 15.)

Source Law

(c) The pool manager shall:

. . .

(3) prepare premium rate schedules and . . . for board approval; and

(4) collect and compile statistical information relating to the liability coverage provided by the pool, including relevant loss, expense, and premium information, and make the information available to the board and the public.

Sec. 15. (a) The board shall determine the premium rates charged and the maximum limits of coverages provided to assure that the pool is actuarially sound.

(b) The pool manager shall prepare statistical information and other necessary information, proposed rate schedules, and maximum limits of coverage for consideration by the board.

(c) The board shall reexamine periodically the rate schedules and the maximum limits of coverage.

Revised Law

Sec. 2205.304. COVERAGE PERIOD. A child-care facility that accepts coverage provided by the pool shall maintain that coverage for at least 24 consecutive months following the date the pool issued the coverage. (V.T.I.C. Art. 21.49-18, Sec. 16(a).)

Source Law

Sec. 16. (a) On accepting coverage from the pool, a child-care facility shall maintain the coverage for not less than 24 consecutive months after the date that the coverage is issued.

Revised Law

Sec. 2205.305. NONRENEWAL OF COVERAGE. (a) Except as provided by Subsection (b), the pool may refuse to renew the coverage of a child-care facility that fails to comply with the pool's underwriting standards.

(b) The pool may not refuse to renew the coverage of a child-care facility during the first 24 months following the date the facility is first provided coverage by the pool if the facility

maintains the underwriting standards established by the plan of operation. (V.T.I.C. Art. 21.49-18, Sec. 18.)

Source Law

> Sec. 18. (a) Except as provided by Subsection (b) of this section, the pool may refuse to renew the coverage of any child-care facility that fails to comply with the pool's underwriting standards.
>
> (b) If a participant in the pool maintains underwriting standards established by the plan of operation, the pool may not refuse to renew the coverage of a child-care facility for the first 24 months after the date on which the facility was first insured by the pool.

Revisor's Note

Section 18(b), V.T.I.C. Article 21.49-18, prohibits the Texas Child-Care Facility Liability Pool from refusing to renew the coverage of a child-care facility for a certain period if a "participant in the pool" meets certain standards. For consistency, the revised law substitutes "child-care facility" for the quoted language.

Revised Law

Sec. 2205.306. SUBSEQUENT COVERAGE. A child-care facility that voluntarily discontinues coverage provided by the pool is not eligible to subsequently obtain coverage from the pool for at least 12 months following the date the coverage is discontinued. (V.T.I.C. Art. 21.49-18, Sec. 16(b).)

Source Law

> (b) A child-care facility that voluntarily discontinues coverage in the pool is ineligible to obtain coverage from the pool for at least 12 months after the date on which the coverage was discontinued.

Revised Law

Sec. 2205.307. PAYMENT OF CLAIMS AND JUDGMENTS. (a) If money in the fund would be exhausted by the payment of all final and settled claims and final judgments during a fiscal year, the pool shall prorate the amount paid to each person having the claim or judgment.

(b) If the amount paid by the pool is prorated under this section, each person described by Subsection (a) shall receive an

amount equal to the percentage that the amount owed to that person by the pool bears to the total amount owed, outstanding, and payable by the pool.

(c) The pool shall pay in the next fiscal year the remaining amount that is due and unpaid to a person who receives a prorated payment under this section. (V.T.I.C. Art. 21.49-18, Sec. 19.)

Source Law

> Sec. 19. (a) If money in the fund will be exhausted by payment of all final and settled claims and final judgments during a fiscal year, the amount paid by the pool to each person who has a claim or judgment shall be prorated, with each person receiving an amount equal to the percentage that the amount owed to that person bears to the total amount owed, outstanding, and payable by the pool.
>
> (b) The balance of the amount due and unpaid to a person who receives prorated payment under Subsection (a) of this section shall be paid in the subsequent fiscal year.

CHAPTER 2206. RISK MANAGEMENT POOLS FOR CERTAIN EDUCATIONAL ENTITIES

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CHAPTER 2206. RISK MANAGEMENT POOLS FOR CERTAIN EDUCATIONAL ENTITIES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2206.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of trustees of a pool.

(2) "Fund" means a risk management fund.

(3) "Junior college district" means a junior college district created under the laws of this state.

(4) "Pool" means a risk management pool created under this chapter.

(5) "School district" means a public school district created under the laws of this state. (V.T.I.C. Art. 21.49-17, Secs. 1(1), (2), (4), (5), (6).)

Source Law

Art. 21.49-17
Sec. 1. In this article:
(1) "School district" means a public school district created under the laws of this state.
(2) "Junior college district" means a junior college district organized under the laws of this state.

(4) "Pool" means a risk management pool created under this article.
(5) "Fund" means a risk management fund.
(6) "Board" means the board of trustees of a pool.

Revisor's Note

(1) Section 1(2), V.T.I.C. Article 21.49-17, refers to a junior college district "organized under the laws of this state." The revised law substitutes "created" for "organized" for consistency with the definition of "school district" in Section 1(1), V.T.I.C. Article 21.49-17, revised in this section, and because, in context, the words have the same meaning.

(2) Sections 1(3) and (7), V.T.I.C. Article 21.49-17, define "entity" and "plan," respectively. The revised law omits those definitions and, throughout this chapter, substitutes the applicable substance of those definitions for the terms "entity" and "plan." The omitted law reads:

(3) "Entity" means a school district or junior college district.

(7) "Plan" means a pool's plan of operation.

Revised Law

Sec. 2206.002. APPLICABILITY OF OTHER LAWS. (a) Except as provided by Subsection (b), a pool is not considered insurance under this code or other laws of this state, and the department does not have jurisdiction over the pool.

(b) The pool:

(1) shall collect the necessary information and file with the department the reports required by Subchapter D, Chapter

38; and

(2) is subject to Chapter 541 and Section 543.001.

(V.T.I.C. Art. 21.49-17, Sec. 15.)

Source Law

Sec. 15. (a) Except as provided by Subsection (b) of this section, a pool provided by this article is not considered insurance under this code and other laws of this state and the State Board of Insurance has no jurisdiction over the pool.

(b) The pool shall collect the necessary data, information, and statements and shall file with the State Board of Insurance the reports and statements required by Articles 1.24A and 1.24B and is subject to 21.21 of this code.

Revisor's Note

(1) Section 15, V.T.I.C. Article 21.49-17, 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 references to the State Board of Insurance have been changed appropriately.

(2) Section 15(b), V.T.I.C. Article 21.49-17, requires a risk management pool to collect "data, information, and statements" and file "reports and statements" required by V.T.I.C. Articles 1.24A and 1.24B. The revised law omits the reference to "data" because "data" is included within the meaning of "information." The revised law also omits the references to "statements" because V.T.I.C. Article 1.24B, codified as Subchapter D, Chapter 38, of this code, does not require that statements be collected or filed, and V.T.I.C. Article 1.24A is repealed (see Revisor's Note (3) to this section).

(3) Section 15(b), V.T.I.C. Article 21.49-17, refers to V.T.I.C. Article 1.24A. The revised law omits the reference to Article 1.24A because that

article was repealed by Section 8.12, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993.

[Sections 2206.003-2206.050 reserved for expansion]

SUBCHAPTER B. SCHOOL DISTRICT RISK MANAGEMENT POOL

Revised Law

Sec. 2206.051. CREATION OF SCHOOL DISTRICT RISK MANAGEMENT POOL. (a) The boards of trustees of five or more school districts may create the school district risk management pool by adopting a resolution to create the pool.

(b) The school district risk management pool insures each school district that purchases coverage in the pool against liability under law for the district's acts and omissions.

(c) Not more than one school district risk management pool may be created under this subchapter. (V.T.I.C. Art. 21.49-17, Secs. 2(b) (part), (c) (part), (e) (part).)

Source Law

> (b) On the adoption of a resolution by not fewer than five boards of trustees of school districts to create the school district risk management pool or . . . the risk management pool for the type of governmental entity is created.
>
> (c) The risk management pool for school districts is created to insure each school district that purchases coverage in the pool against liability for its acts and omissions under the law. . . .
>
> (e) There may not be more than one school district risk management pool and . . . .

Revised Law

Sec. 2206.052. PARTICIPATION IN POOL. (a) A school district that meets the criteria established by the school district risk management pool in the pool's plan of operation may:

(1) purchase coverage from the pool; and

(2) use district money to pay the fees, contributions, or premiums required to participate in the pool and obtain the coverage.

(b) A junior college district may not participate in the school district risk management pool. (V.T.I.C. Art. 21.49-17, Secs. 2(d) (part), 3 (part).)

Source Law

[Sec. 2]

(d) . . . junior college districts may not participate in the school district risk management pool.

Sec. 3. A school district or . . . in this state that meets the criteria established by its respective pool in that pool's plan may purchase from that pool coverage insuring the district against liability for its acts or omissions under the law and may use funds of the district to pay any fees, contributions, or premiums required to be a part of the pool and to obtain that coverage.

Revisor's Note

(1) Section 3, V.T.I.C. Article 21.49-17, refers to a school district "in this state." The revised law omits "in this state" as unnecessary because the phrase is implied by the definition of "school district" under Section 1(1), V.T.I.C. Article 21.49-17, revised in this chapter as Section 2206.001(5), which provides that "school district" means "a public school district created under the laws of this state."

(2) Section 3, V.T.I.C. Article 21.49-17, states that a school district may purchase coverage "insuring the district against liability for its acts or omissions under the law." The revised law omits the quoted language as duplicative of Section 2(c), V.T.I.C. Article 21.49-17, revised in this chapter as Section 2206.051(b), which provides that the risk management pool insures each participating school district against liability for the district's acts and omissions under the law.

(3) Section 3, V.T.I.C. Article 21.49-17, states that a school district may use district "funds" for certain purposes. Throughout this chapter, the revised law substitutes "money" for "funds" because, in context, the terms are synonymous and the former is more commonly used.

Revised Law

Sec. 2206.053. ORGANIZATIONAL MEETING; SELECTION OF TEMPORARY BOARD. (a) On authorization to create the school district risk management pool as provided by Section 2206.051, the board of trustees of each school district adopting a resolution to create the pool shall select one representative to meet with representatives of the other school districts adopting the resolution.

(b) At the meeting, the representatives shall:

(1) adopt guidelines for developing an organizational plan for the pool; and

(2) select nine individuals to serve as a temporary board for the pool. (V.T.I.C. Art. 21.49-17, Secs. 4(a) (part), (b).)

Source Law

> Sec. 4. (a) On authorization to create a pool as provided by Section 2 of this article, each board adopting a resolution to create the pool shall select one representative to meet with representatives of the other school districts or . . . adopting the resolution.
>
> (b) At the meeting, the representatives shall adopt guidelines for developing an organizational plan for the pool and shall select nine persons to serve as a temporary board of trustees.

Revisor's Note

Section 4(a), V.T.I.C. Article 21.49-17, refers to each "board" adopting a resolution to create the school district risk management pool. The revised law substitutes "board of trustees of each school district" for "board" to clarify that, in this section, the reference to "board" is not a reference to the board of trustees of a pool, as the term "board" is defined by Section 1(6), V.T.I.C. Article 21.49-17, revised in this chapter as Section 2206.001(1).

[Sections 2206.054-2206.100 reserved for expansion]

SUBCHAPTER C. JUNIOR COLLEGE DISTRICT RISK MANAGEMENT POOL

Revised Law

Sec. 2206.101. CREATION OF JUNIOR COLLEGE DISTRICT RISK MANAGEMENT POOL. (a) The board of trustees of five or more junior college districts may create the junior college district risk management pool by adopting a resolution to create the pool.

(b) The junior college district risk management pool insures each junior college district that purchases coverage in the pool against liability under law for the district's acts and omissions.

(c) Not more than one junior college district risk management pool may be created under this subchapter. (V.T.I.C. Art. 21.49-17, Secs. 2(b) (part), (c) (part), (e) (part).)

Source Law

> (b) On the adoption of a resolution by . . . not fewer than five boards of trustees of junior college districts to create the junior college risk management pool, the risk management pool for the type of governmental entity is created.
>
> (c) . . . The risk management pool for junior college districts is created to insure each junior college district that purchases coverage in the pool against liability for its acts and omissions under the law.
>
> (e) There may . . . be . . . not more than one junior college district risk management pool created under this article.

Revised Law

Sec. 2206.102. PARTICIPATION IN POOL. (a) A junior college district that meets the criteria established by the junior college district risk management pool in the pool's plan of operation may:

(1) purchase coverage from the pool; and

(2) use district money to pay the fees, contributions, or premiums required to participate in the pool and obtain the coverage.

(b) A school district may not participate in the junior college district risk management pool. (V.T.I.C. Art. 21.49-17, Secs. 2(d) (part), 3 (part).)

Source Law

[Sec. 2]

(d) School districts may not participate in the junior college district risk management pool and . . . .

Sec. 3. . . . a junior college district in this state that meets the criteria established by its respective pool in that pool's plan may purchase from that pool coverage insuring the district against liability for its acts or omissions under the law and may use funds of the district to pay any fees, contributions, or premiums required to be a part of the pool and to obtain that coverage.

Revisor's Note

(1) Section 3, V.T.I.C. Article 21.49-17, refers to a junior college district "in this state." The revised law omits "in this state" as unnecessary because the phrase is implied by the definition of "junior college district" under Section 1(2), V.T.I.C. Article 21.49-17, revised in this chapter as Section 2206.001(3), which provides that "junior college district" means "a junior college district organized under the laws of this state."

(2) Section 3, V.T.I.C. Article 21.49-17, states that a junior college district may purchase coverage "insuring the district against liability for its acts or omissions under the law." The revised law omits the quoted language as duplicative of Section 2(c), V.T.I.C. Article 21.49-17, revised in this chapter as Section 2206.101(b), which provides that the risk management pool insures each participating junior college district against liability for the district's acts and omissions under the law.

Revised Law

Sec. 2206.103. ORGANIZATIONAL MEETING; SELECTION OF TEMPORARY BOARD. (a) On authorization to create the junior college district risk management pool as provided by Section 2206.101, the board of trustees of each junior college district adopting a resolution to create the pool shall select one

representative to meet with representatives of the other junior college districts adopting the resolution.

(b) At the meeting, the representatives shall:

(1) adopt guidelines for developing an organizational plan for the pool; and

(2) select nine individuals to serve as a temporary board for the pool. (V.T.I.C. Art. 21.49-17, Secs. 4(a) (part), (b).)

Source Law

> Sec. 4. (a) On authorization to create a pool as provided by Section 2 of this article, each board adopting a resolution to create the pool shall select one representative to meet with representatives of the other . . . junior college districts adopting the resolution.
>
> (b) At the meeting, the representatives shall adopt guidelines for developing an organizational plan for the pool and shall select nine persons to serve as a temporary board of trustees.

Revisor's Note

Section 4(a), V.T.I.C. Article 21.49-17, refers to each "board" adopting a resolution to create the junior college district risk management pool. The revised law substitutes "board of trustees of each junior college district" for "board" to clarify that, in this section, the reference to "board" is not a reference to the board of trustees of a pool, as the term "board" is defined by Section 1(6), V.T.I.C. Article 21.49-17, revised in this chapter as Section 2206.001(1).

[Sections 2206.104-2206.150 reserved for expansion]

SUBCHAPTER D. PLAN OF OPERATION

Revised Law

Sec. 2206.151. TIME FOR CREATION OF PLAN OF OPERATION. (a) Not later than the 30th day after the date the temporary board of a pool is selected, the temporary board shall meet and begin preparing a detailed plan of operation for the pool.

(b) The temporary board shall complete the plan of operation

not later than the 90th day after the date the temporary board is selected. (V.T.I.C. Art. 21.49-17, Secs. 5(a), (c).)

Source Law

> Sec. 5. (a) Within 30 days after selection, the members of the temporary board shall meet and begin to prepare a detailed plan of operation for the pool.
>
> (c) The temporary board shall complete the plan within 90 days after the date of the appointment of the temporary board.

Revised Law

Sec. 2206.152. CONTENTS OF PLAN OF OPERATION. (a) Subject to the requirements of this chapter, a pool's plan of operation must include:

(1) the organizational structure of the pool, including:

(A) the number of regular board members;

(B) the method of selecting the board members;

(C) the board's method of procedure and operation; and

(D) a summary of the method for managing and operating the pool;

(2) a description of the fees, contributions, or financial arrangements necessary to cover the initial expenses of the pool and estimates, supported by statistical data, of the amounts of those fees, contributions, or other financial arrangements;

(3) underwriting guidelines and procedures for evaluating risks;

(4) procedures for purchasing reinsurance;

(5) methods, procedures, and guidelines for establishing:

(A) premium rates for pool coverage; and

(B) pool coverage limits;

(6) procedures for processing and paying claims;

(7) methods and procedures for defraying losses and expenses of the pool;

(8) methods, procedures, and guidelines for managing and investing the money in the fund created for the pool;

(9) minimum capital and surplus to be maintained by the pool; and

(10) minimum standards for reserve requirements for the pool.

(b) The plan of operation may include any matter relating to the organization and operation of the pool and the pool's finances. (V.T.I.C. Art. 21.49-17, Sec. 5(b).)

Source Law

(b) The plan may include any matters relating to the organization and operation of the pool and its finances and shall include:

(1) the organizational structure of the pool, including the number, method of selection, and method of procedure and operation of the regular board for the pool and a summary of the method for managing and operating the pool;

(2) a description of the fees, contributions, or financial arrangements necessary to cover the initial expenses of the pool and estimates supported by statistical data of the amounts of those fees, contributions, or other financial arrangements;

(3) underwriting guidelines and procedures for the evaluation of risks;

(4) procedures for purchase of reinsurance;

(5) methods, procedures, and guidelines for establishing rates for premiums for and limits of coverage in the pool;

(6) procedures for the processing and payment of claims;

(7) methods and procedures for defraying losses and expenses of the pool;

(8) methods, procedures, and guidelines for the management and investment of the fund;

(9) minimum limits of capital and surplus to be maintained by the pool; and

(10) minimum standards for reserve requirements for the pool.

Revisor's Note

Section 5(b), V.T.I.C. Article 21.49-17, specifies certain provisions that a risk management pool must include in the plan of operation. For the convenience of the reader, the revised law adds a reference to "the requirements of this chapter" because other provisions of V.T.I.C. Article 21.49-17, revised in this chapter, specify additional

requirements applicable to the provisions of the plan of operation.

[Sections 2206.153-2206.200 reserved for expansion]

SUBCHAPTER E. BOARD OF TRUSTEES

Revised Law

Sec. 2206.201. BOARD OF TRUSTEES. (a) A pool is governed by a board of trustees as provided by the plan of operation.

(b) Not later than the 15th day after the date the temporary board of a pool completes the plan of operation, the initial regular board must be selected and take office as provided by the plan.

(c) An individual serving on the board who is an officer or employee of a school district or junior college district covered by the pool performs duties on the board as additional duties required of the individual's original office or employment. (V.T.I.C. Art. 21.49-17, Secs. 6(a), (b), (c).)

Source Law

Sec. 6. (a) The pool is governed by a board of trustees as provided in the plan.

(b) Not later than the 15th day after the plan is completed by the temporary board, the initial regular board must be selected and take office as provided by the plan.

(c) A person serving on the board who is an officer or employee of an entity covered by the pool performs duties on the board as additional duties required of his original office or employment.

Revised Law

Sec. 2206.202. GENERAL AUTHORITY OF BOARD; RULES. (a) A board is responsible for the general administration and operation of the pool and the pool's fund.

(b) The board may:

(1) exercise powers and enter into contracts necessary to implement this chapter and the plan of operation; and

(2) adopt rules to implement this chapter and the plan of operation. (V.T.I.C. Art. 21.49-17, Secs. 6(d), 10, 14.)

Source Law

[Sec. 6]

(d) The general administration and operation of the pool and its fund are vested in the board.

Sec. 10. The board may exercise any powers and may enter into any contracts necessary to carry out this article and the plan.

Sec. 14. The board may adopt rules to carry out this article and the plan.

Revised Law

Sec. 2206.203. PERSONNEL; CONTRACTS FOR SERVICES. (a) A board may employ a fund manager and other persons necessary to implement this chapter and the plan of operation.

(b) The board may employ or contract with a person or insurer for underwriting, accounting, claims, and other services. (V.T.I.C. Art. 21.49-17, Sec. 11.)

Source Law

Sec. 11. (a) The board may employ a fund manager and other persons necessary to carry out this article and the plan.

(b) The board may employ or contract with persons or insurance carriers for underwriting, accounting, claims, and other services.

Revised Law

Sec. 2206.204. PERFORMANCE BOND REQUIRED. (a) Each board member and each board employee who has authority over money in the fund or money collected or invested by the pool shall execute a bond in an amount determined by the board. The bond must be payable to the pool and conditioned on the faithful performance of the person's duties.

(b) The pool shall pay the cost of a bond executed under Subsection (a). (V.T.I.C. Art. 21.49-17, Sec. 6(f).)

Source Law

(f) Each member of the board and each employee of the board who has any authority over money in the fund or money collected or invested by the pool shall execute a bond in an amount determined by the board, payable to the pool, conditioned on the faithful performance of his duties. The cost of the bond shall be paid by the pool.

Revised Law

Sec. 2206.205. IMMUNITY FROM CERTAIN LIABILITIES. A board member or board employee is not liable:

(1) with respect to a claim or judgment for which coverage is provided by the pool; or

(2) for a claim or judgment made against a school district or junior college district covered by the pool. (V.T.I.C. Art. 21.49-17, Sec. 6(e).)

Source Law

(e) A member or employee of the board is not liable with respect to any claim or judgment for which coverage is provided by the pool or for a claim or judgment against any entity covered by the pool against whom a claim is made.

[Sections 2206.206-2206.250 reserved for expansion]

SUBCHAPTER F. RISK MANAGEMENT FUND

Revised Law

Sec. 2206.251. FUND CREATION; MANAGEMENT. (a) Immediately after taking office, an initial regular board shall create a risk management fund. The fund must include:

(1) fees, contributions, and premiums collected by the pool;

(2) investments of money in the fund;

(3) interest earned on investments made by the pool; and

(4) all other income received by the pool.

(b) The board shall manage and invest the money in the fund in the manner provided by the plan of operation. (V.T.I.C. Art. 21.49-17, Secs. 7(a), (b).)

Source Law

Sec. 7. (a) Immediately after taking office, the initial regular board shall create a risk management fund. The fund must include:

(1) fees, contributions, and premiums collected by the pool;

(2) investments of money in the fund;

(3) interest earned on investments made by the pool; and

(4) any other income received by the pool from any sources.

(b) The board shall manage and invest the money in the fund in the manner provided by the plan.

Revised Law

Sec. 2206.252. USES OF FUND. (a) The money in a pool's fund:

(1) shall be used to pay liability claims and

judgments against school districts or junior college districts that participate in the pool, not to exceed the limits of the coverage provided by the pool; and

(2) may be used to pay the administrative and management costs of the pool and the fund, not to exceed the limits provided in the plan of operation.

(b) On the board's approval, a pool may pay commissions from the fund. (V.T.I.C. Art. 21.49-17, Secs. 7(c), 13.)

Source Law

[Sec. 7]

(c) The money in the fund shall be used to pay liability claims and judgments against entities that are participants in the pool up to the limits of the coverage provided by the pool. Also, money in the fund may be used to pay the administrative and management costs of the pool and the fund up to the limits provided in the plan.

Sec. 13. A pool may pay commissions from the fund on approval of the board.

[Sections 2206.253-2206.300 reserved for expansion]

SUBCHAPTER G. PREMIUM RATES AND COVERAGE; REINSURANCE

Revised Law

Sec. 2206.301. PREMIUM RATES AND COVERAGE LIMITS. A pool's board shall determine the premium rates charged by the pool and pool coverage limits to ensure that the pool and the fund are actuarially sound. (V.T.I.C. Art. 21.49-17, Sec. 8.)

Source Law

Sec. 8. The board shall determine the rates for premiums that will be charged and the limits of coverage provided to assure that the pool and the fund are actuarially sound.

Revised Law

Sec. 2206.302. GUARANTEED ISSUANCE OF INITIAL COVERAGE; RISK MANAGEMENT. (a) Subject to Subsection (b), a school district or junior college district that applies for initial coverage through a pool is entitled to that coverage for a period of not less than one year, regardless of loss history. The board may approve a longer period for the initial coverage.

(b) For a school district or junior college district to

obtain initial coverage, the board may require that the district participate in a risk management appraisal and comply with the recommendations resulting from the appraisal.

(c) If complying with the recommended risk management techniques resulting from the appraisal does not reduce the school district's or junior college district's losses during the initial coverage period sufficiently to meet the pool's underwriting standards, the board may deny the district subsequent coverage through the pool.

(d) The pool may assess a surcharge to a school district or junior college district covered during the initial coverage period if the district does not meet the basic underwriting guidelines for the pool. (V.T.I.C. Art. 21.49-17, Sec. 12.)

Source Law

> Sec. 12. (a) An entity that applies for initial coverage from a pool is entitled to coverage for an initial period of not less than one year regardless of loss history.
>
> (b) The board may approve a longer period of initial coverage.
>
> (c) To obtain coverage for the initial period, the board may require that the entity participate in a risk management appraisal and comply with the recommendations obtained from the appraisal.
>
> (d) If risk management techniques suggested by the appraisal do not sufficiently reduce losses during the initial coverage period to meet the pool's underwriting standards, the board may deny an entity further coverage by the pool.
>
> (e) A pool may assess a surcharge to any risk covered during the initial period if the risk does not meet the basic underwriting guidelines for the pool.

Revisor's Note

Section 12(e), V.T.I.C. Article 21.49-17, authorizes a risk management pool to assess a surcharge to "any risk" covered during the period of initial coverage if "the risk" fails to meet certain guidelines. The revised law substitutes "school district or junior college district" for "risk" because in this context, "risk" means a school district or junior college district that is covered by the insurance obtained through the pool and,

consequently, the entity against which the pool would assess the surcharge.

Revised Law

Sec. 2206.303. REINSURANCE. A board may purchase reinsurance for a risk covered through the pool. (V.T.I.C. Art. 21.49-17, Sec. 9.)

Source Law

Sec. 9. The board may purchase reinsurance for any risks covered by the pool.

Revisor's Note
(End of Chapter)

Section 2(a), V.T.I.C. Article 21.49-17, allows for the creation of separate risk management pools for school districts and junior college districts. The revised law omits the provision as unnecessary because it duplicates the substance of Section 2(b), V.T.I.C. Article 21.49-17, revised in this chapter as Sections 2206.051(a) and 2206.101(a). The omitted law reads:

Sec. 2. (a) Separate risk management pools may be created for school districts and for junior college districts as provided by this article.

CHAPTER 2207. EXCESS LIABILITY POOLS FOR COUNTIES AND CERTAIN EDUCATIONAL ENTITIES

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CHAPTER 2207. EXCESS LIABILITY POOLS FOR COUNTIES AND CERTAIN EDUCATIONAL ENTITIES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2207.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of trustees of a pool.

(2) "County" means a county in this state.

(3) "Fund" means an excess liability fund.

(4) "Junior college district" means a junior college district created under the laws of this state.

(5) "Pool" means an excess liability pool created

under this chapter.

(6) "School district" means a public school district created under the laws of this state. (V.T.I.C. Art. 21.49-13, Secs. 1(1), (2), (3), (4), (5), (6).)

Source Law

Art. 21.49-13
Sec. 1. In this article:
(1) "Pool" means an excess liability pool created under this article.
(2) "Fund" means an excess liability fund.
(3) "Board" means the board of trustees of a pool.
(4) "County" means a county in this state.
(5) "School district" means a public school district created under the laws of this state.
(6) "Junior college district" means a junior college district organized under the laws of this state.

Revisor's Note

(1) Section 1(6), V.T.I.C. Article 21.49-13, refers to a junior college district "organized under the laws of this state." The revised law substitutes "created" for "organized" for consistency with the definition of "school district" in Section 1(5), V.T.I.C. Article 21.49-13, revised in this section, and because, in context, the words have the same meaning.

(2) Section 1(7), V.T.I.C. Article 21.49-13, defines "entity." The revised law omits this definition and, throughout this chapter, substitutes the substance of the definition for the term "entity." The omitted law reads:

(7) "Entity" means a county, school district, or junior college district.

Revised Law

Sec. 2207.002. POOL NOT ENGAGED IN BUSINESS OF INSURANCE. (a) Except as provided by Subsection (b), a pool is not engaged in the business of insurance under this code or other laws of this state, and the department does not have jurisdiction over a pool.

(b) A pool:

(1) shall collect the necessary information and file with the department the reports required by Subchapter D, Chapter 38; and

(2) is subject to Chapter 541 and Section 543.001. (V.T.I.C. Art. 21.49-13, Sec. 22.)

Source Law

Sec. 22. (a) Except as provided by Subsection (b) of this section, the pool is not considered insurance under the Insurance Code and other laws of this state, and the State Board of Insurance has no jurisdiction over the pool.

(b) The pool shall collect the necessary data, information, and statements and shall file with the State Board of Insurance the reports and statements required by Articles 1.24A and 1.24B and is subject to 21.21 of this code.

Revisor's Note

(1) Section 22, V.T.I.C. Article 21.49-13, 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 references to the State Board of Insurance have been changed appropriately.

(2) Section 22(b), V.T.I.C. Article 21.49-13, requires an excess liability pool to collect "data, information, and statements" and file "reports and statements" required by V.T.I.C. Articles 1.24A and 1.24B. The revised law omits the reference to "data" because "data" is included within the meaning of "information." The revised law also omits the references to "statements" because V.T.I.C. Article 1.24B, codified as Subchapter D, Chapter 38, of this code, does not require that statements be collected or filed, and V.T.I.C. Article 1.24A is repealed (see Revisor's Note (3) to this section).

(3) Section 22(b), V.T.I.C. Article 21.49-13, refers to V.T.I.C. Article 1.24A. The revised law omits the reference to Article 1.24A because that article was repealed by Section 8.12, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993.

[Sections 2207.003-2207.050 reserved for expansion]

SUBCHAPTER B. COUNTY EXCESS LIABILITY POOL

Revised Law

Sec. 2207.051. CREATION OF COUNTY EXCESS LIABILITY POOL. (a) The county judges of five or more counties may, on written agreement, create a county excess liability pool.

(b) The county excess liability pool provides excess liability insurance coverage as provided by this chapter and the pool's plan of operation.

(c) Not more than one county excess liability pool may be created under this subchapter. (V.T.I.C. Art. 21.49-13, Secs. 2(b) (part), (c), (d) (part).)

Source Law

(b) An excess liability pool may be created:

(1) for counties, on written agreement to create the pool by the county judges of not fewer than five counties in this state;

. . .

(c) An excess liability pool is created to provide excess liability insurance coverage as provided by this article and the plan.

(d) . . . There may not be more than one county excess liability pool, . . . .

Revisor's Note

Section 2(b)(1), V.T.I.C. Article 21.49-13, refers to "counties in this state." The revised law omits the phrase "in this state" because "in this state" is included in the definition of "county" in Section 1(4), V.T.I.C. Article 21.49-13, revised in this chapter as Section 2207.001(2).

Revised Law

Sec. 2207.052. PARTICIPATION IN OTHER POOLS NOT PERMITTED. A county may participate only in a pool created for counties.

(V.T.I.C. Art. 21.49-13, Sec. 2(d) (part).)

Source Law

(d) An entity may participate only in a pool created for that type of entity. . . .

Revised Law

Sec. 2207.053. SELECTION OF TEMPORARY BOARD. At the time a written agreement is executed under Section 2207.051, the county judges of each county executing the agreement to create the pool shall select nine individuals to:

(1) serve as a temporary board; and

(2) draft the plan of operation for the pool. (V.T.I.C. Art. 21.49-13, Sec. 6(a).)

Source Law

Sec. 6. (a) At the time the written agreement is executed under Section 2 of this article, the creators shall select nine persons to serve as a temporary board to draft the plan of operation for a pool.

[Sections 2207.054-2207.100 reserved for expansion]

SUBCHAPTER C. SCHOOL DISTRICT EXCESS LIABILITY POOL

Revised Law

Sec. 2207.101. CREATION OF SCHOOL DISTRICT EXCESS LIABILITY POOL. (a) Acting on behalf of their boards, the presidents of the boards of trustees of five or more school districts may, on written agreement, create a school district excess liability pool.

(b) The school district excess liability pool provides excess liability insurance coverage as provided by this chapter and the pool's plan of operation.

(c) Not more than one school district excess liability pool may be created under this subchapter. (V.T.I.C. Art. 21.49-13, Secs. 2(b) (part), (c), (d) (part).)

Source Law

(b) [An excess liability pool may be created:]

. . .

(2) for school districts, on written agreement to create the pool by the presidents of the boards of trustees, acting on behalf of their boards, of not fewer than five school districts in this state; or

. . .

(c) An excess liability pool is created to provide excess liability insurance coverage as provided by this article and the plan.

(d) . . . There may not be more than . . . one school district excess liability pool, and . . . .

Revisor's Note

Section 2(b)(2), V.T.I.C. Article 21.49-13, refers to "school districts in this state." "School district," as defined by Section 1(5), V.T.I.C. Article 21.49-13, revised in this chapter as Section 2207.001(6), is a school district created "under the laws of this state." To be a school district created under the laws of this state, the district must be in this state. Therefore, the revised law omits "in this state" as included within the definition of "school district."

Revised Law

Sec. 2207.102. PARTICIPATION IN OTHER POOLS NOT PERMITTED. A school district may participate only in a pool created for school districts. (V.T.I.C. Art. 21.49-13, Sec. 2(d) (part).)

Source Law

(d) An entity may participate only in a pool created for that type of entity. . . .

Revised Law

Sec. 2207.103. SELECTION OF TEMPORARY BOARD. At the time a written agreement is executed under Section 2207.101, the presidents of the boards of trustees of each school district executing the agreement to create the pool shall select nine individuals to:

(1) serve as a temporary board; and

(2) draft the plan of operation for the pool. (V.T.I.C. Art. 21.49-13, Sec. 6(a).)

Source Law

Sec. 6. (a) At the time the written agreement is executed under Section 2 of this article, the creators shall select nine persons to serve as a temporary board to draft the plan of operation for a pool.

[Sections 2207.104-2207.150 reserved for expansion]

SUBCHAPTER D. JUNIOR COLLEGE DISTRICT EXCESS LIABILITY POOL

Revised Law

Sec. 2207.151. CREATION OF JUNIOR COLLEGE DISTRICT EXCESS LIABILITY POOL. (a) Acting on behalf of their boards, the presiding officers of the boards of trustees of five or more junior college districts may, on written agreement, create a junior college district excess liability pool.

(b) The junior college district excess liability pool provides excess liability insurance coverage as provided by this chapter and the pool's plan of operation.

(c) Not more than one junior college district excess liability pool may be created under this subchapter. (V.T.I.C. Art. 21.49-13, Secs. 2(b) (part), (c), (d) (part).)

Source Law

> (b) [An excess liability pool may be created:]
>
> . . .
>
> (3) for junior college districts, on written agreement to create the pool by the presiding officers of the boards of trustees, acting on behalf of their boards, of not fewer than five junior college districts in this state.
>
> (c) An excess liability pool is created to provide excess liability insurance coverage as provided by this article and the plan.
>
> (d) . . . There may not be more than . . . one junior college district excess liability pool.

Revisor's Note

Section 2(b)(3), V.T.I.C. Article 21.49-13, refers to "junior college districts in this state." "Junior college district," as defined by Section 1(6), V.T.I.C. Article 21.49-13, revised in this chapter as Section 2207.001(4), is a junior college district created "under the laws of this state." To be a junior college district created under the laws of this state, the district must be in this state. Therefore, the revised law omits "in this state" as included within the definition of "junior college district."

Revised Law

Sec. 2207.152. PARTICIPATION IN OTHER POOLS NOT PERMITTED. A junior college district may participate only in a pool created for junior college districts. (V.T.I.C. Art. 21.49-13, Sec. 2(d) (part).)

Source Law

> (d) An entity may participate only in a pool created for that type of entity. . . .

Revised Law

Sec. 2207.153. SELECTION OF TEMPORARY BOARD. At the time a written agreement is executed under Section 2207.151, the presiding officers of the boards of trustees of each junior college district executing the agreement to create the pool shall select nine individuals to:

(1) serve as a temporary board; and

(2) draft the plan of operation for the pool. (V.T.I.C. Art. 21.49-13, Sec. 6(a).)

Source Law

> Sec. 6. (a) At the time the written agreement is executed under Section 2 of this article, the creators shall select nine persons to serve as a temporary board to draft the plan of operation for a pool.

[Sections 2207.154-2207.200 reserved for expansion]

SUBCHAPTER E. PLAN OF OPERATION

Revised Law

Sec. 2207.201. TIME FOR CREATION OF PLAN OF OPERATION. (a) Not later than the 30th day after the date the temporary board of a pool is selected, the temporary board shall meet to prepare a detailed plan of operation for the pool.

(b) The temporary board shall complete and adopt the plan of operation not later than the 90th day after the date the temporary board is selected. (V.T.I.C. Art. 21.49-13, Secs. 6(b), (d).)

Source Law

> (b) Within 30 days after selection, the members of a temporary board shall meet to prepare a detailed plan of operation for the pool.

(d) The temporary board shall complete and adopt the plan of operation within 90 days after the date of the appointment of the temporary board.

Revised Law

Sec. 2207.202. CONTENTS OF PLAN OF OPERATION. (a) Subject to the requirements of this chapter, a pool's plan of operation must include:

(1) the organizational structure of the pool, including:

(A) the method of selecting the board;

(B) the board's method of procedure and operation; and

(C) a summary of the method for managing and operating the pool;

(2) a description of the contributions and other financial arrangements necessary to cover the initial expenses of the pool and estimates, supported by statistical data, of the amounts of those contributions or other financial arrangements;

(3) underwriting standards and procedures for evaluating risks;

(4) procedures for purchasing reinsurance;

(5) methods, procedures, and guidelines for:

(A) establishing the premium rates for and maximum limits of excess liability insurance coverage available from the pool; and

(B) managing and investing money in the fund created for the pool;

(6) procedures for processing and paying claims;

(7) methods and procedures for defraying losses and expenses of the pool;

(8) guidelines for nonrenewal of coverage;

(9) minimum capital and surplus to be maintained by the pool; and

(10) minimum standards for reserve requirements for the pool.

(b) The plan of operation may include any matter relating to the organization and operation of the pool or to the pool's finances. (V.T.I.C. Art. 21.49-13, Sec. 6(c).)

Source Law

(c) The plan of operation may include any matters relating to the organization and operation of the pool and the pool's finances. The plan must include:

(1) the organizational structure of the pool, including the method of selection of the board, the method of procedure and operation of the board, and a summary of the method for managing and operating the pool;

(2) a description of the contributions and other financial arrangements necessary to cover the initial expenses of the pool and estimates supported by statistical data of the amounts of those contributions or other financial arrangements;

(3) underwriting standards and procedures for the evaluation of risks;

(4) procedures for purchase of reinsurance;

(5) methods, procedures, and guidelines for establishing rates for premiums for and maximum limits of excess coverage available from the pool;

(6) procedures for the processing and payment of claims;

(7) methods and procedures for defraying any losses and expenses of the pool;

(8) methods, procedures, and guidelines for the management and investment of the fund;

(9) guidelines for nonrenewal of coverage;

(10) minimum limits of capital and surplus to be maintained by the pool; and

(11) minimum standards for reserve requirements for the pool.

Revisor's Note

Section 6(c), V.T.I.C. Article 21.49-13, specifies certain provisions that an excess liability pool must include in the plan of operation. For the convenience of the reader, the revised law adds a reference to "the requirements of this chapter" because other provisions of V.T.I.C. Article 21.49-13, revised in this chapter, specify additional requirements applicable to the provisions of the plan of operation.

[Sections 2207.203-2207.250 reserved for expansion]

SUBCHAPTER F. BOARD OF TRUSTEES

Revised Law

Sec. 2207.251. BOARD OF TRUSTEES. (a) A pool is governed by a board of trustees composed of nine members selected as provided by the plan of operation.

(b) Not later than the 15th day after the date the temporary board of a pool adopts the plan of operation, the initial regular board must be selected as provided by the plan. The members of the initial regular board shall take office not later than the 30th day after the date the plan of operation is adopted.

(c) An individual serving on the board who is an officer or employee of a county, school district, or junior college district covered by the pool performs duties on the board as additional duties required of the individual's original office or employment. (V.T.I.C. Art. 21.49-13, Secs. 6(e), 7(a), (d).)

Source Law

[Sec. 6]

(e) Within 15 days following the day on which the plan of operation is adopted, the first board must be selected as provided by the plan of operation. The members of the first board shall take office not later than the 30th day following the date of the adoption of the plan of operation.

Sec. 7. (a) A pool is governed by a board of nine trustees selected as provided by the plan of operation.

(d) A person serving on the board who is an officer or employee of an entity covered by the pool performs duties on the board as additional duties required of his original office or employment.

Revisor's Note

Section 7(a), V.T.I.C. Article 21.49-13, provides that an excess liability pool is governed by a board of nine "trustees." Throughout this chapter, the revised law substitutes "members" for "trustees" for consistency and because "member" is more commonly used in this chapter to describe a person serving on the board of trustees.

Revised Law

Sec. 2207.252. TERMS; VACANCY. (a) Board members serve

two-year terms that expire at the time provided by the plan of operation.

(b) A vacancy on the board shall be filled as provided by the plan of operation. (V.T.I.C. Art. 21.49-13, Secs. 7(b), (c).)

Source Law

> (b) Members of the board serve for terms of two years with the terms expiring at the time provided by the plan of operation.
>
> (c) A vacancy on the board shall be filled as provided by the plan of operation.

Revised Law

Sec. 2207.253. PERFORMANCE BOND REQUIRED. (a) Each board member shall execute a bond in the amount required by the plan of operation. The bond must be payable to the pool and conditioned on the faithful performance of the member's duties.

(b) The pool shall pay the cost of the bond executed under this section. (V.T.I.C. Art. 21.49-13, Sec. 7(e).)

Source Law

> (e) Each member of the board shall execute a bond in the amount required by the plan of operation payable to the pool and conditioned on the faithful performance of his duties. The pool shall pay the cost of the bond.

Revised Law

Sec. 2207.254. COMPENSATION. A board member is not entitled to compensation for the member's service on the board. (V.T.I.C. Art. 21.49-13, Sec. 7(f).)

Source Law

> (f) Members of the board are not entitled to compensation for their service on the board.

Revised Law

Sec. 2207.255. OFFICERS; MEETINGS. (a) The board shall select from the board members a presiding officer, an assistant presiding officer, and a secretary who serve one-year terms that expire as provided by the plan of operation.

(b) The board shall hold meetings at the call of the presiding officer and at times established by the board's rules.

(c) A majority of the board members constitutes a quorum.

(V.T.I.C. Art. 21.49-13, Secs. 7(g), (h), (i).)

Source Law

(g) The board shall select from its membership persons to serve as chairman, vice-chairman, and secretary. The persons selected serve for terms of one year that expire as provided by the plan of operation.

(h) The board shall hold meetings at the call of the chairman and at times established by its rules.

(i) A majority of the members of the board constitutes a quorum.

Revisor's Note

Section 7(g), V.T.I.C. Article 21.49-13, refers to the "chairman" and "vice-chairman" of the board of trustees. Section 7(h), V.T.I.C. Article 21.49-13, refers to the "chairman" of the board of trustees. The revised law substitutes "presiding officer" and "assistant presiding officer" for "chairman" and "vice-chairman" respectively because, in context, the terms have the same meaning and "presiding officer" and "assistant presiding officer" are more commonly used and are gender-neutral.

Revised Law

Sec. 2207.256. GENERAL POWERS AND DUTIES OF BOARD. (a) In addition to other duties provided by the plan of operation, the board shall:

(1) approve contracts other than excess liability insurance contracts issued by the pool to a county, school district, or junior college district, as applicable;

(2) adopt premium rate schedules and policy forms for the pool; and

(3) receive service of summons on behalf of the pool.

(b) The board may:

(1) adopt necessary rules, including rules to implement this chapter;

(2) delegate specific responsibilities to the pool manager; and

(3) amend the plan of operation to ensure the orderly

management and operation of the pool. (V.T.I.C. Art. 21.49-13, Secs. 7(j) (part), (k), 11.)

Source Law

[Sec. 7]

(j) In addition to other duties provided by this article and the plan of operation, the board shall:

(1) approve contracts other than excess liability insurance contracts issued to entities by the pool;

(2) consider and adopt premium rate schedules for the pool;

(3) consider and adopt policy forms for the pool;

(4) receive service of summons on behalf of the pool; and

. . .

(k) In addition to other authority provided by this article, the board may:

(1) adopt necessary rules;

(2) delegate specific responsibilities to the pool manager; and

(3) amend the plan of operation to assure the orderly management and operation of the pool.

Sec. 11. The board may adopt and amend rules to carry out this article.

Revisor's Note

(1) Section 7(j), V.T.I.C. Article 21.49-13, prescribes certain duties of the board of trustees of an excess liability pool that are "[i]n addition to other duties provided by this article," and Section 7(k), V.T.I.C. Article 21.49-13, grants the board certain powers that are "[i]n addition to other authority provided by this article." The revised law omits these provisions as unnecessary. It is a common rule of statutory construction that statutes are intended to be read cumulatively. A provision of Article 21.49-13, revised as this chapter, that grants additional powers to or prescribes additional duties for the board applies by its own terms without the necessity of additional references either specifically or generally in this chapter.

(2) Sections 7(j)(2) and (3), V.T.I.C. Article 21.49-13, require the board of trustees of an excess liability pool to "consider and adopt" premium rate

schedules and policy forms, respectively. The revised law omits the reference to "consider" as unnecessary because it is implied that the board must consider a rate schedule or policy form before adopting the rate schedule or policy form.

(3) Section 11, V.T.I.C. Article 21.49-13, authorizes the board of trustees of an excess liability pool to adopt and "amend" rules to carry out the article. The revised law omits as unnecessary the reference to amending rules because the authority to amend rules is implied in the authority to adopt rules.

Revised Law

Sec. 2207.257. ANNUAL AUDIT; REPORT. (a) Each year as provided by the plan of operation, the board shall have an actuary audit the capital, surplus, and reserves of the pool and prepare a formal report for the pool and the members of the pool.

(b) The actuary must be a member of the American Academy of Actuaries. (V.T.I.C. Art. 21.49-13, Sec. 13(h).)

Source Law

(h) Each year as provided by the plan of operation, the board shall have an actuary who is a member of the American Academy of Actuaries audit the capital, surplus, and reserves of the pool and prepare for the pool and its members a formal report.

Revised Law

Sec. 2207.258. IMMUNITY OF BOARD MEMBERS FROM CERTAIN LIABILITIES. A board member is not liable:

(1) with respect to a claim or judgment for which coverage is provided by the pool; or

(2) for a claim or judgment against a county, school district, or junior college district covered by the applicable pool. (V.T.I.C. Art. 21.49-13, Sec. 7(l).)

Source Law

(l) A member of the board is not liable with respect to a claim or judgment for which coverage is provided by the pool or for a claim or judgment against an entity covered by the pool against whom a claim is made.

[Sections 2207.259-2207.300 reserved for expansion]

SUBCHAPTER G. OPERATION OF POOL

Revised Law

Sec. 2207.301. GENERAL POWERS AND DUTIES OF POOL. (a) A pool shall:

(1) issue excess liability insurance coverage to each county, school district, or junior college district entitled to coverage under this chapter;

(2) collect premiums for coverage issued or renewed by the pool;

(3) process and pay valid claims; and

(4) maintain detailed data regarding the pool.

(b) The pool may:

(1) enter into contracts;

(2) purchase reinsurance;

(3) cancel or refuse to renew coverage; and

(4) perform any other act necessary to implement this chapter, the plan of operation, or a rule adopted by the board. (V.T.I.C. Art. 21.49-13, Sec. 12.)

Source Law

Sec. 12. (a) A pool shall:

(1) issue excess liability coverage to each entity entitled to coverage under this article;

(2) collect premiums for coverage issued or renewed by the pool;

(3) process and pay valid claims; and

(4) maintain detailed data regarding the pool.

(b) The pool may:

(1) enter into contracts;

(2) purchase reinsurance;

(3) cancel or refuse to renew coverage; and

(4) perform any other acts necessary to carry out this article, the plan of operation, and the rules adopted by the board.

Revised Law

Sec. 2207.302. POOL MANAGER; PERFORMANCE BOND REQUIRED. (a) The board shall appoint a pool manager who serves at the pleasure of the board, and the board shall supervise the pool manager's activities.

(b) The pool manager is entitled to receive the compensation authorized by the board.

(c) The pool manager shall execute a bond in the amount determined by the board. The bond must be payable to the pool and conditioned on the faithful performance of the pool manager's duties.

(d) The pool shall pay the cost of the bond executed under this section. (V.T.I.C. Art. 21.49-13, Secs. 7(j) (part), 8(a), (b), (c).)

Source Law

[Sec. 7]

(j) . . . the board shall:

. . .

(5) appoint and supervise the activities of the pool manager.

Sec. 8. (a) The board shall appoint a pool manager who shall serve at the pleasure of the board.

(b) The pool manager is entitled to receive the compensation authorized by the board.

(c) The pool manager shall execute a bond in the amount determined by the board, payable to the pool, conditioned on the faithful performance of his duties. The pool shall pay the cost of the bond.

Revised Law

Sec. 2207.303. GENERAL POWERS AND DUTIES OF POOL MANAGER. (a) The pool manager shall manage and conduct the affairs of the pool under the general supervision of the board and shall perform any other duties as directed by the board.

(b) In addition to any other duties provided by the board, the pool manager shall:

(1) receive and pass on applications for excess liability insurance coverage from the pool;

(2) negotiate contracts for the pool; and

(3) prepare and submit to the board for approval proposed policy forms for coverage from the pool.

(c) The pool manager may refuse to renew the coverage of a county, school district, or junior college district insured by the pool based on the guidelines included in the plan of operation. (V.T.I.C. Art 21.49-13, Secs. 8(d), (e) (part), (f).)

Source Law

(d) The pool manager shall manage and conduct the affairs of the pool under the general supervision of the board and shall perform any other duties directed by the board.

(e) In addition to any other duties provided by this article or by the board, the pool manager shall:

(1) receive and pass on applications from entities for excess liability coverage from the pool;

(2) negotiate contracts for the pool;

. . .

(5) prepare and submit to the board for approval proposed policy forms for pool coverage.

(f) The pool manager may refuse to renew the coverage of any entity insured by the pool based on the guidelines provided by the plan of operation.

Revisor's Note

Section 8(e), V.T.I.C. Article 21.49-13, provides that the manager of an excess liability pool has certain duties in addition to any other duties provided "by this article," meaning V.T.I.C. Article 21.49-13, revised as this chapter. The revised law omits the quoted language for the reason stated in Revisor's Note (1) to Section 2207.256.

Revised Law

Sec. 2207.304. PERSONNEL. (a) The pool manager shall employ or contract with persons necessary to assist the board and the pool manager in implementing the powers and duties of the pool.

(b) The board must approve:

(1) the compensation paid to a pool employee; and

(2) a contract made with a person under this section.

(V.T.I.C. Art. 21.49-13, Secs. 9(a), (b).)

Source Law

Sec. 9. (a) The pool manager shall employ or contract with persons necessary to assist the board and pool manager in carrying out the powers and duties of the pool.

(b) The board shall approve compensation paid to employees of the pool and contracts made with other persons under this section.

Revised Law

Sec. 2207.305. PERFORMANCE BOND AUTHORIZED. The board may require an employee or a person with whom the pool manager contracts under Section 2207.304 to execute a bond in an amount determined by

the board. The bond must be payable to the board and conditioned on the faithful performance of the employee's or other person's duties to the pool. (V.T.I.C. Art. 21.49-13, Sec. 9(c).)

Source Law

(c) The board may require any employee or person with whom it contracts under this section to execute a bond in an amount determined by the board, payable to the board, and conditioned on the faithful performance of the employee's or person's duties or responsibilities to the pool.

Revisor's Note

Section 9(c), V.T.I.C. Article 21.49-13, authorizes the board of trustees to require an employee or contract personnel to execute a bond conditioned on the faithful performance of that person's "duties or responsibilities" to the pool. The revised law omits the reference to "responsibilities" as unnecessary because, in context, "responsibility" is included within the meaning of "duty."

Revised Law

Sec. 2207.306. IMMUNITY OF EMPLOYEES AND CONTRACTORS FROM CERTAIN LIABILITIES. An employee or a person with whom the pool manager contracts under Section 2207.304 is not liable:

(1) with respect to a claim or judgment for which coverage is provided by the pool; or

(2) for a claim or judgment against a county, school district, or junior college district covered by the applicable pool. (V.T.I.C. Art. 21.49-13, Sec. 9(d).)

Source Law

(d) An employee or person with whom the pool has contracted under this section is not liable with respect to any claim or judgment for which coverage is provided by the pool or for any claim or judgment against any entity covered by the pool against whom a claim is made.

Revised Law

Sec. 2207.307. OFFICE; RECORDS. (a) A pool shall maintain the pool's principal office in Austin, Texas.

(b) Records, files, and other documents and information

relating to the pool must be maintained in the pool's principal office. (V.T.I.C. Art. 21.49-13, Sec. 10.)

Source Law

Sec. 10. (a) A pool shall maintain its principal office in Austin, Texas.

(b) The records, files, and other documents and information relating to the pool must be maintained in the pool's principal office.

[Sections 2207.308-2207.350 reserved for expansion]

SUBCHAPTER H. EXCESS LIABILITY FUND

Revised Law

Sec. 2207.351. FUND CREATION; MANAGEMENT. (a) On creation of a pool, the initial regular board shall create an excess liability fund.

(b) The fund is composed of:

(1) premiums paid by counties, school districts, or junior college districts, as applicable, for coverage provided by the pool;

(2) contributions and other money received by the pool to cover the initial expenses of the fund;

(3) investments of the fund and money earned from those investments; and

(4) any other money received by the pool.

(c) The pool manager shall manage the fund under the general supervision of the board. The fund manager, under the general supervision of the board, shall manage and invest the money in the fund in the manner provided by the plan of operation.

(d) Money earned by the investment of money in the fund must be deposited in the fund or reinvested for the fund. (V.T.I.C. Art. 21.49-13, Secs. 13(a), (b), (c), 14.)

Source Law

Sec. 13. (a) On creation of a pool, the first board shall create an excess liability fund.

(b) The fund is composed of:

(1) premiums paid by entities for coverage by the pool;

(2) contributions and other money received by the pool to cover the initial expenses of the fund;

(3) investments and money earned from investments of the fund; and

(4) any other money received by the pool.

(c) The pool manager shall manage the fund under the general supervision of the board.

Sec. 14. (a) The fund manager, under the general supervision of the board, shall manage and invest the money in the fund in the manner provided by the plan of operation.

(b) Money earned by investment of money in the fund must be deposited in the fund or reinvested for the fund.

Revised Law

Sec. 2207.352. CONTRIBUTIONS. The board shall determine the amount of any contributions necessary to meet the initial expenses of the pool. The board shall make this determination based on the data provided by the plan of operation. (V.T.I.C. Art. 21.49-13, Sec. 15.)

Source Law

Sec. 15. The board shall determine the amount of any contributions necessary to meet initial expenses of the pool. The board shall make this determination based on the data provided in the plan of operation.

Revised Law

Sec. 2207.353. USES OF FUND. (a) Administrative expenses of the pool may be paid from the fund. Payments for administrative expenses during a fiscal year of the pool may not exceed the amount established by the board.

(b) The pool may pay commissions from the fund on approval of the board.

(c) Money in the fund may not be used to pay:

(1) punitive damages; or

(2) a fine or penalty imposed for a violation of:

(A) a statute;

(B) an administrative rule or regulation; or

(C) an order, rule, or ordinance.

(d) Money for a claim may not be paid from the fund under excess liability insurance coverage until all benefits payable under any other underlying liability insurance policy covering the claim or judgment are exhausted. (V.T.I.C. Art. 21.49-13, Secs. 13(d), (e), (f), 21.)

Source Law

[Sec. 13]

(d) Administrative expenses of the pool may be paid from the fund, but payments for this purpose during any fiscal year of the pool may not exceed the amount established by the board.

(e) Money in the fund may not be used to pay punitive damages, fines or penalties for violation of a civil or criminal statute, or fines or penalties imposed for violation of an administrative rule or regulation, or an order, rule, or ordinance.

(f) Money for a claim may not be paid from the fund under excess liability insurance coverage unless and until all benefits payable under any other underlying policy of liability insurance covering the claim or judgment are exhausted.

Sec. 21. A pool may pay commissions from the fund on approval of the board.

Revisor's Note

Section 13(e), V.T.I.C. Article 21.49-13, refers to "fines or penalties for violation of a civil or criminal statute." The revised law omits the reference to "civil or criminal" as unnecessary because all statutes are either "civil" or "criminal."

Revised Law

Sec. 2207.354. DEPOSITORY BANK. (a) The board may select one or more banks to serve as a depository for money in the fund.

(b) A depository bank must execute a bond or provide other security before the pool manager may deposit fund money in the bank in an amount that exceeds the maximum amount secured by the Federal Deposit Insurance Corporation. The bond or other security must be in an amount sufficient to secure the excess amount of the deposit. (V.T.I.C. Art. 21.49-13, Sec. 13(g).)

Source Law

(g) The board may select one or more banks to serve as depository for money of the fund. Before the pool manager deposits fund money in a depository bank in an amount that exceeds the maximum amount secured by the Federal Deposit Insurance Corporation, the bank must execute a bond or provide other security in an amount sufficient to secure from loss the fund money that exceeds the amount secured by the Federal Deposit Insurance Corporation.

[Sections 2207.355-2207.400 reserved for expansion]

SUBCHAPTER I. POOL COVERAGE

Revised Law

Sec. 2207.401. ENTITLEMENT TO COVERAGE. A county, school district, or junior college district is entitled to coverage from the pool if the county, school district, or junior college district:

(1) submits a complete application;

(2) provides other information required by the pool;

(3) meets the underwriting standards established by the pool; and

(4) pays the premiums required for the coverage. (V.T.I.C. Art. 21.49-13, Sec. 4.)

Source Law

Sec. 4. An entity is entitled to coverage from the pool on:

(1) submitting a complete application;

(2) providing any other information required by the pool;

(3) meeting the underwriting standards established by the pool; and

(4) paying the premiums required for the coverage.

Revised Law

Sec. 2207.402. SCOPE OF COVERAGE. (a) A pool shall insure a county, school district, or junior college district and the entity's officers and employees against liability for acts and omissions under the laws governing that county, school district, or junior college district and the entity's officers and employees in their official or employment capacities.

(b) Except as provided by Subsection (c), under the excess liability insurance coverage, a pool shall pay any portion of a claim against a county, school district, or junior college district, as applicable, and the entity's officers and employees that:

(1) exceeds $500,000; and

(2) is finally determined or settled or is included in a final judgment of a court.

(c) The amount paid by a pool under this section may not

exceed the amount the board determines is actuarially sound for the pool.

(d) A pool may participate in evaluating, settling, or defending a claim made under the excess liability insurance coverage. (V.T.I.C. Art. 21.49-13, Sec. 3.)

Source Law

> Sec. 3. (a) A pool shall insure an entity and its officers and employees against liability for acts and omissions under the laws governing that entity and its officers and employees in their official or employment capacities.
>
> (b) Under excess liability insurance coverage, a pool shall pay that portion of a claim against an entity and its officers and employees that is finally determined or settled or is included in a final judgment of a court and that is in excess of $500,000, but the amount paid by the pool may not be in excess of the amount determined by the board to be actuarially sound for the pool.
>
> (c) Under the insurance coverage, the pool may participate in the evaluation, settlement, or defense of any claim.

Revised Law

Sec. 2207.403. BASIS OF COVERAGE. The pool may provide excess liability insurance coverage on a claims-made basis or an occurrence basis. (V.T.I.C. Art. 21.49-13, Sec. 18.)

Source Law

> Sec. 18. Excess liability coverage provided by the pool may be provided on a claims-made or an occurrence basis.

Revised Law

Sec. 2207.404. RATES AND LIMITS OF COVERAGE. (a) To ensure that the pool is actuarially sound, the board shall:

(1) set the premium rates charged; and

(2) determine the maximum limits of coverage provided.

(b) The pool manager, for the board's consideration, shall:

(1) collect and compile statistical data relating to the excess liability insurance coverage provided by the pool, including relevant loss, expense, and premium data, and other information;

(2) prepare the proposed premium rate schedules for the approval of the board; and

(3) prepare the maximum limits of coverage.

(c) The board shall periodically reexamine the rate schedules and the maximum limits of coverage as conditions change.

(d) The pool manager shall make available to the public the information described by Subsection (b)(1). (V.T.I.C. Art. 21.49-13, Secs. 8(e) (part), 16.)

Source Law

[Sec. 8]

(e) . . . the pool manager shall:

. . .

(3) prepare premium rate schedules for the approval of the board;

(4) collect and compile statistical data relating to the excess liability coverage provided by the pool, including relevant loss, expense, and premium data, and make that information available to the board and to the public; and

. . .

Sec. 16. (a) The board shall determine the rates for premiums that will be charged and the maximum limits of coverage provided to assure that the pool is actuarially sound.

(b) The pool manager shall prepare the statistical data and other information and the proposed rate schedules and maximum limits of coverage for consideration of the board.

(c) The board shall periodically reexamine the rate schedules and the maximum limits of coverage as conditions change.

Revised Law

Sec. 2207.405. USE OF ENTITY MONEY FOR POOL COVERAGE AUTHORIZED. A county, school district, or junior college district may use its money to pay any contributions or premiums required by the applicable pool to purchase excess liability insurance coverage from the pool. (V.T.I.C. Art. 21.49-13, Sec. 5.)

Source Law

Sec. 5. An entity purchasing excess liability insurance coverage from the pool may use funds of the entity to pay any contributions or premiums required by the pool for the coverage.

Revisor's Note

Section 5, V.T.I.C. Article 21.49-13, states that a county, school district, or junior college district may use the entity's "funds" to purchase excess liability insurance coverage. The revised law substitutes "money" for "funds" because, in context,

the terms are synonymous and the former is more commonly used.

Revised Law

Sec. 2207.406. COVERAGE PERIOD. A county, school district, or junior college district that accepts coverage provided by the applicable pool shall maintain that coverage for at least 36 calendar months following the month in which the pool issued the coverage. (V.T.I.C. Art. 21.49-13, Sec. 17(a).)

Source Law

> Sec. 17. (a) On accepting coverage from the pool, an entity shall maintain that coverage for a period not less than 36 calendar months following the month the coverage is issued.

Revised Law

Sec. 2207.407. NONRENEWAL OF COVERAGE. (a) Except as provided by Subsection (b), the applicable pool may refuse to renew the coverage of a county, school district, or junior college district that fails to comply with the pool's underwriting standards.

(b) The applicable pool may not refuse to renew the coverage of a county, school district, or junior college district during the first 36 calendar months following the month in which the entity is first provided coverage by the pool. (V.T.I.C. Art. 21.49-13, Secs. 19(a), (b).)

Source Law

> Sec. 19. (a) Except as provided by Subsection (b) of this section, the pool may refuse to renew the coverage of any entity that fails to comply with the pool's underwriting standards.
>
> (b) The pool may not refuse to renew the coverage of an entity for the first 36 calendar months following the month in which the entity was first insured by the pool.

Revised Law

Sec. 2207.408. SUBSEQUENT COVERAGE. (a) A county, school district, or junior college district that voluntarily discontinues coverage provided by the applicable pool may not subsequently obtain coverage from the pool for at least 36 calendar months following the month in which the entity discontinues the coverage.

(b) A county, school district, or junior college district whose coverage is not renewed under Section 2207.407 is not eligible to subsequently apply for coverage during the 12 calendar months following the month in which the applicable pool gives written notice of nonrenewal. (V.T.I.C. Art. 21.49-13, Secs. 17(b), 19(c) (part).)

Source Law

[Sec. 17]

(b) An entity that voluntarily discontinues coverage in the pool may not again obtain coverage from the pool for at least 36 calendar months following the month in which the coverage was discontinued.

[Sec. 19]

(c) . . . An entity whose coverage is not renewed is not eligible to apply for new coverage during the 12 calendar months beginning after the month in which the pool gave written notice that it would not renew the coverage.

Revisor's Note

Section 19(c), V.T.I.C. Article 21.49-13, provides that Section 17(b) of that article does not apply if an excess liability pool refuses to renew the coverage of a county, school district, or junior college district, as applicable, and provides procedures for obtaining coverage subsequent to a refusal to renew. Section 17(b), according to its terms, prohibits a county, school district, or junior college district from obtaining subsequent coverage for a specified period if the entity voluntarily discontinued previous pool coverage. Because the pool's refusal to renew coverage under Section 19(c) is not a voluntary discontinuance of coverage by a county, school district, or junior college district, Section 17(b) would not apply by its terms. Therefore, the revised law omits as unnecessary the statement in Section 19(c) that Section 17(b) does not apply if the pool refuses to renew coverage. The omitted law reads:

(c) Section 17(b) of this article does not apply to discontinuance of an

> entity's coverage if the pool refuses renewal under this section. . . .

Revised Law

Sec. 2207.409. PAYMENT OF CLAIMS AND JUDGMENTS. (a) If money in the fund would be exhausted by the payment of all final and settled claims and final judgments during a fiscal year, the pool shall prorate the amount paid to each person having the claim or judgment.

(b) If the amount paid by the pool is prorated under this section, each person described by Subsection (a) shall receive an amount equal to the percentage that the amount owed to that person by the pool bears to the total amount owed, outstanding, and payable by the pool.

(c) The pool shall pay in the next fiscal year the remaining amount that is due and unpaid to a person who receives a prorated payment under this section. (V.T.I.C. Art. 21.49-13, Sec. 20.)

Source Law

> Sec. 20. (a) If money in the fund will be exhausted by payment of all final and settled claims and final judgments during the fiscal year, the amount paid by the pool to each person having a claim or judgment shall be prorated, with each person receiving an amount that is equal to the percentage the amount owed to him by the pool bears to the total amount owed, outstanding, and payable by the pool.
>
> (b) The remaining amount that is due and unpaid to a person who receives prorated payment under Subsection (a) of this section must be paid in the immediately following fiscal year.

Revisor's Note
(End of Chapter)

Section 2(a), V.T.I.C. Article 21.49-13, allows for the creation of separate excess liability pools for counties, school districts, and junior college districts. The revised law omits the provision as unnecessary because it duplicates the authority provided by Section 2(b), V.T.I.C. Article 21.49-13, revised in this chapter as Sections 2207.051(a), 2207.101(a), and 2207.151(a), to create excess liability pools for different entities. The omitted law reads:

Sec. 2. (a) Separate excess liability pools may be created for counties, school districts, and junior college districts as provided by this article.

CHAPTER 2208. TEXAS PUBLIC ENTITY EXCESS INSURANCE POOL

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CHAPTER 2208. TEXAS PUBLIC ENTITY EXCESS INSURANCE POOL

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2208.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of trustees of the pool.

(2) "Fund" means the Texas public entity excess insurance fund.

(3) "Insurance" means liability insurance or workers' compensation insurance.

(4) "Pool" means the Texas public entity excess insurance pool.

(5) "Public entity" means one or more municipalities that have formed an insurance pool under Chapter 791, Government Code. (V.T.I.C. Art. 21.49-11, Secs. 1(1), (2), (3), (4), (6).)

Source Law

Art. 21.49-11
Sec. 1. In this article:
(1) "Pool" means the Texas public entity excess insurance pool.
(2) "Fund" means the Texas public entity excess insurance fund.
(3) "Board" means the board of trustees of the pool.
(4) "Public entity" means a city or a group of cities who have formed an insurance pool under the provisions of The Interlocal Cooperation Act (Article 4413(32c), Vernon's Texas Civil Statutes).
. . .
(6) "Insurance" means liability insurance or workers' compensation insurance.

Revisor's Note

(1) Section 1(4), V.T.I.C. Article 21.49-11, refers to "a city or a group of cities." The revised law substitutes the term "municipality" for "city" because "municipality" is the term used in the Local Government Code.

(2) Section 1(4), V.T.I.C. Article 21.49-11, refers to The Interlocal Cooperation Act (Article 4413(32c), Vernon's Texas Civil Statutes). That law was codified in 1991 as Chapter 791, Government Code. The revised law is drafted accordingly.

(3) Section 1(5), V.T.I.C. Article 21.49-11, defines the term "association." The revised law omits that definition as unnecessary because the substance of the definition is included in Section 5(a), V.T.I.C. Article 21.49-11, revised in this chapter as Section 2208.101. The omitted law reads:

Sec. 1. [In this article:]
. . .
(5) "Association" means an association whose governing board is designated by this article to administer the pool.

Revised Law

Sec. 2208.002. POOL NOT ENGAGED IN BUSINESS OF INSURANCE. (a) Except as provided by Subsection (b), the pool is not engaged in the business of insurance under this code or other

laws of this state, and the department has no jurisdiction over the pool.

(b) The pool is subject to Chapter 541 and Subchapter D, Chapter 38. (V.T.I.C. Art. 21.49-11, Sec. 20.)

Source Law

Sec. 20. (a) Except as provided by Subsection (b) of this section, the pool is not considered insurance under the Insurance Code and other laws of this state, and the State Board of Insurance has no jurisdiction over the pool.

(b) The pool is subject to Articles 1.24A, 1.24B, and 21.21 of this code.

Revisor's Note

(1) Section 20(a), V.T.I.C. Article 21.49-11, 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, and the revised law is drafted accordingly.

(2) Section 20(b), V.T.I.C. Article 21.49-11, states that the Texas Public Entity Excess Insurance Pool is subject to V.T.I.C. Article 1.24A. The revised law omits the reference to Article 1.24A because that article was repealed by Section 8.12, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993.

(3) Section 20(b), V.T.I.C. Article 21.49-11, states that the Texas Public Entity Excess Insurance Pool is subject to V.T.I.C. Article 21.21. That article has been revised in various chapters of this code. The relevant portions of Article 21.21 are revised in Chapter 541 of this code. For that reason, the revised law substitutes a reference to Chapter 541 for the reference to Article 21.21.

[Sections 2208.003-2208.050 reserved for expansion]

SUBCHAPTER B. CREATION OF POOL

Revised Law

Sec. 2208.051. CREATION OF POOL. (a) The Texas Public Entity Excess Insurance Pool is created on the written agreement of the presiding officers of 25 or more public entities in this state.

(b) The pool provides excess liability and workers' compensation insurance coverage to a public entity and the entity's officers and employees as provided by this chapter. (V.T.I.C. Art. 21.49-11, Sec. 2(a).)

Source Law

> Sec. 2. (a) On written agreement of the presiding officers of not fewer than 25 public entities in this state, the Texas public entity excess insurance pool is created to provide excess liability and workers' compensation insurance coverage to a public entity and its officers and employees as provided by this article.

Revised Law

Sec. 2208.052. PARTICIPATION IN POOL. A public entity is entitled to coverage from the pool if the entity:

(1) submits a complete application;

(2) provides other relevant information required by the pool;

(3) meets the underwriting guidelines established by the pool; and

(4) pays the premiums required for the coverage. (V.T.I.C. Art. 21.49-11, Sec. 3.)

Source Law

> Sec. 3. A public entity is entitled to coverage from the pool on:
>
> (1) submitting a complete application;
>
> (2) providing any other relevant information required by the pool;
>
> (3) meeting the underwriting guidelines established by the pool; and
>
> (4) paying the premiums required for the coverage.

[Sections 2208.053-2208.100 reserved for expansion]

SUBCHAPTER C. BOARD OF TRUSTEES

Revised Law

Sec. 2208.101. ADMINISTRATION OF POOL; BOARD

MEMBERSHIP. (a) A board of trustees shall administer the pool.

(b) The board is composed of the members of the governing board of an association that:

(1) on September 2, 1987, had been providing pooled self-insurance in this state for more than five years; and

(2) has as the association's members the public entities that entered into the written agreement under Section 2208.051.

(c) Board members shall represent members of the pool. (V.T.I.C. Art. 21.49-11, Secs. 5(a), (c).)

Source Law

> Sec. 5. (a) The members of the governing board of an association that has been in operation providing pooled self-insurance within this state for more than five years on the effective date of this article and that has as its members the public entities that entered into the written agreement under Section 2 of this article shall serve as the board of trustees of the pool and shall administer the pool.
>
> (c) Members of the board must represent members of the pool.

Revisor's Note

> Section 5(a), V.T.I.C. Article 21.49-11, refers to "the effective date of this article." The revised law substitutes a reference to "September 2, 1987," because that is the effective date of Article 21.49-11.

Revised Law

Sec. 2208.102. COMPENSATION. A board member is not entitled to compensation for the member's service on the board. (V.T.I.C. Art. 21.49-11, Sec. 5(b).)

Source Law

> (b) Members of the board are not entitled to compensation for their service on the board.

Revised Law

Sec. 2208.103. OFFICERS; MEETINGS. (a) Each individual who serves as an officer of the governing board of the association described by Section 2208.101(b) serves as an officer of the board.

(b) The board shall hold meetings at the call of the presiding officer and at times established by the board's rules.

(c) A majority of the board members constitutes a quorum. (V.T.I.C. Art. 21.49-11, Secs. 5(d), (e), (f).)

Source Law

> (d) The persons who serve as officers of the governing board of the association shall serve as officers of the board.
>
> (e) The board shall hold meetings at the call of the chairman and at times established by its rules.
>
> (f) A majority of the members of the board constitutes a quorum.

Revisor's Note

Section 5(e), V.T.I.C. Article 21.49-11, refers to the "chairman" of the board of trustees of the Texas Public Entity Excess Insurance Pool. The revised law substitutes "presiding officer" for that term because, in context, the terms have the same meaning and "presiding officer" is more commonly used and is gender neutral.

Revised Law

Sec. 2208.104. GENERAL POWERS AND DUTIES OF BOARD. (a) In addition to other duties provided by the plan of operation, the board shall:

(1) approve contracts other than excess insurance contracts issued to public entities by the pool;

(2) adopt premium rate schedules and policy forms for the pool; and

(3) receive service of summons on behalf of the pool.

(b) The board may:

(1) adopt necessary rules, including rules to implement this chapter;

(2) delegate specific responsibilities to the pool manager; and

(3) amend the plan of operation to ensure the orderly management and operation of the pool. (V.T.I.C. Art. 21.49-11, Secs. 5(g) (part), (h), 10.)

Source Law

[Sec. 5]

(g) In addition to other duties provided by this article and the plan of operation, the board shall:

(1) approve contracts other than excess insurance contracts issued to public entities by the pool;

(2) consider and adopt premium rate schedules for the pool;

(3) consider and adopt policy forms for the pool;

(4) receive service of summons on behalf of the pool; and . . . .

(h) In addition to other authority provided by this article, the board may:

(1) adopt necessary rules;

(2) delegate specific responsibilities to the pool manager; and

(3) amend the plan of operation to assure the orderly management and operation of the pool.

Sec. 10. The board may adopt and amend rules to carry out this article.

Revisor's Note

(1) Section 5(g), V.T.I.C. Article 21.49-11, prescribes certain duties of the board of trustees of the Texas Public Entity Excess Insurance Pool that are "[i]n addition to other duties provided by this article," and Section 5(h), V.T.I.C. Article 21.49-11, grants the board certain powers that are "[i]n addition to other authority provided by this article." The revised law omits these provisions as unnecessary. It is a common rule of statutory construction that statutes are intended to be read cumulatively. A provision of Article 21.49-11, revised as this chapter, that grants additional powers to or prescribes additional duties for the board applies by its own terms without the necessity of additional references either specifically or generally in this chapter.

(2) Sections 5(g)(2) and (3), V.T.I.C. Article 21.49-11, require the board of trustees of the Texas Public Entity Excess Insurance Pool to "consider and adopt" premium rate schedules and policy forms,

respectively. The revised law omits the reference to "consider" as unnecessary because it is implied that the board must consider a rate schedule or policy form before adopting the rate schedule or policy form.

(3) Section 10, V.T.I.C. Article 21.49-11, authorizes the board of trustees of the Texas Public Entity Excess Insurance Pool to adopt and "amend" rules to carry out the article. The revised law omits as unnecessary the reference to amending rules because the authority to amend rules is implied in the authority to adopt rules.

Revised Law

Sec. 2208.105. IMMUNITY OF BOARD MEMBERS FROM CERTAIN LIABILITIES. A board member is not liable:

(1) with respect to a claim or judgment for which coverage is provided by the pool; or

(2) for a claim or judgment against a public entity covered by the pool. (V.T.I.C. Art. 21.49-11, Sec. 5(i).)

Source Law

(i) A member of the board is not liable with respect to any claim or judgment for which coverage is provided by the pool or for any claim or judgment against a public entity covered by the pool against whom a claim is made.

[Sections 2208.106-2208.150 reserved for expansion]

SUBCHAPTER D. PLAN OF OPERATION

Revised Law

Sec. 2208.151. TIME FOR CREATION OF PLAN OF OPERATION. Not later than the 30th day after the date the pool is created, the board shall meet to prepare a detailed plan of operation for the pool. (V.T.I.C. Art. 21.49-11, Sec. 6(a).)

Source Law

Sec. 6. (a) Within 30 days after creation of the pool under Section 2(a) of this article, the board shall meet to prepare a detailed plan of operation for the pool.

Revised Law

Sec. 2208.152. CONTENTS OF PLAN OF OPERATION. (a) Subject to the requirements of this chapter, the plan of operation must include:

(1) the organizational structure of the pool, the board's method of procedure and operation, and a summary of the method for managing and operating the pool;

(2) a description of the financial arrangements necessary to cover the initial expenses of the pool and estimates, supported by statistical data, of the amounts of those contributions or other financial arrangements;

(3) underwriting guidelines and procedures for evaluating risks;

(4) procedures for purchasing reinsurance;

(5) methods, procedures, and guidelines for:

(A) establishing premium rates for and maximum limits of excess coverage available from the pool; and

(B) managing and investing the fund;

(6) procedures for processing and paying claims;

(7) methods and procedures for defraying losses and expenses of the pool; and

(8) guidelines for nonrenewal of coverage.

(b) The plan of operation may include any matter relating to the organization and operation of the pool or to the pool's finances. (V.T.I.C. Art. 21.49-11, Sec. 6(b).)

Source Law

(b) The plan of operation may include any matters relating to the organization and operation of the pool and the pool's finances. The plan must include:

(1) the organizational structure of the pool, the method of procedure and operation of the board, and a summary of the method for managing and operating the pool;

(2) a description of the financial arrangements necessary to cover the initial expenses of the pool and estimates supported by statistical data of the amounts of those contributions or other financial arrangements;

(3) underwriting guidelines and procedures for the evaluation of risks;

(4) procedures for purchase of reinsurance;

(5) methods, procedures, and guidelines for establishing rates for premiums for and maximum limits of excess coverage available from the pool;

(6) procedures for the processing and payment of claims;

(7) methods and procedures for defraying any losses and expenses of the pool;

(8) methods, procedures, and guidelines for the management and investment of the fund; and

(9) guidelines for nonrenewal of coverage.

Revisor's Note

Section 6(b), V.T.I.C. Article 21.49-11, specifies certain provisions that the Texas Public Entity Excess Insurance Pool must include in the plan of operation. For the convenience of the reader, the revised law adds a reference to "the requirements of this chapter" because other provisions of V.T.I.C. Article 21.49-11, revised as this chapter, specify additional requirements applicable to the provisions of the plan of operation.

[Sections 2208.153-2208.200 reserved for expansion]

SUBCHAPTER E. OPERATION OF POOL

Revised Law

Sec. 2208.201. GENERAL POWERS AND DUTIES OF POOL. (a) The pool shall:

(1) issue insurance coverage to each public entity entitled to coverage under this chapter;

(2) collect premiums for coverage issued or renewed by the pool;

(3) process and pay valid claims; and

(4) maintain detailed data regarding the pool.

(b) The pool may:

(1) enter into contracts;

(2) purchase reinsurance;

(3) cancel or refuse to renew coverage; and

(4) perform any other act necessary to implement this chapter, the plan of operation, or a rule adopted by the board. (V.T.I.C. Art. 21.49-11, Sec. 11.)

Source Law

Sec. 11. (a) The pool shall:

(1) issue insurance coverage to each public entity entitled to coverage under this article;

(2) collect premiums for coverage issued or renewed by the pool;

(3) process and pay valid claims; and

(4) maintain detailed data regarding the pool.

(b) The pool may:

(1) enter into contracts;

(2) purchase reinsurance;

(3) cancel or refuse to renew coverage; and

(4) perform any other acts necessary to carry out this article, the plan of operation, and the rules adopted by the board.

Revised Law

Sec. 2208.202. POOL MANAGER. (a) The board shall appoint a pool manager who serves at the pleasure of the board, and the board shall supervise the pool manager's activities.

(b) The pool manager is entitled to receive compensation as authorized by the board. (V.T.I.C. Art. 21.49-11, Secs. 5(g)(5), 7(a), (b).)

Source Law

[Sec. 5]

(g) . . . the board shall:

. . .

(5) appoint and supervise the activities of the pool manager.

Sec. 7. (a) The board shall appoint a pool manager who shall serve at the pleasure of the board.

(b) The pool manager is entitled to receive the compensation authorized by the board.

Revised Law

Sec. 2208.203. GENERAL POWERS AND DUTIES OF POOL MANAGER. (a) The pool manager shall manage and conduct the affairs of the pool under the general supervision of the board and shall perform any other duties as directed by the board.

(b) In addition to any other duties provided by the board, the pool manager shall:

(1) receive and pass on applications for insurance coverage from the pool;

(2) negotiate contracts for the pool; and

(3) prepare, and submit to the board for approval,

proposed policy forms for coverage from the pool.

(c) The pool manager may refuse to renew the coverage of a public entity insured by the pool based on the guidelines included in the plan of operation. (V.T.I.C. Art. 21.49-11, Secs. 7(c), (d) (part), (e).)

Source Law

> (c) The pool manager shall manage and conduct the affairs of the pool under the general supervision of the board and shall perform any other duties directed by the board.
>
> (d) In addition to any other duties provided by this article or by the board, the pool manager shall:
>
> (1) receive and pass on applications from public entities for insurance coverage from the pool;
>
> (2) negotiate contracts for the pool;
>
> . . .
>
> (5) prepare and submit to the board for approval proposed policy forms for pool coverage.
>
> (e) The pool manager may refuse to renew the coverage of any public entity insured by the pool based on the guidelines provided by the plan of operation.

Revisor's Note

Section 7(d), V.T.I.C. Article 21.49-11, provides that the manager of the Texas Public Entity Excess Insurance Pool has certain duties in addition to any other duties provided "by this article," meaning V.T.I.C. Article 21.49-11, revised as this chapter. The revised law omits the quoted language for the reason stated in Revisor's Note (1) to Section 2208.104.

Revised Law

Sec. 2208.204. PERSONNEL. (a) The pool manager shall employ or contract with persons necessary to assist the board and the pool manager in implementing the powers and duties of the pool.

(b) The board must approve:

(1) the compensation paid to a pool employee; and

(2) a contract made with a person under this section.

(V.T.I.C. Art. 21.49-11, Secs. 8(a), (b).)

Source Law

> Sec. 8. (a) The pool manager shall employ or contract with persons necessary to assist the board and pool manager in carrying out the powers and duties

of the pool.

(b) The board shall approve compensation paid to employees of the pool and contracts made with other persons under this section.

Revised Law

Sec. 2208.205. PERFORMANCE BOND AUTHORIZED. The board may require an employee or a person with whom the pool manager contracts under Section 2208.204 to execute a bond in an amount determined by the board. The bond must be payable to the board and conditioned on the faithful performance of the employee's or other person's duties to the pool. (V.T.I.C. Art. 21.49-11, Sec. 8(c).)

Source Law

(c) The board may require any employee or person with whom it contracts under this section to execute a bond in an amount determined by the board, payable to the board, and conditioned on the faithful performance of the employee's or person's duties or responsibilities to the pool.

Revisor's Note

Section 8(c), V.T.I.C. Article 21.49-11, authorizes the board of trustees of the Texas Public Entity Excess Insurance Pool to require an employee or contract personnel to execute a bond conditioned on the faithful performance of that person's "duties or responsibilities" to the pool. The revised law omits the reference to "responsibilities" as unnecessary because, in context, "responsibility" is included in the meaning of "duty."

Revised Law

Sec. 2208.206. IMMUNITY OF EMPLOYEES AND CONTRACTORS FROM CERTAIN LIABILITIES. An employee or a person with whom the pool manager contracts under Section 2208.204 is not liable:

(1) with respect to a claim or judgment for which coverage is provided by the pool; or

(2) for a claim or judgment against a public entity covered by the pool. (V.T.I.C. Art. 21.49-11, Sec. 8(d).)

Source Law

(d) An employee or person with whom the pool has contracted under this section is not liable with

respect to any claim or judgment for which coverage is provided by the pool or for any claim or judgment against any public entity covered by the pool against whom a claim is made.

Revised Law

Sec. 2208.207. OFFICE; RECORDS. (a) The pool shall maintain the pool's principal office in Austin, Texas.

(b) Records, files, and other documents and information relating to the pool must be maintained in the pool's principal office. (V.T.I.C. Art. 21.49-11, Sec. 9.)

Source Law

Sec. 9. (a) The pool shall maintain its principal office in Austin, Texas.

(b) The records, files, and other documents and information relating to the pool must be maintained in the pool's principal office.

[Sections 2208.208-2208.250 reserved for expansion]

SUBCHAPTER F. TEXAS PUBLIC ENTITY EXCESS INSURANCE FUND

Revised Law

Sec. 2208.251. FUND CREATION; MANAGEMENT. (a) On creation of the pool, the board shall create the Texas public entity excess insurance fund.

(b) The fund is composed of:

(1) premiums paid by public entities for coverage provided by the pool;

(2) proceeds from bonds and other money received by the pool to cover the expenses of the fund;

(3) investments of the fund and money earned from those investments; and

(4) any other money received by the pool.

(c) The pool manager shall manage the fund under the general supervision of the board. The fund manager, under the general supervision of the board, shall manage and invest the money in the fund in the manner provided by the plan of operation.

(d) Money earned by the investment of money in the fund must be deposited in the fund or reinvested for the fund. (V.T.I.C. Art. 21.49-11, Secs. 12(a), (b), (c), 13.)

Source Law

Sec. 12. (a) On creation of the pool, the board shall create the Texas public entity excess insurance fund.

(b) The fund is composed of:

(1) premiums paid by public entities for coverage by the pool;

(2) proceeds from bonds and other money received by the pool to cover the expenses of the fund;

(3) investments and money earned from investments of the fund; and

(4) any other money received by the pool.

(c) The pool manager shall manage the fund under the general supervision of the board.

Sec. 13. (a) The fund manager, under the general supervision of the board, shall manage and invest the money in the fund in the manner provided by the plan of operation.

(b) Money earned by investment of money in the fund must be deposited in the fund or reinvested for the fund.

Revised Law

Sec. 2208.252. USES OF FUND. (a) Administrative expenses of the pool may be paid from the fund.

(b) Money in the fund may not be used to pay:

(1) punitive damages;

(2) a fine or penalty imposed for a violation of:

(A) a statute;

(B) an administrative rule or regulation; or

(C) an order or ordinance of a public entity; or

(3) a claim under excess insurance coverage until all benefits payable under any other underlying policy or self-insurance covering the claim or judgment are exhausted. (V.T.I.C. Art. 21.49-11, Secs. 12(d), (e), (f).)

Source Law

(d) Administrative expenses of the pool may be paid from the fund.

(e) Money in the fund may not be used to pay punitive damages, fines or penalties for violation of a civil or criminal statute, or fines or penalties imposed for violation of an administrative rule or regulation or a public entity order or ordinance.

(f) Money for a claim may not be paid from the fund under excess insurance coverage unless and until all benefits payable under any other underlying policy or self-insurance covering the claim or judgment are exhausted.

Revisor's Note

Section 12(e), V.T.I.C. Article 21.49-11, refers to "punitive damages, fines or penalties for violation of a civil or criminal statute." The revised law omits the reference to "civil or criminal" as unnecessary because all statutes are either "civil" or "criminal."

Revised Law

Sec. 2208.253. DEPOSITORY. (a) The board may select one or more banks to serve as depository for money in the fund.

(b) A depository bank must execute a bond or provide other security before the pool manager may deposit fund money in the bank in an amount that exceeds the maximum amount secured by the Federal Deposit Insurance Corporation. The bond or other security must be in an amount sufficient to secure the excess amount of the deposit. (V.T.I.C. Art. 21.49-11, Sec. 12(g).)

Source Law

(g) The board may select one or more banks to serve as depository for money of the fund. Before the pool manager deposits fund money in a depository bank in an amount that exceeds the maximum amount secured by the Federal Deposit Insurance Corporation, the bank must execute a bond or provide other security in an amount sufficient to secure from loss the fund money that exceeds the amount secured by the Federal Deposit Insurance Corporation.

[Sections 2208.254-2208.300 reserved for expansion]

SUBCHAPTER G. POOL COVERAGE

Revised Law

Sec. 2208.301. SCOPE OF COVERAGE. (a) Except as provided by Subsection (b), under the excess insurance coverage, the pool shall pay any portion of a claim against a public entity and the entity's officers and employees that:

(1) exceeds $1 million; and

(2) is finally determined or settled or is included in a final judgment of a court.

(b) The amount paid by the pool under this section may not exceed the amount the board determines is actuarially sound for the pool.

(c) The pool may participate in evaluating or defending a claim made under the insurance coverage. (V.T.I.C. Art. 21.49-11, Secs. 2(b), (c).)

Source Law

> (b) Under the excess insurance coverage, the pool shall pay that portion of a claim against a public entity and its officers and employees that is finally determined or settled or is included in a final judgment of a court and that is in excess of $1 million, but the amount paid by the pool may not be in excess of the amount determined by the board to be actuarially sound for the pool.
>
> (c) Under the insurance coverage, the pool may participate in the evaluation or defense of any claim.

Revised Law

Sec. 2208.302. BASIS OF COVERAGE. The pool may provide excess insurance coverage on a claims-made basis or an occurrence basis. (V.T.I.C. Art. 21.49-11, Sec. 16.)

Source Law

> Sec. 16. Excess coverage provided by the pool may be provided on a claims-made or an occurrence basis.

Revised Law

Sec. 2208.303. PUNITIVE DAMAGES NOT COVERED. Excess insurance coverage provided by the pool may not include coverage for punitive damages. (V.T.I.C. Art. 21.49-11, Sec. 17.)

Source Law

> Sec. 17. Excess coverage provided by the pool may not provide coverage for punitive damages.

Revised Law

Sec. 2208.304. RATES AND LIMITS OF COVERAGE. (a) To ensure that the pool is actuarially sound, the board shall:

(1) set the premium rates charged; and

(2) determine the maximum limits of insurance coverage provided.

(b) The pool manager, for the board's consideration, shall:

(1) collect and compile statistical data relating to the insurance coverage provided by the pool, including relevant loss, expense, and premium data and other information;

(2) prepare the proposed premium rate schedules for

the approval of the board; and

(3) prepare the maximum limits of insurance coverage.

(c) The board shall periodically reexamine the rate schedules and the maximum limits of insurance coverage as conditions change. (V.T.I.C. Art. 21.49-11, Secs. 7(d) (part), 14.)

Source Law

[Sec. 7]

(d) . . . the pool manager shall:

. . .

(3) prepare premium rate schedules for the approval of the board;

(4) collect and compile statistical data relating to the insurance coverage provided by the pool, including relevant loss, expense, and premium data, and make that information available to the board; and . . . .

Sec. 14. (a) The board shall determine the rates for premiums that will be charged and the maximum limits of coverage provided to assure that the pool is actuarially sound.

(b) The pool manager shall prepare the statistical data and other information and the proposed rate schedules and maximum limits of insurance coverage for consideration of the board.

(c) The board shall periodically reexamine the rate schedules and the maximum limits of insurance coverage as conditions change.

Revised Law

Sec. 2208.305. USE OF PUBLIC MONEY FOR POOL COVERAGE AUTHORIZED. A public entity may use the entity's money to pay any contributions or premiums required by the pool to purchase excess insurance coverage from the pool. (V.T.I.C. Art. 21.49-11, Sec. 4.)

Source Law

Sec. 4. A public entity purchasing excess insurance coverage from the pool may use funds of the public entity to pay any contributions or premiums required by the pool for the coverage.

Revisor's Note

Section 4, V.T.I.C. Article 21.49-11, states that a public entity may use the entity's "funds" to purchase excess insurance coverage. The revised law substitutes "money" for "funds" because, in context, the terms are synonymous and the former is more

commonly used.

Revised Law

Sec. 2208.306. COVERAGE PERIOD. A public entity that accepts coverage provided by the pool shall maintain that coverage for at least 35 calendar months following the month in which the pool issued the coverage. (V.T.I.C. Art. 21.49-11, Sec. 15(a).)

Source Law

> Sec. 15. (a) On accepting insurance coverage from the pool, a public entity is authorized to and shall maintain that coverage for a period not less than 35 calendar months following the month the coverage is issued.

Revised Law

Sec. 2208.307. NONRENEWAL OF COVERAGE. The pool may refuse to renew the insurance coverage of a public entity that fails to comply with the pool's underwriting or risk management guidelines. (V.T.I.C. Art. 21.49-11, Sec. 18(a).)

Source Law

> Sec. 18. (a) The pool may refuse to renew the insurance coverage of any public entity that fails to comply with the pool's underwriting or risk management guidelines.

Revised Law

Sec. 2208.308. SUBSEQUENT COVERAGE. (a) A public entity that voluntarily discontinues insurance coverage provided by the pool may not subsequently obtain coverage from the pool for at least 36 calendar months following the month in which the entity discontinues the coverage.

(b) A public entity whose insurance coverage is not renewed by the pool is not eligible to subsequently apply for coverage during the 11 calendar months following the month in which the pool gives written notice of nonrenewal. (V.T.I.C. Art. 21.49-11, Secs. 15(b), 18(b).)

Source Law

> [Sec. 15]
> (b) A public entity that voluntarily discontinues insurance coverage in the pool may not again obtain coverage from the pool for at least 36 calendar months following the month in which the coverage was discontinued.

[Sec. 18]

(b) A public entity whose insurance coverage is not renewed by the pool is not eligible to apply for new coverage during the 11 calendar months beginning after the month in which the pool gave written notice that it would not renew the coverage.

Revised Law

Sec. 2208.309. PAYMENT OF CLAIMS AND JUDGMENTS. (a) If money in the fund would be exhausted by the payment of all final and settled claims and final judgments during a fiscal year, the pool shall prorate the amount paid to each person having the claim or judgment.

(b) If the amount paid by the pool is prorated under this section, each person described by Subsection (a) shall receive an amount equal to the percentage that the amount owed to that person by the pool bears to the total amount owed, outstanding, and payable by the pool.

(c) The public entity incurring the original liability shall pay the remaining amount that is due and unpaid to a person who receives a prorated payment under this section. (V.T.I.C. Art. 21.49-11, Sec. 19.)

Source Law

Sec. 19. (a) If money in the fund will be exhausted by payment of all final and settled claims and final judgments during the fiscal year, the amount paid by the pool to each person having a claim or judgment shall be prorated, with each person receiving an amount that is equal to the percentage the amount owed to him by the pool bears to the total amount owed, outstanding, and payable by the pool.

(b) The remaining amount that is due and unpaid to a person who receives prorated payment under Subsection (a) of this section must be paid by the member city incurring the original liability.

CHAPTER 2209. TEXAS NONPROFIT ORGANIZATIONS LIABILITY POOL

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[Sections 2209.004-2209.050 reserved for expansion]

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CHAPTER 2209. TEXAS NONPROFIT ORGANIZATIONS LIABILITY POOL

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2209.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of trustees of the pool.

(2) "Fund" means the Texas nonprofit organizations liability fund.

(3) "Nonprofit organization" means an organization that is exempt from federal income taxation under Section 501(a), Internal Revenue Code of 1986, by being described as an exempt organization by Section 501(c)(3) or (4), Internal Revenue Code of 1986.

(4) "Pool" means the Texas Nonprofit Organizations Liability Pool. (V.T.I.C. Art. 21.49-14, Sec. 1.)

Source Law

Art. 21.49-14
Sec. 1. In this article:
(1) "Pool" means the Texas Nonprofit Organizations Liability Pool.
(2) "Fund" means the Texas nonprofit organizations liability fund.
(3) "Board" means the board of trustees of the pool.
(4) "Nonprofit organization" means an organization that is exempt under Section 501(c)(3) or (4), Internal Revenue Code of 1986.

Revisor's Note

Section 1(4), V.T.I.C. Article 21.49-14, refers to an organization that is "exempt under Section 501(c)(3) or (4), Internal Revenue Code of 1986." The revised law substitutes "exempt from federal income taxation under Section 501(a), Internal Revenue Code of 1986, by being described as an exempt organization by Section 501(c)(3) or (4), Internal Revenue Code of 1986" for the quoted language because it more accurately reflects the structure of the applicable federal income tax exemption.

Revised Law

Sec. 2209.002. POOL NOT ENGAGED IN BUSINESS OF INSURANCE. (a) Except as provided by this section and Section 2209.003(b), the pool is not engaged in the business of insurance under this code or other laws of this state, and this code, including Chapter 462, and other insurance laws of this state do not apply to the pool.

(b) The pool is subject to:

(1) this chapter;

(2) the requirements of this code or the commissioner relating to reporting liability claims data; and

(3) the requirements of Chapter 2251 and Article 5.13-2 relating to making, filing, and approving rates. (V.T.I.C. Art. 21.49-14, Secs. 21(a), (b) (part), (d).)

Source Law

Sec. 21. (a) Except as provided by Subsection (c) of this section, the pool is not engaged in the business of insurance under this code and other laws of this state, and this code and other insurance laws of this state do not apply to the pool.

(b) In addition to this article, the pool is subject to:

(1) the requirement of this code and the State Board of Insurance relating to reporting liability claims data;

(2) the requirements of Subchapter B, Chapter 5, of this code relating to the making, filing, and approval of rates; and

. . . .

(d) Article 21.28-C of this code does not apply to the pool.

Revisor's Note

(1) Section 21(b)(1), V.T.I.C. Article 21.49-14, 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. Throughout this chapter, references to the board have been changed appropriately.

(2) Section 21(b)(2), V.T.I.C. Article 21.49-14, refers to the requirements of Subchapter B, V.T.I.C. Chapter 5, relating to making, filing, and approving rates. That subchapter has been revised in part in various titles of this code. The relevant provisions of Subchapter B, Chapter 5, that regulate making, filing, and approving rates are in V.T.I.C. Article 5.13-2, revised in part in Chapter 2251 of this code. For that reason, the revised law substitutes a reference to "Chapter 2251 and Article 5.13-2" for the reference to "Subchapter B, Chapter 5."

Revised Law

Sec. 2209.003. DEPARTMENT AND COMMISSIONER SUPERVISION. (a) The pool is subject to the department's continuing supervision relating to the pool's solvency.

(b) The commissioner may set certain minimum requirements to ensure the capability of the pool to satisfy the pool's obligations.

(c) The department shall charge the pool reasonable fees for services performed by the department under this chapter. (V.T.I.C. Art. 21.49-14, Secs. 21(b) (part), (c), (e).)

Source Law

(b) . . . the pool is subject to:

. . .

(3) the continuing supervision of the

State Board of Insurance relating to the pool's solvency.

(c) The State Board of Insurance may set certain minimum requirements to assure the capability of the pool to satisfy its obligations.

(e) The State Board of Insurance shall charge the pool reasonable fees for services performed by the board pursuant to this Act.

[Sections 2209.004-2209.050 reserved for expansion]

SUBCHAPTER B. CREATION OF POOL

Revised Law

Sec. 2209.051. CREATION OF POOL. (a) The Texas Nonprofit Organizations Liability Pool is created on the written agreement of the chief executive officers of 15 or more nonprofit organizations.

(b) The pool provides primary and excess liability insurance coverage as provided by this chapter. (V.T.I.C. Art. 21.49-14, Sec. 2.)

Source Law

Sec. 2. On written agreement of the chief executive officers of not fewer than 15 nonprofit organizations, the Texas Nonprofit Organizations Liability Pool is created to provide primary and excess liability insurance coverage as provided by this article.

Revised Law

Sec. 2209.052. PARTICIPATION IN POOL. A nonprofit organization is entitled to coverage from the pool if the organization:

(1) submits a complete application;

(2) provides other information required by the pool;

(3) meets the underwriting standards established by the pool; and

(4) pays the premiums required for the coverage. (V.T.I.C. Art. 21.49-14, Sec. 4.)

Source Law

Sec. 4. A nonprofit organization is entitled to coverage from the pool on:

(1) submitting a complete application;

(2) providing any other information required by the pool;

(3) meeting the underwriting standards established by the pool; and

(4) paying the premiums required for the coverage.

Revised Law

Sec. 2209.053. SELECTION OF TEMPORARY BOARD. At the time the chief executive officers of the nonprofit organizations enter into the written agreement under Section 2209.051, the officers shall select nine individuals to:

(1) serve as the temporary board; and

(2) draft the plan of operation for the pool. (V.T.I.C. Art. 21.49-14, Sec. 5(a).)

Source Law

Sec. 5. (a) At the time the chief executive officers of the nonprofit organizations enter into the written agreement under Section 2 of this article, the chief executive officers shall select nine persons to serve as a temporary board to draft the plan of operation for the pool.

[Sections 2209.054-2209.100 reserved for expansion]

SUBCHAPTER C. PLAN OF OPERATION

Revised Law

Sec. 2209.101. TIME FOR CREATION OF PLAN OF OPERATION. (a) Not later than the 30th day after the date the temporary board is selected, the temporary board shall meet to prepare a detailed plan of operation for the pool.

(b) The temporary board shall complete and adopt the plan of operation not later than the 90th day after the date the temporary board is selected. (V.T.I.C. Art. 21.49-14, Secs. 5(b), (d).)

Source Law

(b) Within 30 days after selection, the members of the temporary board shall meet to prepare a detailed plan of operation for the pool.

(d) The temporary board shall complete and adopt the plan of operation within 90 days after the date of the appointment of the temporary board.

Revised Law

Sec. 2209.102. CONTENTS OF PLAN OF OPERATION. (a) Subject to the requirements of this chapter, the plan of operation must include:

(1) the organizational structure of the pool, including:

(A) the method of selecting the board;

(B) the board's method of procedure and operation; and

(C) a summary of the method for managing and operating the pool;

(2) a description of the contributions and other financial arrangements necessary to cover the initial expenses of the pool and estimates, supported by statistical data, of the amounts of those contributions or other financial arrangements;

(3) underwriting standards and procedures for evaluating risks, including a requirement that all participants in the pool receive ongoing training in the methods of controlling liability losses;

(4) procedures for purchasing reinsurance;

(5) methods, procedures, and guidelines for:

(A) establishing premium rates for and maximum limits of excess coverage available from the pool;

(B) negotiating and paying settlements, defending claims, and paying judgments; and

(C) managing and investing the fund;

(6) procedures for processing and paying claims;

(7) methods and procedures for defraying losses and expenses of the pool; and

(8) guidelines for nonrenewal of coverage.

(b) The plan of operation may include any matter relating to the organization and operation of the pool or to the pool's finances. (V.T.I.C. Art. 21.49-14, Sec. 5(c).)

Source Law

(c) The plan of operation may include any matters relating to the organization and operation of the pool and the pool's finances. The plan must include:

(1) the organizational structure of the pool, including the method of selection of the board, the method of procedure and operation of the board, and a summary of the method for managing and operating the pool;

(2) a description of the contributions and other financial arrangements necessary to cover the

initial expenses of the pool and estimates supported by statistical data of the amounts of those contributions or other financial arrangements;

(3) underwriting standards and procedures for the evaluation of risks; provided that such standards shall include, but not be limited to, the requirement that all participants in the pool receive on-going training in the methods of controlling liability losses;

(4) procedures for purchase of reinsurance;

(5) methods, procedures, and guidelines for establishing rates for premiums for and maximum limits of excess coverage available from the pool;

(6) methods, procedures, and guidelines for negotiating and paying settlements, defense of claims, and paying judgments;

(7) procedures for the processing and payment of claims;

(8) methods and procedures for defraying any losses and expenses of the pool;

(9) methods, procedures, and guidelines for the management and investment of the fund; and

(10) guidelines for nonrenewal of coverage.

Revisor's Note

(1) Section 5(c), V.T.I.C. Article 21.49-14, specifies certain provisions that the Texas Nonprofit Organizations Liability Pool must include in the plan of operation. For the convenience of the reader, the revised law adds a reference to "the requirements of this chapter" because other provisions of V.T.I.C. Article 21.49-14, revised in this chapter, specify additional requirements applicable to the provisions of the plan of operation.

(2) Section 5(c)(3), V.T.I.C. Article 21.49-14, requires that underwriting standards and procedures for evaluating risks "include, but not be limited to," the requirement that participants in the Texas Nonprofit Organizations Liability Pool receive certain training. The revised law omits "but not be 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 definitions apply to the revised law.

Revised Law

Sec. 2209.103. APPROVAL OF PLAN. (a) On completion of the plan of operation, the temporary board shall submit the plan to the department for examination, suggested changes, and final approval.

(b) The department shall approve the plan of operation only if the department is satisfied that the pool is able and will continue to be able to pay valid claims made against the pool. (V.T.I.C. Art. 21.49-14, Sec. 5(e).)

Source Law

> (e) On completion of the plan of operation, the temporary board shall submit the plan to the State Board of Insurance for examination, suggested changes, and final approval. The State Board of Insurance shall approve the plan of operation under this subsection only if it is satisfied that the pool has and will continue to possess the ability to pay valid claims made against it.

[Sections 2209.104-2209.150 reserved for expansion]

SUBCHAPTER D. BOARD OF TRUSTEES

Revised Law

Sec. 2209.151. GOVERNANCE OF POOL; BOARD MEMBERSHIP. (a) The pool is governed by a board of trustees composed of nine members selected as provided by the plan of operation.

(b) Not later than the 15th day after the date the department approves the plan of operation, the initial regular board must be selected as provided by the plan of operation. The members of the initial regular board shall take office not later than the 30th day after the date the plan of operation is adopted.

(c) Four board members must be representatives of the public. A public representative may not:

(1) be an officer, director, or employee of an insurer, insurance agency, agent, broker, solicitor, adjuster, or 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 consanguinity or affinity. (V.T.I.C. Art. 21.49-14, Secs. 5(g), 6(a).)

Source Law

[Sec. 5]

(g) Within 15 days after the day on which the plan of operation is approved by the State Board of Insurance, the first board must be selected as provided by the plan of operation. The members of the first board shall take office not later than the 30th day after the date of the adoption of the plan of operation.

Sec. 6. (a) The pool is governed by a board of nine trustees selected as provided by the plan of operation. Four of the members of the board of trustees shall be representatives of the general public. 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.

Revisor's Note

(1) Section 6(a), V.T.I.C. Article 21.49-14, provides that the Texas Nonprofit Organizations Liability Pool is governed by a board of nine "trustees." Throughout this chapter, the revised law substitutes "members" for "trustees" for consistency and because "member" is more commonly used in this chapter to describe a person serving on the board of trustees.

(2) Section 6(a)(2), V.T.I.C. Article 21.49-14, refers to a person "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, a person 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. 2209.152. TERMS; VACANCY. (a) Board members serve staggered two-year terms. The terms of four members expire in odd-numbered years as provided by the plan of operation.

(b) A vacancy on the board shall be filled as provided by the plan of operation. (V.T.I.C. Art. 21.49-14, Secs. 6(b), (c).)

Source Law

> (b) Members of the board serve for staggered terms of two years with the terms of four trustees expiring in odd-numbered years as provided by the plan of operation.
>
> (c) A vacancy on the board shall be filled as provided by the plan of operation.

Revised Law

Sec. 2209.153. PERFORMANCE BOND REQUIRED. (a) Each board member shall execute a bond in the amount required by the plan of operation. The bond must be payable to the pool and conditioned on the faithful performance of the member's duties.

(b) The pool shall pay the cost of the bond executed under this section. (V.T.I.C. Art. 21.49-14, Sec. 6(d).)

Source Law

> (d) Each member of the board shall execute a bond in the amount required by the plan of operation payable to the pool and conditioned on the faithful performance of his duties. The pool shall pay the cost of the bond.

Revised Law

Sec. 2209.154. COMPENSATION. A board member is not entitled to compensation for the member's service on the board. (V.T.I.C. Art. 21.49-14, Sec. 6(e).)

Source Law

> (e) Members of the board are not entitled to compensation for their service on the board.

Revised Law

Sec. 2209.155. OFFICERS; MEETINGS. (a) The board shall select from the board members a presiding officer, an assistant

presiding officer, and a secretary, who serve one-year terms that expire as provided by the plan of operation.

(b) The board shall hold meetings at the call of the presiding officer and at times established by the board's rules.

(c) A majority of the board members constitutes a quorum. (V.T.I.C. Art. 21.49-14, Secs. 6(f), (g), (h).)

Source Law

> (f) The board shall select from its membership persons to serve as chairman, vice-chairman, and secretary. The persons selected serve in that capacity for terms of one year that expire as provided by the plan of operation.
>
> (g) The board shall hold meetings at the call of the chairman and at times established by its rules.
>
> (h) A majority of the members of the board constitutes a quorum.

Revisor's Note

Section 6(f), V.T.I.C. Article 21.49-14, refers to the "chairman" and "vice-chairman" of the board of trustees of the Texas Nonprofit Organizations Liability Pool. The revised law substitutes "presiding officer" and "assistant presiding officer" for those terms in this section and throughout this chapter because, in context, the terms have the same meaning and "presiding officer" and "assistant presiding officer" are more commonly used and are gender-neutral.

Revised Law

Sec. 2209.156. GENERAL POWERS AND DUTIES OF BOARD. (a) In addition to other duties provided by the plan of operation, the board shall:

(1) approve contracts other than insurance contracts issued by the pool to nonprofit organizations;

(2) adopt premium rate schedules and policy forms for the pool; and

(3) receive service of summons on behalf of the pool.

(b) The board may:

(1) adopt necessary rules, including rules to

implement this chapter;

(2) delegate specific responsibilities to the pool manager; and

(3) with the department's approval, amend the plan of operation to ensure the orderly management and operation of the pool. (V.T.I.C. Art. 21.49-14, Secs. 5(f) (part), 6(i) (part), (j), 10.)

Source Law

[Sec. 5]

(f) The plan of operation may be amended by the board with the approval of the State Board of Insurance; . . . .

[Sec. 6]

(i) In addition to other duties provided by this article and the plan of operation, the board shall:

(1) approve contracts other than insurance contracts issued to nonprofit organizations by the pool;

(2) consider and adopt premium rate schedules for the pool;

(3) consider and adopt policy forms for the pool;

(4) receive service of summons on behalf of the pool; and

. . . .

(j) In addition to other authority provided by this article, the board may:

(1) adopt necessary rules;

(2) delegate specific responsibilities to the pool manager; and

(3) amend the plan of operation to assure the orderly management and operation of the pool.

Sec. 10. The board may adopt and amend rules to carry out this article.

Revisor's Note

(1) Section 6(i), V.T.I.C. Article 21.49-14, prescribes certain duties of the board of trustees of the Texas Nonprofit Organizations Liability Pool that are "[i]n addition to other duties provided by this article," and Section 6(j), V.T.I.C. Article 21.49-14, grants the board certain powers that are "[i]n addition to other authority provided by this article." The revised law omits these provisions as unnecessary. It is a common rule of statutory construction that statutes are intended to be read cumulatively. A

provision of Article 21.49-14, revised as this chapter, that grants additional powers to or prescribes additional duties for the board applies by its own terms without the necessity of additional references either specifically or generally in this chapter.

(2) Sections 6(i)(2) and (3), V.T.I.C. Article 21.49-14, require the board of trustees of the Texas Nonprofit Organizations Liability Pool to "consider and adopt" premium rate schedules and policy forms, respectively. The revised law omits the reference to "consider" as unnecessary because it is implied that the board must consider a rate schedule or policy form before adopting the rate schedule or policy form.

(3) Section 10, V.T.I.C. Article 21.49-14, authorizes the board of trustees of the Texas Nonprofit Organizations Liability Pool to adopt and "amend" rules to carry out the article. The revised law omits as unnecessary the reference to amending rules because the authority to amend rules is implied in the authority to adopt rules.

(4) Section 5(f), V.T.I.C. Article 21.49-14, requires the amended plan of operation to require participants in the Texas Nonprofit Organizations Liability Pool to receive certain training. The revised law omits this provision as duplicative of Section 5(c)(3), V.T.I.C. Article 21.49-14, revised in this chapter as Section 2209.102(a)(3). The omitted law reads:

> (f) . . . provided that such plan shall maintain the requirement that all participants in the pool receive on-going training in the methods of controlling liability losses.

<u>Revised Law</u>

Sec. 2209.157. IMMUNITY OF BOARD MEMBERS FROM CERTAIN

LIABILITIES. A board member is not liable:

(1) with respect to a claim or judgment for which coverage is provided by the pool; or

(2) for a claim or judgment against a nonprofit organization covered by the pool. (V.T.I.C. Art. 21.49-14, Sec. 6(k).)

Source Law

(k) A member of the board is not liable with respect to any claim or judgment for which coverage is provided by the pool or for a claim or judgment against a nonprofit organization covered by the pool against whom a claim is made.

[Sections 2209.158-2209.200 reserved for expansion]

SUBCHAPTER E. OPERATION OF POOL

Revised Law

Sec. 2209.201. GENERAL POWERS AND DUTIES OF POOL. (a) The pool shall:

(1) issue primary and excess liability coverage to each nonprofit organization entitled to coverage under this chapter;

(2) collect premiums for coverage issued or renewed by the pool;

(3) process and pay valid claims;

(4) maintain detailed data regarding the pool; and

(5) establish a plan to conduct loss control training or contract with an outside organization or individual to establish ongoing training and facilities inspection programs designed to reduce the potential liability losses of pool participants.

(b) The pool may:

(1) enter into contracts;

(2) purchase reinsurance;

(3) cancel or refuse to renew coverage; and

(4) perform any other act necessary to carry out this chapter, the plan of operation, or a rule adopted by the board. (V.T.I.C. Art. 21.49-14, Sec. 11.)

Source Law

Sec. 11. (a) The pool shall:

(1) issue primary and excess liability coverage to each nonprofit organization entitled to coverage under this article;

(2) collect premiums for coverage issued or renewed by the pool;

(3) process and pay valid claims;

(4) maintain detailed data regarding the pool; and

(5) establish a plan to conduct loss control training or contract with an outside organization or individual to establish on-going training and facilities inspection programs designed to reduce the potential liability losses of participants in the pool.

(b) The pool may:

(1) enter into contracts;

(2) purchase reinsurance;

(3) cancel or refuse to renew coverage; and

(4) perform any other acts necessary to carry out this article, the plan of operation, and the rules adopted by the board.

Revised Law

Sec. 2209.202. POOL MANAGER; PERFORMANCE BOND REQUIRED. (a) The board shall appoint a pool manager who serves at the pleasure of the board, and the board shall supervise the pool manager's activities.

(b) The pool manager is entitled to receive compensation as authorized by the board.

(c) The pool manager shall execute a bond in the amount determined by the board. The bond must be payable to the pool and conditioned on the faithful performance of the pool manager's duties.

(d) The pool shall pay the cost of the bond executed under this section. (V.T.I.C. Art. 21.49-14, Secs. 6(i) (part), 7(a), (b), (c).)

Source Law

[Sec. 6]

(i) . . . the board shall:

. . .

(5) appoint and supervise the activities of the pool manager.

Sec. 7. (a) The board shall appoint a pool manager who shall serve at the pleasure of the board.

(b) The pool manager is entitled to receive the compensation authorized by the board.

(c) The pool manager shall execute a bond in the amount determined by the board, payable to the pool,

conditioned on the faithful performance of his duties. The pool shall pay the cost of the bond.

Revised Law

Sec. 2209.203. GENERAL POWERS AND DUTIES OF POOL MANAGER. (a) The pool manager shall manage and conduct the affairs of the pool under the general supervision of the board and shall perform any other duties as directed by the board.

(b) In addition to any other duties provided by the board, the pool manager shall:

(1) receive and pass on applications for liability coverage from the pool;

(2) negotiate contracts for the pool; and

(3) prepare, and submit to the board for approval, proposed policy forms for coverage from the pool.

(c) The pool manager may refuse to renew the coverage of a nonprofit organization insured by the pool based on the guidelines included in the plan of operation. (V.T.I.C. Art. 21.49-14, Secs. 7(d), (e) (part), (f).)

Source Law

(d) The pool manager shall manage and conduct the affairs of the pool under the general supervision of the board and shall perform any other duties directed by the board.

(e) In addition to any other duties provided by this article or by the board, the pool manager shall:

(1) receive and pass on applications from nonprofit organizations for liability coverage from the pool;

(2) negotiate contracts for the pool;

. . .

(5) prepare and submit to the board for approval proposed policy forms for pool coverage.

(f) The pool manager may refuse to renew the coverage of any nonprofit organization insured by the pool based on the guidelines provided by the plan of operation.

Revisor's Note

Section 7(e), V.T.I.C. Article 21.49-14, provides that the manager of the Texas Nonprofit Organizations Liability Pool has certain duties in addition to any other duties provided "by this article," meaning V.T.I.C. Article 21.49-14, revised as this chapter. The revised law omits the quoted

language for the reason stated in Revisor's Note (1) to Section 2209.156.

Revised Law

Sec. 2209.204. PERSONNEL. (a) The pool manager shall employ or contract with persons necessary to assist the board and the pool manager in carrying out the powers and duties of the pool.

(b) The board must approve:

(1) the compensation paid to a pool employee; and

(2) a contract made with a person under this section. (V.T.I.C. Art. 21.49-14, Secs. 8(a), (b).)

Source Law

Sec. 8. (a) The pool manager shall employ or contract with persons necessary to assist the board and pool manager in carrying out the powers and duties of the pool.

(b) The board shall approve compensation paid to employees of the pool and contracts made with other persons under this section.

Revised Law

Sec. 2209.205. PERFORMANCE BOND AUTHORIZED. The board may require an employee or a person with whom the pool manager contracts under Section 2209.204 to execute a bond in an amount determined by the board. The bond must be payable to the board and conditioned on the faithful performance of the employee's or other person's duties to the pool. (V.T.I.C. Art. 21.49-14, Sec. 8(c).)

Source Law

(c) The board may require any employee or person with whom it contracts under this section to execute a bond in an amount determined by the board, payable to the board, and conditioned on the faithful performance of the employee's or person's duties or responsibilities to the pool.

Revisor's Note

Section 8(c), V.T.I.C. Article 21.49-14, authorizes the board of trustees of the Texas Nonprofit Organizations Liability Pool to require an employee or contract personnel to execute a bond conditioned on the faithful performance of that person's "duties or responsibilities" to the pool. The

revised law omits the reference to "responsibilities" as unnecessary because, in context, "responsibility" is included within the meaning of "duty."

Revised Law

Sec. 2209.206. IMMUNITY OF EMPLOYEES AND CONTRACTORS FROM CERTAIN LIABILITIES. An employee or a person with whom the pool manager contracts under Section 2209.204 is not liable:

(1) with respect to a claim or judgment for which coverage is provided by the pool; or

(2) for a claim or judgment against a nonprofit organization covered by the pool. (V.T.I.C. Art. 21.49-14, Sec. 8(d).)

Source Law

(d) An employee or person with whom the pool has contracted under this section is not liable with respect to any claim or judgment for which coverage is provided by the pool or for any claim or judgment against a nonprofit organization covered by the pool against whom a claim is made.

Revised Law

Sec. 2209.207. RECORDS. Records, files, and other documents and information relating to the pool must be maintained in the pool's principal office. (V.T.I.C. Art. 21.49-14, Sec. 9.)

Source Law

Sec. 9. The records, files, and other documents and information relating to the pool must be maintained in the pool's principal office.

[Sections 2209.208-2209.250 reserved for expansion]

SUBCHAPTER F. TEXAS NONPROFIT ORGANIZATIONS LIABILITY FUND

Revised Law

Sec. 2209.251. FUND CREATION; MANAGEMENT. (a) On creation of the pool, the initial regular board shall create the Texas nonprofit organizations liability fund.

(b) The fund is composed of:

(1) premiums paid by nonprofit organizations for coverage provided by the pool;

(2) contributions and other money received by the pool

to cover the initial expenses of the fund;

(3) investments of the fund and money earned from those investments; and

(4) any other money received by the pool.

(c) The pool manager shall manage the fund under the general supervision of the board. The fund manager, under the general supervision of the board, shall manage and invest the money in the fund in the manner provided by the plan of operation.

(d) Money earned by the investment of money in the fund must be deposited in the fund or reinvested for the fund. (V.T.I.C. Art. 21.49-14, Secs. 12(a), (b), (c), 13.)

Source Law

Sec. 12. (a) On creation of the pool, the first board shall create the Texas nonprofit organizations liability fund.

(b) The fund is composed of:

(1) premiums paid by nonprofit organizations for coverage by the pool;

(2) contributions and other money received by the pool to cover the initial expenses of the fund;

(3) investments and money earned from investments of the fund; and

(4) any other money received by the pool.

(c) The pool manager shall manage the fund under the general supervision of the board.

Sec. 13. (a) The fund manager, under the general supervision of the board, shall manage and invest the money in the fund in the manner provided by the plan of operation.

(b) Money earned by investment of money in the fund must be deposited in the fund or reinvested for the fund.

Revised Law

Sec. 2209.252. CONTRIBUTIONS. The board shall determine the amount of any contributions necessary to meet the initial expenses of the pool. The board shall make this determination based on the data provided by the plan of operation. (V.T.I.C. Art. 21.49-14, Sec. 14.)

Source Law

Sec. 14. The board shall determine the amount of any contributions necessary to meet initial expenses of the pool. The board shall make this determination based on the data provided in the plan of operation.

Revised Law

Sec. 2209.253. USES OF FUND. (a) Administrative expenses of the pool may be paid from the fund. Payments for administrative expenses during a fiscal year of the pool may not exceed 10 percent of the total amount of the money in the fund during that fiscal year.

(b) Money in the fund may not be used to pay:

(1) punitive damages; or

(2) a fine or penalty imposed for a violation of:

(A) a statute;

(B) an administrative rule of a state agency; or

(C) an ordinance or order of a local government.

(V.T.I.C. Art. 21.49-14, Secs. 12(d), (e).)

Source Law

(d) Administrative expenses of the pool may be paid from the fund, but payments for this purpose during any fiscal year of the pool may not exceed 10 percent of the total amount of the money in the fund during that fiscal year.

(e) Money in the fund may not be used to pay punitive damages, fines or penalties for violation of a civil or criminal statute, or fines or penalties imposed for violation of an administrative rule or regulation of a state agency or an ordinance or order of a local government.

Revisor's Note

(1) Section 12(e), V.T.I.C. Article 21.49-14, refers to "punitive damages, fines or penalties for violation of a civil or criminal statute." The revised law omits the reference to "civil or criminal" as unnecessary because all statutes are either "civil" or "criminal."

(2) Section 12(e), V.T.I.C. Article 21.49-14, refers to "an administrative rule or regulation of a state agency." 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.

Revised Law

Sec. 2209.254. DEPOSITORY BANK. (a) The board may select one or more banks to serve as a depository for money in the fund.

(b) A depository bank must execute a bond or provide other security before the pool manager may deposit fund money in the bank in an amount that exceeds the maximum amount secured by the Federal Deposit Insurance Corporation. The bond or other security must be in an amount sufficient to secure the excess amount of the deposit. (V.T.I.C. Art. 21.49-14, Sec. 12(f).)

Source Law

> (f) The board may select one or more banks to serve as depository for money of the fund. Before the pool manager deposits fund money in a depository bank in an amount that exceeds the maximum amount secured by the Federal Deposit Insurance Corporation, the bank must execute a bond or provide other security in an amount sufficient to secure from loss the fund money that exceeds the amount secured by the Federal Deposit Insurance Corporation.

[Sections 2209.255-2209.300 reserved for expansion]

SUBCHAPTER G. POOL COVERAGE

Revised Law

Sec. 2209.301. SCOPE OF COVERAGE. (a) The pool shall insure a nonprofit organization and the organization's officers and employees against liability for acts and omissions under the laws of this state.

(b) The pool shall provide to a nonprofit organization that qualifies under this chapter and the plan of operation:

(1) primary liability insurance coverage in an amount not to exceed $250,000; and

(2) excess liability insurance coverage in an amount that the board finds is actuarially sound.

(c) The pool may participate in evaluating, settling, and defending a claim against a nonprofit organization insured by the pool if the claim is covered by pool coverage.

(d) The pool is liable in an amount not to exceed the limit of coverage provided to a nonprofit organization on a claim made against the organization. (V.T.I.C. Art. 21.49-14, Sec. 3.)

Source Law

Sec. 3. (a) The pool shall insure a nonprofit organization and its officers and employees against liability for acts and omissions under the laws of this state.

(b) Under the liability insurance coverage, the pool shall provide primary and excess liability coverage to nonprofit organizations that qualify under this article and the plan of operation for the pool.

(c) The pool may provide primary liability coverage to a nonprofit organization in an amount not to exceed $250,000. The pool may provide excess liability coverage to a nonprofit organization in an amount that is found by the board to be actuarially sound.

(d) The pool may participate in the evaluation, settlement, and defense of a claim against a nonprofit organization insured by the pool if the claim is covered by pool coverage.

(e) Under pool coverage, the pool is liable on any claim only to the limit provided by the coverage of the nonprofit organization against which the claim is made.

Revised Law

Sec. 2209.302. COVERAGE ON CLAIMS-MADE BASIS. The pool may provide liability insurance coverage on a claims-made basis on forms approved by the department. (V.T.I.C. Art. 21.49-14, Sec. 17.)

Source Law

Sec. 17. Liability insurance coverage provided by the pool may be provided on a claims-made basis on forms approved by the State Board of Insurance.

Revised Law

Sec. 2209.303. PUNITIVE DAMAGES NOT COVERED. Liability insurance coverage provided by the pool may not include coverage for punitive damages. (V.T.I.C. Art. 21.49-14, Sec. 18.)

Source Law

Sec. 18. Liability insurance coverage provided by the pool may not provide coverage for punitive damages.

Revised Law

Sec. 2209.304. RATES AND LIMITS OF COVERAGE. (a) To ensure that the pool is actuarially sound, the board shall:

(1) set the premium rates charged; and

(2) determine the maximum limits of coverage provided.

(b) The pool manager, for the board's consideration, shall:

(1) collect and compile statistical data relating to the liability insurance coverage provided by the pool, including relevant loss, expense, and premium data, and other information;

(2) prepare the proposed premium rate schedules for the approval of the board; and

(3) prepare the maximum limits of coverage.

(c) The board shall periodically reexamine the rate schedules and the maximum limits of coverage as conditions change.

(d) The pool manager shall make available to the public the information described by Subsection (b)(1). (V.T.I.C. Art. 21.49-14, Secs. 7(e) (part), 15.)

Source Law

[Sec. 7]

(e) . . . the pool manager shall:

. . .

(3) prepare premium rate schedules for the approval of the board;

(4) collect and compile statistical data relating to the liability coverage provided by the pool, including relevant loss, expense, and premium data, and make that information available to the board and to the public; and

. . . .

Sec. 15. (a) The board shall determine the rates for premiums that will be charged and the maximum limits of coverage provided to assure that the pool is actuarially sound.

(b) The pool manager shall prepare the statistical data and other information and the proposed rate schedules and maximum limits of coverage for consideration of the board.

(c) The board shall periodically reexamine the rate schedules and the maximum limits of coverage as conditions change.

Revised Law

Sec. 2209.305. COVERAGE PERIOD. A nonprofit organization that accepts coverage provided by the pool shall maintain that coverage for at least 24 calendar months following the month in which the pool issued the coverage. (V.T.I.C. Art. 21.49-14, Sec. 16(a).)

Source Law

Sec. 16. (a) On accepting coverage from the pool, a nonprofit organization shall maintain that coverage for a period of not less than 24 calendar months following the month the coverage is issued.

Revised Law

Sec. 2209.306. NONRENEWAL OF COVERAGE. (a) Except as provided by Subsection (b), the pool may refuse to renew the coverage of a nonprofit organization that fails to comply with the pool's underwriting standards.

(b) The pool may not refuse to renew the coverage of a nonprofit organization during the first 24 calendar months following the month in which the nonprofit organization is first provided coverage by the pool if the organization maintains the underwriting standards established by the plan of operation. (V.T.I.C. Art. 21.49-14, Secs. 19(a), (b).)

Source Law

Sec. 19. (a) Except as provided by Subsection (b) of this section, the pool may refuse to renew the coverage of any nonprofit organization that fails to comply with the pool's underwriting standards.

(b) The pool may not refuse to renew the coverage of a nonprofit organization for the first 24 calendar months following the month in which the nonprofit organization was first insured by the pool; provided that the pool participant maintains underwriting standards established by the plan of operation.

Revisor's Note

Section 19(b), V.T.I.C. Article 21.49-14, prohibits the Texas Nonprofit Organizations Liability Pool from refusing to renew the coverage of a nonprofit organization for a certain period if the "pool participant" meets certain standards. For consistency, the revised law substitutes "nonprofit organization" for the quoted language.

Revised Law

Sec. 2209.307. SUBSEQUENT COVERAGE. (a) A nonprofit organization that voluntarily discontinues coverage provided by the pool may not subsequently obtain coverage from the pool for at least 12 calendar months following the month in which the organization discontinues the coverage.

(b) A nonprofit organization whose coverage is not renewed under Section 2209.306 is not eligible to subsequently apply for

coverage during the 12 calendar months following the month in which the pool gives written notice of nonrenewal. (V.T.I.C. Art. 21.49-14, Secs. 16(b), 19(c) (part).)

Source Law

> [Sec. 16]
> (b) A nonprofit organization that voluntarily discontinues coverage in the pool may not again obtain coverage from the pool for at least 12 calendar months following the month in which the coverage was discontinued.
>
> [Sec. 19]
> (c) . . . A nonprofit organization whose coverage is not renewed is not eligible to apply for new coverage during the 12 calendar months beginning after the month in which the pool gave written notice that it would not renew the coverage.

Revisor's Note

Section 19(c), V.T.I.C. Article 21.49-14, provides that Section 16(b) of that article does not apply if the Texas Nonprofit Organizations Liability Pool refuses to renew a nonprofit organization's coverage and provides procedures for obtaining coverage subsequent to a refusal to renew. Section 16(b), according to its terms, prohibits a nonprofit organization from obtaining subsequent coverage for a specified period if the organization voluntarily discontinued previous pool coverage. Because the pool's refusal to renew coverage under Section 19(c) is not a voluntary discontinuance of coverage by a nonprofit organization, Section 16(b) would not apply by its terms. Therefore, the revised law omits as unnecessary the statement in Section 19(c) that Section 16(b) does not apply if the pool refuses to renew coverage. The omitted law reads:

> (c) Subsection (b) of Section 16 of this article does not apply to discontinuance of a nonprofit organization's coverage if the pool refuses renewal under this section. . . .

Revised Law

Sec. 2209.308. PAYMENT OF CLAIMS AND JUDGMENTS. (a) If

money in the fund would be exhausted by the payment of all final and settled claims and final judgments during a fiscal year, the pool shall prorate the amount paid to each person having the claim or judgment.

(b) If the amount paid by the pool is prorated under this section, each person described by Subsection (a) shall receive an amount equal to the percentage that the amount owed to that person by the pool bears to the total amount owed, outstanding, and payable by the pool.

(c) The pool shall pay in the next fiscal year the remaining amount that is due and unpaid to a person who receives a prorated payment under this section. (V.T.I.C. Art. 21.49-14, Sec. 20.)

Source Law

> Sec. 20. (a) If money in the fund will be exhausted by payment of all final and settled claims and final judgments during the fiscal year, the amount paid by the pool to each person having a claim or judgment shall be prorated, with each person receiving an amount that is equal to the percentage the amount owed to that person by the pool bears to the total amount owed, outstanding, and payable by the pool.
>
> (b) The remaining amount that is due and unpaid to a person who receives prorated payment under Subsection (a) of this section must be paid in the immediately following fiscal year.

CHAPTER 2210. TEXAS WINDSTORM INSURANCE ASSOCIATION

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CHAPTER 2210. TEXAS WINDSTORM INSURANCE ASSOCIATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2210.001. PURPOSE. An adequate market for windstorm, hail, and fire insurance is necessary to the economic welfare of this state, and without that insurance, the orderly growth and development of this state would be severely impeded. This chapter provides a method by which adequate windstorm, hail, and fire insurance may be obtained in certain designated portions of this state. (V.T.I.C. Art. 21.49, Sec. 1.)

Source Law

Art. 21.49

Sec. 1. It is hereby declared by the Legislature that an adequate market for windstorm, hail and fire insurance is necessary to the economic welfare of the State of Texas and that without such insurance the orderly growth and development of the State of Texas would be severely impeded. It is therefore the purpose of this Act to provide a method whereby adequate windstorm, hail and fire insurance may be obtained in certain designated portions of the State of Texas.

Revised Law

Sec. 2210.002. SHORT TITLE. This chapter may be cited as the Texas Windstorm Insurance Association Act. (V.T.I.C.

Art. 21.49, Sec. 2.)

Source Law

Sec. 2. This Act shall be known as the "Texas Windstorm Insurance Association Act."

Revised Law

Sec. 2210.003. GENERAL DEFINITIONS. In this chapter, unless the context clearly indicates otherwise:

(1) "Association" means the Texas Windstorm Insurance Association.

(2) "Board of directors" means the board of directors of the association.

(3) "Catastrophe area" means a municipality, a part of a municipality, a county, or a part of a county designated by the commissioner under Section 2210.005.

(4) "First tier coastal county" means:

(A) Aransas County;

(B) Brazoria County;

(C) Calhoun County;

(D) Cameron County;

(E) Chambers County;

(F) Galveston County;

(G) Jefferson County;

(H) Kenedy County;

(I) Kleberg County;

(J) Matagorda County;

(K) Nueces County;

(L) Refugio County;

(M) San Patricio County; or

(N) Willacy County.

(5) "Inadequate fire insurance area" means a municipality or county designated by the commissioner under Section 2210.005 that constitutes, or is located in, a catastrophe area.

(6) "Insurance" means Texas fire and explosion insurance and Texas windstorm and hail insurance.

(7) "Net direct premium" means gross direct written premium less return premium on each canceled contract, regardless of assumed or ceded reinsurance, that is written on property in this state, as defined by the board of directors.

(8) "New building code" means a building standard, specification, or guideline adopted by the commissioner after May 1, 1997, that must be satisfied before new residential construction qualifies for a certificate of compliance that constitutes evidence of insurability of the structure by the association.

(9) "Plan of operation" means the plan adopted under this chapter for the operation of the association.

(10) "Seacoast territory" means the territory of this state composed of the first tier coastal counties and the second tier coastal counties.

(11) "Second tier coastal county" means:

(A) Bee County;

(B) Brooks County;

(C) Fort Bend County;

(D) Goliad County;

(E) Hardin County;

(F) Harris County;

(G) Hidalgo County;

(H) Jackson County;

(I) Jim Wells County;

(J) Liberty County;

(K) Live Oak County;

(L) Orange County;

(M) Victoria County; or

(N) Wharton County.

(12) "Texas fire and explosion insurance" means insurance against direct loss to insurable property incurred as a result of fire or explosion, as those terms are defined and limited in policies and forms approved by the department.

(13) "Texas windstorm and hail insurance" means

deductible insurance against:

(A) direct loss to insurable property incurred as a result of windstorm or hail, as those terms are defined and limited in policies and forms approved by the department; and

(B) indirect losses resulting from the direct loss. (V.T.I.C. Art. 21.49, Secs. 3(b), (c) (part), (d), (e), (g), (h) (part), (i) (part), (j), (l), (m), (n), (o); New.)

Source Law

Sec. 3. In this Act, unless the context clearly dictates to the contrary:

(b) "Association" means the Texas Windstorm Insurance Association as established pursuant to the provisions of this Act.

(c) "Plan of Operation" means the plan . . . for operation by the Association pursuant to the provisions of this Act, . . . .

(d) "Texas Windstorm and Hail Insurance" means deductible insurance against direct loss, and indirect losses resulting from a direct loss, to insurable property as a result of windstorm or hail, as such terms shall be defined and limited in policies and forms approved by the State Board of Insurance.

(e) "Texas Fire and Explosion Insurance" means insurance against direct loss to insurable property as a result of fire and explosion as such terms shall be defined and limited in policies and forms approved by the State Board of Insurance.

(g) "Net Direct Premiums" means gross direct written premiums less return premiums upon canceled contracts (irrespective of reinsurance assumed or ceded) written on property in this State as defined by the Board of Directors of the Association.

(h) "Catastrophe Area" means a city or a part of a city or a county or a part of a county in which it may be determined by the commissioner, . . . .

(i) "Inadequate Fire Insurance Area" means a city or county which is, or is within an area, designated as a catastrophe area, as defined in Paragraph (h), above, and . . . .

(j) "Insurance" as hereinafter used in this Act shall mean the types of insurance described in Paragraphs (d) and (e) of this Section 3.

(l) "First Tier Coastal County" means:

(1) Aransas County;
(2) Brazoria County;
(3) Calhoun County;
(4) Cameron County;
(5) Chambers County;
(6) Galveston County;
(7) Jefferson County;
(8) Kenedy County;
(9) Kleberg County;
(10) Matagorda County;
(11) Nueces County;
(12) Refugio County;
(13) San Patricio County; or

(14) Willacy County.

(m) "Second Tier Coastal County" means:

(1) Bee County;

(2) Brooks County;

(3) Fort Bend County;

(4) Goliad County;

(5) Hardin County;

(6) Harris County;

(7) Hidalgo County;

(8) Jackson County;

(9) Jim Wells County;

(10) Liberty County;

(11) Live Oak County;

(12) Orange County;

(13) Victoria County; or

(14) Wharton County.

(n) "Seacoast Territory" means the area of this state composed of the first tier coastal counties and the second tier coastal counties.

(o) "New building code" means any new building standard, specification, or guideline adopted by the commissioner after May 1, 1997, that must be met before any new residential construction qualifies for a certificate of compliance that is evidence of insurability of the structure by the Association.

Revisor's Note

(1) The definition of "board of directors" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

(2) Section 3(h), V.T.I.C. Article 21.49, refers to "a city." Throughout this chapter, the revised law substitutes the term "municipality" for "city" because that is the term used in the Local Government Code.

(3) Section 3(a), V.T.I.C. Article 21.49, defines "board" as 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 board have been changed appropriately. For this reason, the revised law omits the definition of "board." The omitted law reads:

Sec. 3. (a) "Board" means the State Board of Insurance of the State of Texas.

Revised Law

Sec. 2210.004. DEFINITION OF INSURABLE PROPERTY. (a) For purposes of this chapter and subject to this section, "insurable property" means immovable property at a fixed location in a catastrophe area or corporeal movable property located in that immovable property, as designated in the plan of operation, that is determined by the association according to the criteria specified in the plan of operation to be in an insurable condition against windstorm and hail or fire and explosion, as appropriate, as determined by normal underwriting standards.

(b) A structure located in a catastrophe area, construction of which began on or after the 30th day after the date of publication of the plan of operation, that is not built in compliance with building specifications set forth in the plan of operation or continued in compliance with those specifications, does not constitute an insurable risk for purposes of windstorm and hail insurance except as otherwise provided by this chapter.

(c) A structure, or an addition to a structure, that is constructed in conformity with plans and specifications that comply with the specifications set forth in the plan of operation at the time construction begins may not be declared ineligible for windstorm and hail insurance as a result of subsequent changes in the building specifications set forth in the plan of operation.

(d) Except as otherwise provided by this section, if repair of damage to a structure involves replacement of items covered in the building specifications set forth in the plan of operation, the repairs must be completed in a manner that complies with those specifications for the structure to continue to be insurable property for windstorm and hail insurance.

(e) If repair to a structure, other than a roof repair that exceeds 100 square feet, is less than five percent of the total amount of property coverage on the structure, the repairs may be completed in a manner that returns the structure to the structure's condition immediately before the loss without affecting the

eligibility of the structure to qualify as insurable property.

(f) This chapter does not preclude special rating of individual risks as may be provided in the plan of operation.

(g) For purposes of this chapter, a residential structure is insurable property if:

(1) the residential structure is not:

(A) a condominium, apartment, duplex, or other multifamily residence; or

(B) a hotel or resort facility;

(2) the residential structure is located within an area designated as a unit under the Coastal Barrier Resources Act (Pub. L. No. 97-348); and

(3) a building permit or plat for the residential structure was filed with the municipality, the county, or the United States Army Corps of Engineers before January 1, 2004. (V.T.I.C. Art. 21.49, Sec. 3(f).)

Source Law

[Sec. 3. In this Act, unless the context clearly dictates to the contrary:]

(f) "Insurable Property" means immovable property at fixed locations in a catastrophe area or corporeal movable property located therein (as may be designated in the plan of operation) which property is determined by the Association, pursuant to the criteria specified in the plan of operation to be in an insurable condition against windstorm, hail and/or fire and explosion as appropriate, as determined by normal underwriting standards; provided, however, that insofar as windstorm and hail insurance is concerned, any structure located within a catastrophe area, commenced on or after the 30th day following the publication of the plan of operation, not built or continuing in compliance with building specifications set forth in the plan of operation shall not be an insurable risk under this Act except as otherwise provided under this Act. A structure, or an addition thereto, which is constructed in conformity with plans and specifications that comply with the specifications set forth in the plan of operation at the time construction commences shall not be declared ineligible for windstorm and hail insurance as a result of subsequent changes in the building specifications set forth in the plan of operation. Except as otherwise provided by this subsection, if repair of damage to a structure involves replacement of items covered in the building specifications as set forth in the plan of operation, such repairs must be completed in a manner to comply with such specifications for the structure to continue within

the definition of Insurable Property for windstorm and hail insurance. If repair to a structure, other than a roof repair that exceeds 100 square feet, is less than five percent of the amount of total property coverage on the structure, the repairs may be completed in a manner that returns the structure to its condition immediately before the loss without affecting the eligibility of the structure to qualify as insurable property. Nothing in this Act shall preclude special rating of individual risks as may be provided in the plan of operation. For purposes of this Act, all residential structures, other than a condominium, apartment, duplex, or other multifamily residence, or a hotel or resort facility, which are located within those areas designated as units under the federal Coastal Barrier Resources Act (Public Law 97-348) and for which a building permit or plat has been filed with the municipality, the county, or the United States Army Corps of Engineers before the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003, are insurable property.

Revisor's Note

(1) Section 3(f), V.T.I.C. Article 21.49, provides a definition of "insurable property" for purposes of Article 21.49, revised as this chapter, that applies "unless the context clearly dictates to the contrary." The revised law omits the quoted language with respect to the definition of "insurable property" because the references to that term throughout Article 21.49 are consistent with the definition provided in Section 3(f).

(2) Section 3(f), V.T.I.C. Article 21.49, refers to the "effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003." The various articles of that bill had different effective dates. Article 21.49 was amended by Article 9 of that bill. The effective date of that article was January 1, 2004. The revised law is drafted accordingly.

Revised Law

Sec. 2210.005. DESIGNATION AS CATASTROPHE AREA OR INADEQUATE FIRE INSURANCE AREA; REVOCATION OF DESIGNATION. (a) After at least 10 days' notice and a hearing, the commissioner may designate an area of this state as a catastrophe area if the commissioner determines that windstorm and

hail insurance is not reasonably available to a substantial number of the owners of insurable property located in that territory because the territory is subject to unusually frequent and severe damage resulting from windstorms or hailstorms.

(b) After at least 10 days' notice and a hearing, the commissioner may designate an area of this state as an inadequate fire insurance area if the commissioner determines that fire and explosion insurance is not reasonably available to a substantial number of owners of insurable property located in that area.

(c) The commissioner shall revoke a designation made under Subsection (a) or (b) if the commissioner determines, after at least 10 days' notice and a hearing, that the applicable insurance coverage is no longer reasonably unavailable to a substantial number of owners of insurable property within the designated territory.

(d) If the association determines that windstorm and hail insurance or fire and explosion insurance is no longer reasonably unavailable to a substantial number of owners of insurable property in a territory designated as a catastrophe area or inadequate fire insurance area, as applicable, the association may request in writing that the commissioner revoke the designation. After at least 10 days' notice and a hearing, but not later than the 30th day after the date of the hearing, the commissioner shall:

(1) approve the request and revoke the designation; or

(2) reject the request. (V.T.I.C. Art. 21.49, Secs. 3(h) (part), (i) (part).)

Source Law

(h) "Catastrophe Area" [means a city or a part of a city or a county or a part of a county] in which it may be determined by the commissioner, after notice of not less than 10 days and a hearing, that windstorm and hail insurance is not reasonably available to a substantial number of owners of insurable property within that city or a part of that city or a county or a part of that county, due to such insurable property being located within a city or a part of that city or a county or a part of that county that is subject to unusually frequent and severe damage resulting from windstorms and/or hailstorms. Such designation shall be revoked by the commissioner if the commissioner

determines, after notice of not less than 10 days and a hearing, that windstorm and hail insurance in such catastrophe area is no longer reasonably unavailable to a substantial number of owners of insurable property within such designated city or a part of that city or county or a part of that county. If the Association shall determine that windstorm and hail insurance is no longer reasonably unavailable to a substantial number of owners of insurable property in any designated catastrophe area or areas, then the Association may request in writing that the commissioner revoke the designation of any or all of such catastrophe areas and, after notice of not less than 10 days and a hearing, but within 30 days of such hearing, the commissioner shall either approve or reject the Association's request and shall, if such request be approved, revoke such designation or designations.

(i) "Inadequate Fire Insurance Area" [means a city or county which is, or is within an area, designated as a catastrophe area, as defined in Paragraph (h), above, and] in which it may be determined by the Board, after notice of not less than 10 days and a hearing, that fire and explosion insurance is not reasonably available to a substantial number of owners of insurable property within such city or county. Such designation shall be revoked by the Board if it determines, after 10 days' notice and a hearing, that fire and explosion insurance in such inadequate fire insurance area is no longer reasonably unavailable to a substantial number of owners of insurable property within such designated city or county. If the Association shall determine that fire and explosion insurance is no longer reasonably unavailable to a substantial number of owners of insurable property in any designated inadequate fire insurance area or areas, then the Association may request in writing that the Board revoke the designation of any or all such inadequate fire insurance areas, and, after notice of not less than 10 days and a hearing, but within 30 days of such hearing, the Board shall either approve or reject the Association's request and shall, if such request is approved, revoke such designation or designations.

Revised Law

Sec. 2210.006. APPLICABILITY OF CHAPTER TO CERTAIN INSURERS. (a) Except as provided by Subsection (b), this chapter applies to each insurer authorized to engage in the business of property insurance in this state, including a county mutual insurance company, a Lloyd's plan, and a reciprocal or interinsurance exchange.

(b) This chapter does not apply to:

(1) a farm mutual insurance company operating under Chapter 911;

(2) a county mutual fire insurance company described by Section 912.310; or

(3) a mutual insurance company or a statewide mutual assessment company engaged in business under Chapter 12 or 13, Title 78, Revised Statutes, respectively, before those chapters' repeal by Section 18, Chapter 40, Acts of the 41st Legislature, 1st Called Session, 1929, as amended by Section 1, Chapter 60, General Laws, Acts of the 41st Legislature, 2nd Called Session, 1929, that retains the rights and privileges under the repealed law to the extent provided by those sections. (V.T.I.C. Art. 21.49, Secs. 3(k), 18.)

Source Law

[Sec. 3. In this Act, unless the context clearly dictates to the contrary:]

(k) "Insurers" means all property insurers authorized to transact property insurance in this State and specifically includes and makes this Act applicable to county mutual companies, Lloyds and reciprocal or interinsurance exchanges, but shall not include (a) farm mutual insurance companies as authorized in Chapter 16 of this Code; (b) county mutual fire insurance companies which are writing exclusively industrial fire insurance policies as defined in Article 17.02 of this Code; and (c) any companies now operating under Chapters 12 and 13 of Title 78 of the Revised Civil Statutes of Texas, 1925, as amended, which have heretofore been repealed.

Sec. 18. This Act does not apply to farm mutual insurance companies, as defined in Article 16.01 of the Insurance Code, nor does it apply to any existing company chartered under old Chapter 12, Title 78, Revised Civil Statutes of Texas, 1925, repealed by Chapter 40, Acts of the 41st Legislature, 1st Called Session, 1929, Chapter 40.

Revisor's Note

(1) Section 3(k), V.T.I.C. Article 21.49, provides a definition of "insurer" for purposes of Article 21.49, revised as this chapter, that applies "unless the context clearly dictates to the contrary." The revised law omits the quoted language with respect to the definition of "insurer" because the references to that term throughout Article 21.49 are consistent with the definition provided in Section 3(k).

(2) Section 3(k), V.T.I.C. Article 21.49, refers to "Lloyds and reciprocal or interinsurance

exchanges" and further refers to "county mutual companies." The revised law substitutes "Lloyd's plan" for "Lloyds" and "county mutual insurance company" for "county mutual companies" for consistency of terminology throughout this code.

(3) Section 3(k), V.T.I.C. Article 21.49, refers to county mutual fire insurance companies "which are writing exclusively industrial fire insurance policies as defined in Article 17.02 of this Code." The revised law omits the quoted language and substitutes a cross-reference to Section 912.310 of this code because those county mutual insurance companies and the type of policies that they are authorized to write are described by that section.

Revised Law

Sec. 2210.007. IMMUNITY FROM LIABILITY IN GENERAL. (a) This section applies to:

(1) the association and a director, agent, or association staff;

(2) the commissioner, the department, and department staff; and

(3) a participating insurer and the insurer's agents and staff.

(b) A person described by Subsection (a) is not liable, and a cause of action does not arise against the person, for:

(1) an inspection made under the plan of operation; or

(2) any statement made in good faith by the person:

(A) in a report or communication concerning risks submitted to the association; or

(B) at any administrative hearing conducted under this chapter in connection with the inspection or statement. (V.T.I.C. Art. 21.49, Sec. 10(c).)

Source Law

(c) There shall be no liability on the part of

and no cause of action of any nature shall arise against a director of the association, the Board or any of its staff, the Association or its agents or employees, or against any participating insurer or its agents or employees, for any inspections made under the plan of operation or any statements made in good faith by them in any reports or communications concerning risks submitted to the Association, or at any administrative hearings conducted in connection therewith under the provisions of this Act.

Revised Law

Sec. 2210.008. DEPARTMENT ORDERS. (a) After notice and hearing as provided by Subsection (b), the commissioner may issue any orders that the commissioner considers necessary to implement this chapter, including orders regarding maximum rates, competitive rates, and policy forms.

(b) Before the commissioner adopts an order, the department shall post notice of the hearing on the order at the secretary of state's office in Austin and shall hold a hearing to consider the proposed order. Any person may appear at the hearing and testify for or against the adoption of the order. (V.T.I.C. Art. 21.49, Sec. 5A.)

Source Law

Sec. 5A. (a) After notice and a hearing as provided in Subsection (b) of this section, the Board may issue any orders which it considers necessary to carry out the purposes of this Act including, but not limited to, maximum rates, competitive rates, and policy forms.

(b) Before an order is adopted by the Board, it shall post notice of a hearing on the order at the Secretary of State's office in the State Capitol and shall hold a hearing to consider the proposed order. Any person may appear and testify for or against the adoption of the order.

Revisor's Note

Section 5A(a), V.T.I.C. Article 21.49, refers to "including, but not limited to" certain rates and forms. The revised law omits "but not limited to" as unnecessary. 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 sections apply to the revised law.

[Sections 2210.009-2210.050 reserved for expansion]

SUBCHAPTER B. ADMINISTRATION OF ASSOCIATION

Revised Law

Sec. 2210.051. COMPOSITION OF ASSOCIATION; REQUIRED MEMBERSHIP. (a) The association is composed of all property insurers authorized to engage in the business of property insurance in this state, other than insurers prevented by law from writing on a statewide basis coverages available through the association.

(b) As a condition of the insurer's authority to engage in the business of insurance in this state, each insurer subject to Subsection (a) must be a member of the association and must remain a member for the duration of the association's existence. An insurer that ceases to be a member of the association remains liable on insurance contracts entered into during the insurer's membership in the association to the same extent and effect as if the insurer's membership in the association had not been terminated.

(c) An insurer that becomes authorized to write and is engaged in writing insurance that requires the insurer to be a member of the association shall become a member of the association on the January 1 following the effective date of that authorization. The determination of the insurer's participation in the association is made as of the date of the insurer's membership in the manner used to determine participation for all other members of the association. (V.T.I.C. Art. 21.49, Secs. 4(a), 5(b) (part).)

Source Law

Sec. 4. (a) The Association which is hereby created shall consist of all property insurers authorized to transact property insurance in this State, except those companies that are prevented by law from writing coverages available through the pool on a Statewide basis. Every such insurer shall be a member of the Association and shall remain a member of the Association so long as the Association is in existence, as a condition of its authority to transact the business of insurance in this State. Any insurer which ceases to be a member of the Association shall

remain liable on contracts of insurance entered into during its membership in the Association to the same extent and effect as if its membership in the Association had not been terminated.

[Sec. 5]

(b) . . . Any insurer authorized to write and engaged in writing any insurance, the writing of which required such insurer to be a member of the Association, who becomes authorized to engage in writing such insurance shall become a member of the Association on the 1st day of January immediately following such authorization and the determination of such insurer's participation in the Association shall be made as of the date of such membership in the same manner as for all other members of the Association.

Revisor's Note

(1) Section 4(a), V.T.I.C. Article 21.49, refers to "coverages available through the pool." Article 21.49, as originally enacted by Chapter 100, Acts of the 62nd Legislature, Regular Session, 1971, adopted the "Texas Catastrophe Property Insurance Pool Act." The "pool" was administered by the Texas Catastrophe Property Insurance Association. "Pool" was never a defined term under Article 21.49, and most amendments to that article referred to the "association," rather than the "pool." In 1997, the short title of the article was changed to the "Texas Windstorm Insurance Association Act" by Chapter 438, Acts of the 75th Legislature, Regular Session. The revised law substitutes "association" for "pool" to conform to the definitions used by this chapter.

(2) Section 5(b), V.T.I.C. Article 21.49, refers to "the 1st day of January immediately following" a specified determination. The revised law omits "immediately" as unnecessary because "the January 1 following" the specified determination means the January 1 immediately following that determination.

Revised Law

Sec. 2210.052. MEMBER PARTICIPATION IN ASSOCIATION. (a) Each member of the association shall participate in the writings,

expenses, profits, and losses of the association in the proportion that the net direct premiums of that member during the preceding calendar year bears to the aggregate net direct premiums by all members of the association, as determined using the information provided under Subsection (b).

(b) The department shall review annual statements, other reports, and other statistics that the department considers necessary to obtain the information required under Subsection (a) and shall provide that information to the association. The department is entitled to obtain the annual statements, other reports, and other statistics from any member of the association.

(c) Each member's participation in the association shall be determined annually in the manner provided by the plan of operation. For purposes of determining participation in the association, two or more members that are subject to common ownership or that operate in this state under common management or control shall be treated as a single member. The determination shall also include the net direct premiums of an affiliate that is under that common management or control, including an affiliate that is not authorized to engage in the business of property insurance in this state.

(d) Notwithstanding Subsection (a), a member, in accordance with the plan of operation, is entitled to receive credit for similar insurance voluntarily written in an area designated by the commissioner. The member's participation in the writings of the association shall be reduced in accordance with the plan of operation. (V.T.I.C. Art. 21.49, Sec. 5(b) (part).)

Source Law

> (b) All members of the Association shall participate in its writings, expenses, profits and losses in the proportion that the net direct premiums of such member written in this State during the preceding calendar year bears to the aggregate net direct premiums written in this State by all members of the Association, as furnished to the Association by the Board after review of annual statements, other reports and other statistics the Board shall deem necessary to provide the information herein required and which the Board is hereby authorized and empowered

to obtain from any member of the Association, provided, however, that a member shall, in accordance with the plan of operation, be entitled to receive credit for similar insurance voluntarily written in the area designated by the Board and its participation in the writings in the Association shall be reduced in accordance with the provisions of the plan of operation. Each member's participation in the Association shall be determined annually in the manner provided in the plan of operation. For purposes of determining participation in the Association, two or more members having a common ownership or operating in this State under common management or control shall be treated as if they constituted a single member and also shall include the net direct premiums, as defined by this article, of any affiliated insurance company that is under such common management or control including affiliated insurance companies that are not authorized to transact property insurance in this State. . . .

Revisor's Note

Section 5(b), V.T.I.C. Article 21.49, refers to "net direct premiums . . . written in this State." The revised law omits the reference to "written in this State" as unnecessary because under Section 3(g), Article 21.49, revised in this chapter as Section 2210.003(7), "net direct premium" is defined in part to mean gross direct written premium on insurance written on property in this state.

Revised Law

Sec. 2210.053. OPERATION OF ASSOCIATION. (a) In accordance with this chapter and the plan of operation, and with respect to insurance on insurable property, the association, on behalf of the association's members, may:

(1) cause issuance of insurance policies to applicants for insurance coverage;

(2) assume reinsurance from the members;

(3) cede reinsurance to the members; and

(4) purchase reinsurance on behalf of the members.

(b) The department may develop programs to improve the efficient operation of the association, including a program designed to create incentives for insurers to write windstorm and hail insurance voluntarily to cover property located in a catastrophe area, especially property located on the barrier

islands of this state. (V.T.I.C. Art. 21.49, Secs. 5(a), (e).)

Source Law

> Sec. 5. (a) The Association shall, pursuant to the provisions of this Act and the plan of operation, and with respect to insurance on insurable property, have the power on behalf of its members to cause to be issued policies of insurance to applicants, to assume reinsurance from its members, and to cede reinsurance to its members and to purchase reinsurance on behalf of its members.
>
> (e) The Board may develop programs to improve the efficient operation of the Association, including a program designed to create incentives for insurers to write windstorm and hail insurance voluntarily to cover property located in a catastrophe area, especially property located on the barrier islands.

Revised Law

Sec. 2210.054. ANNUAL STATEMENT. (a) The association shall file annually with the department a statement covering periods designated by the department that summarizes the transactions, conditions, operations, and affairs of the association during the preceding year.

(b) The statement must:

(1) be filed at times designated by the department;

(2) contain the information prescribed by the department; and

(3) be in the form prescribed by the department. (V.T.I.C. Art. 21.49, Sec. 12.)

Source Law

> Sec. 12. The Association shall file in the office of the Board annually a statement which shall summarize the transactions, conditions, operations and affairs of the Association during the preceding year at such times and covering such periods as may be designated by the Board. Such statement shall contain such matters and information as are prescribed by the Board and shall be in such form as is required by it.

Revised Law

Sec. 2210.055. LEGAL COUNSEL. (a) The association shall establish a plan in the plan of operation under which the association's legal representation before the department and the legislature is without conflict of interest or the appearance of a conflict of interest as defined by the Texas Disciplinary Rules of

Professional Conduct.

(b) The association shall adopt separate and distinct procedures for legal counsel in disputes involving policyholder claims against the association. (V.T.I.C. Art. 21.49, Sec. 12A.)

Source Law

> Sec. 12A. The association shall establish a plan in its plan of operation under which the association's legal representation before the State Board of Insurance, the Texas Department of Insurance, and the Texas legislature is without conflict of interest or the appearance of a conflict of interest as defined in the Texas Disciplinary Rules of Professional Conduct. The association shall also adopt separate and distinct procedures for legal counsel in the handling of disputes involving policyholder claims against the association.

Revised Law

Sec. 2210.056. USE OF ASSOCIATION ASSETS. (a) The association's net earnings may not inure, in whole or in part, to the benefit of a private shareholder or individual.

(b) The association's assets may not be used for or diverted to any purpose other than to:

(1) satisfy, in whole or in part, the liability of the association on claims made on policies written by the association;

(2) make investments authorized under applicable law;

(3) pay reasonable and necessary administrative expenses incurred in connection with the operation of the association and the processing of claims against the association; or

(4) make remittance under the laws of this state to be used by this state to:

(A) pay claims made on policies written by the association;

(B) purchase reinsurance covering losses under those policies; or

(C) prepare for or mitigate the effects of catastrophic natural events.

(c) On dissolution of the association, all assets of the association revert to this state. (V.T.I.C. Art. 21.49, Secs.

4(c), (d).)

Source Law

(c) No part of the net earnings of the association may inure to the benefit of any private shareholder or individual. The assets of the association may not be used for or diverted to any purpose other than to:

(1) satisfy, in whole or in part, the liability of the association regarding a claim made on a policy written by the association;

(2) make investments authorized under applicable law;

(3) pay reasonable and necessary administrative expenses incurred in connection with the establishment and operation of the association and the processing of claims against the association; or

(4) make remittances under the laws of this state to be used by this state to:

(A) pay claims on policies written by the association;

(B) purchase reinsurance covering losses under those policies; or

(C) prepare for or mitigate the effects of catastrophic natural events.

(d) On dissolution of the association, all assets of the association revert to this state.

Revisor's Note

Section 4(c)(3), V.T.I.C. Article 21.49, refers to the payment of expenses incurred "in connection with the establishment and operation of the association." The revised law omits as executed the reference to the establishment of the association.

Revised Law

Sec. 2210.057. EXAMINATION OF ASSOCIATION. (a) The association is subject to Sections 401.051, 401.052, 401.054-401.062, 401.151, 401.152, 401.155, and 401.156 and Subchapter A, Chapter 86.

(b) A final examination report of the association resulting from an examination as provided by this section is a public record and is available to the public at the offices of the department in accordance with Chapter 552, Government Code. (V.T.I.C. Art. 21.49, Sec. 5B.)

Source Law

Sec. 5B. (a) The association is subject to Articles 1.15 and 1.16 of this code.

(b) A final examination report of the Association resulting from an examination under this

section is a public record and available to the public at the Board's offices pursuant to 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) Section 5B(a), V.T.I.C. Article 21.49, refers to V.T.I.C. Articles 1.15 and 1.16. Article 1.15 is revised in part in Subchapter A, Chapter 86, of this code. That subchapter also consists of a provision derived in part from V.T.I.C. Article 1.19. The revised law appropriately refers to Subchapter A, Chapter 86, in its entirety because the provision that is derived from Article 1.19 is also derived from a provision of Article 1.15, and those provisions are substantively identical.

(2) Section 5B(b), V.T.I.C. Article 21.49, refers to the open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes). That statute was codified in 1993 as Chapter 552, Government Code. The revised law is drafted accordingly.

Revised Law

Sec. 2210.058. PAYMENT OF EXCESS LOSSES; PREMIUM TAX CREDIT. (a) If, in any calendar year, an occurrence or series of occurrences in a catastrophe area results in insured losses and operating expenses of the association in excess of premium and other revenue of the association, the excess losses shall be paid as follows:

(1) $100 million shall be assessed against the members of the association as provided by Subsection (b);

(2) losses in excess of $100 million shall be paid from the catastrophe reserve trust fund established under Subchapter J and any reinsurance program established by the association;

(3) for losses in excess of those paid under

Subdivisions (1) and (2), an additional $200 million shall be assessed against the members of the association, as provided by Subsection (b); and

(4) losses in excess of those paid under Subdivisions (1), (2), and (3) shall be assessed against members of the association, as provided by Subsection (b).

(b) The proportion of the losses allocable to each insurer under Subsections (a)(1), (3), and (4) shall be determined in the manner used to determine each insurer's participation in the association for the year under Section 2210.052.

(c) An insurer may credit an amount paid in accordance with Subsection (a)(4) in a calendar year against the insurer's premium tax under Chapter 221. The tax credit authorized under this subsection shall be allowed at a rate not to exceed 20 percent per year for five or more successive years following the year of payment of the claims. The balance of payments made by the insurer and not claimed as a premium 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 an annual statement under Section 862.001. (V.T.I.C. Art. 21.49, Sec. 19.)

Source Law

Sec. 19. (a) If, in any calendar year, an occurrence or series of occurrences within the defined catastrophe area results in insured losses and operating expenses of the association in excess of premium and other revenue of the association, any excess losses shall be paid as follows:

(1) $100 million shall be assessed to the members of the association with the proportion of the loss allocable to each insurer determined in the same manner as its participation in the association has been determined for the year under Section 5(c) of this Act;

(2) any losses in excess of $100 million shall be paid from the catastrophe reserve trust fund established under Section 8(i) of this Act and any reinsurance program established by the association;

(3) for losses in excess of those paid under Subdivisions (1) and (2) of this subsection, an additional $200 million shall be assessed to the members of the association with the proportion of the loss allocable to each insurer determined in the same manner as its participation in the association has been determined for the year under Section 5(c) of this Act;

(4) any losses in excess of those paid

under Subdivisions (1), (2), and (3) of this subsection shall be assessed against members of the association, with the proportion of the total loss allocable to each insurer determined in the same manner as its participation in the association has been determined for the year under Section 5(c) of this Act.

(b) An insurer may credit any amount paid in accordance with Subsection (a)(4) of this section in a calendar year against its premium tax under Article 4.10 of this code. The tax credit herein authorized shall be allowed at a rate not to exceed 20 percent per year for five or more successive years following the year of payment of the claims. The balance of payments paid by the insurer and not claimed as such 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 pursuant to Article 6.12 of this code.

Revisor's Note

(1) Section 19(a), V.T.I.C. Article 21.49, refers to a "defined" catastrophe area. Other provisions of Article 21.49 refer to "designated" catastrophe or inadequate fire insurance areas. Throughout this chapter, the revised law omits "defined" and "designated" in this context as unnecessary because under Sections 3(h) and (i), Article 21.49, revised in relevant part in this chapter as Section 2210.005, the commissioner of insurance designates a defined territory as a catastrophe area or inadequate fire insurance area. A territory that has not been designated as a catastrophe area or inadequate fire insurance area is not one of those areas.

(2) Sections 19(a)(1), (3), and (4), V.T.I.C. Article 21.49, refer to determination of an insurer's participation in the association as made under Section 5(c) of that article. Section 5, Article 21.49, was substantially amended by Section 11.42, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, which repealed the original Subsection (b) of that section and relettered original Subsection (c) as Subsection (b). Section 5(b), Article 21.49, in

relevant part establishes participation requirements and is revised in this chapter as Section 2210.052. The revised law is drafted accordingly.

Revised Law

Sec. 2210.059. NOTIFICATION REGARDING TAX CREDITS. (a) The association shall immediately notify the department if an occurrence or series of occurrences in a catastrophe area results in insured losses that result in a tax credit under Section 2210.058(c) in a calendar year.

(b) On receipt of notice under Subsection (a), the department shall immediately notify the governor and the appropriate committees of each house of the legislature of the amount of insured losses eligible for tax credits under Section 2210.058(c). (V.T.I.C. Art. 21.49, Sec. 5(l).)

Source Law

(l) If an occurrence or series of occurrences within the defined catastrophe area results in insured losses that result in tax credits under Section 19(4) of this article in a single calendar year, the Association shall immediately notify the Board of that fact. The Board on receiving notice shall immediately notify the Governor and appropriate committees of each house of the Legislature of the amount of insured losses eligible for tax credits under Section 19(4) of this article.

Revisor's Note

Section 5(l), V.T.I.C. Article 21.49, refers to "tax credits under Section 19(4) of this article," meaning Section 19(4), Article 21.49. Section 19(4) does not exist; it is clear from the context that the correct cite is to Section 19(b), Article 21.49, revised in this chapter as Section 2210.058(c). The revised law is drafted accordingly.

Revised Law

Sec. 2210.060. INDEMNIFICATION BY ASSOCIATION. (a) Except as provided by Subsection (b), the association shall indemnify each director, officer, and employee of the association and each member of the association against all costs and expenses actually and

necessarily incurred by the person or entity in connection with the defense of an action or proceeding in which the person or entity is made a party because of the person's status as a director, officer, or employee of the association or the member's status as a member of the association.

(b) Subsection (a) does not apply to a matter in which the person or entity is determined in the action or proceeding to be liable because of misconduct in the performance of duties as a director, officer, or employee of the association or a member of the association.

(c) Subsection (a) does not authorize the association to indemnify a member of the association for participating in the writings, expenses, profits, and losses of the association in the manner provided by this chapter.

(d) Indemnification under this section is not exclusive of other rights to which the member or officer may be entitled as a matter of law. (V.T.I.C. Art. 21.49, Sec. 11.)

Source Law

> Sec. 11. Each person serving as a director of the Association, each member of the Association, and each officer and employee of the Association shall be indemnified by the Association against all costs and expenses actually and necessarily incurred by him or it in connection with the defense of any action, suit, or proceeding in which he or it is made a party by reason of his or its being or having been a director or member of the Association, or an officer or employee of the Association except in relation to matters as to which he or it has been judged in such action, suit or proceeding to be liable by reason of misconduct in the performance of his or its duties as a director of the Association or a member or officer or employee of the Association, provided, however, that this indemnification shall in no way indemnify a member of the Association from participating in the writings, expenses, profits, and losses of the Association in the manner set out in this Act. Indemnification hereunder shall not be exclusive of other rights to which such member or officer may be entitled as a matter of law.

Revisor's Note

Section 11, V.T.I.C. Article 21.49, refers to an "action, suit, or proceeding." The revised law omits the reference to "suit" because, in context, "suit" is

included within the meaning of "action."

[Sections 2210.061-2210.100 reserved for expansion]

SUBCHAPTER C. ASSOCIATION BOARD OF DIRECTORS

Revised Law

Sec. 2210.101. ACCOUNTABLE TO COMMISSIONER. The board of directors is responsible and accountable to the commissioner. (V.T.I.C. Art. 21.49, Sec. 5(g) (part).)

Source Law

(g) The board of directors of the Association is responsible and accountable to the Board. . . .

Revised Law

Sec. 2210.102. COMPOSITION. (a) The board of directors is composed of the following nine members:

(1) five representatives of different insurers who are members of the association, elected by the members as provided by the plan of operation;

(2) two public representatives who are nominated by the office of public insurance counsel and who, as of the date of the appointment:

(A) reside in a catastrophe area; and

(B) are policyholders of the association; and

(3) two general property and casualty agents:

(A) who have demonstrated experience in the association; and

(B) whose principal offices, as of the date of the appointment, are located in a catastrophe area.

(b) The persons appointed under Subsections (a)(2) and (3) must be from different counties. (V.T.I.C. Art. 21.49, Secs. 5(g) (part), (i).)

Source Law

(g) . . . The board of directors is composed of nine members as follows:

(1) five representatives of different insurers who are members of the Association who shall be elected by members as provided in the plan of operation;

(2) two representatives of the general public, nominated by the office of public insurance

counsel, who, as of the date of the appointment, reside in a catastrophe area and who are policyholders, as of the date of the appointment, of the Association; and

(3) two local recording agents licensed under this Code with demonstrated experience in the Association, and whose principal offices, as of the date of the appointment, are located in a catastrophe area.

(i) The persons appointed as provided by Subsections (g)(2) and (g)(3) of this section must be from different counties.

Revisor's Note

Section 5(g)(3), V.T.I.C. Article 21.49, refers to "local recording agents licensed under this Code." 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. In addition, throughout this chapter, the revised law omits references to insurance agents being "licensed" as unnecessary because under Section 4001.101 of this code, a person may not act as an agent unless the person holds a license.

Revised Law

Sec. 2210.103. TERMS. (a) Members of the board of directors serve three-year staggered terms, with the terms of three members expiring on the third Tuesday of March of each year.

(b) A person may serve on the board of directors for not more than three consecutive full terms, not to exceed nine years. (V.T.I.C. Art. 21.49, Sec. 5(h).)

Source Law

(h) Members of the board of directors of the Association serve three-year staggered terms, with the terms of three members expiring on the third Tuesday of March of each year. A person may hold a seat on the board of directors for not more than three consecutive

full terms, not to exceed nine years.

Revised Law

Sec. 2210.104. OFFICERS. The board of directors shall elect from the board's membership an executive committee consisting of a presiding officer, assistant presiding officer, and secretary-treasurer. At least one of the officers must be a member appointed under Section 2210.102(a)(2) or (3). (V.T.I.C. Art. 21.49, Sec. 5(j).)

Source Law

(j) The board of directors of the Association shall elect an executive committee consisting of a chairman, vice-chairman, and secretary-treasurer from its membership. At least one of those officers must be a member appointed under Subsection (g)(2) or Subsection (g)(3) of this section.

Revisor's Note

Section 5(j), V.T.I.C. Article 21.49, refers to the election of a "chairman" and "vice-chairman." The revised law substitutes "presiding officer" and "assistant presiding officer" for those terms because, in context, the terms have the same meaning and "presiding officer" and "assistant presiding officer" are more commonly used and are gender neutral.

Revised Law

Sec. 2210.105. MEETINGS. (a) Except for an emergency meeting, the association shall notify the department not later than the 11th day before the date of a meeting of the board of directors or of the members of the association.

(b) Except for a closed meeting authorized by Subchapter D, Chapter 551, Government Code, a meeting of the board of directors or of the members of the association is open to:

(1) the commissioner or the commissioner's designated representative; and

(2) the public.

(c) Notice of a meeting of the board of directors or the association must be given as provided by Chapter 551, Government Code. (V.T.I.C. Art. 21.49, Sec. 5(k).)

Source Law

(k) Except for an emergency meeting of the Association or the board of directors of the Association, the Association shall notify the Board not later than the 11th day before the date of each meeting of the board of directors of the Association or a meeting of the members of the Association. Except for closed or executive sessions authorized by Section 2, Chapter 271, Acts of the 60th Legislature, Regular Session, 1967 (Article 6252-17, Vernon's Texas Civil Statutes), meetings of the board of directors of the Association and members of the Association shall be open to any member of the Board or the member's designated representative and to members of the public. Notice of meetings of the Association or board of directors of the Association shall be given as provided by Chapter 271, Acts of the 60th Legislature, Regular Session, 1967 (Article 6252-17, Vernon's Texas Civil Statutes).

Revisor's Note

(1) Section 5(k), V.T.I.C. Article 21.49, refers to "Chapter 271, Acts of the 60th Legislature, Regular Session, 1967 (Article 6252-17, Vernon's Texas Civil Statutes)," and to Section 2 of that act. Chapter 271, Acts of the 60th Legislature, Regular Session, 1967 (Article 6252-17, Vernon's Texas Civil Statutes), was codified in 1993 as Chapter 551, Government Code. The relevant provisions of Section 2 of that act were codified as Subchapter D, Chapter 551, Government Code. The revised law is drafted accordingly.

(2) Section 5(k), V.T.I.C. Article 21.49, refers to "closed or executive sessions" of the board of directors of the Texas Windstorm Insurance Association that are authorized by Section 2, Chapter 271, Acts of the 60th Legislature, Regular Session, 1967 (Article 6252-17, Vernon's Texas Civil Statutes), the relevant provisions of which were codified as Subchapter D, Chapter 551, Government Code. The revised law substitutes "closed meeting" for the reference to "closed or executive sessions" because "closed meeting" is the term used in Subchapter D,

Chapter 551, Government Code, for that type of meeting.

Revised Law

Sec. 2210.106. IMMUNITY OF DIRECTOR OR OFFICER FROM LIABILITY. (a) A director or officer of the association is not individually liable for an act or failure to act in the performance of official duties in connection with the association.

(b) Subsection (a) does not apply to:

(1) an act or failure to act of the association or an employee of the association;

(2) an act or omission involving a motor vehicle; or

(3) an act or failure to act that constitutes bad faith, intentional misconduct, or gross negligence. (V.T.I.C. Art. 21.49, Secs. 10(a), (b).)

Source Law

Sec. 10. (a) A director or officer of the Association is not individually liable for any act or failure to act in the performance of official duties in connection with the Association.

(b) Subsection (a) does not apply to:

(1) an act or failure to act of an employee of the Association;

(2) an act or failure to act of the Association;

(3) an act or omission involving a motor vehicle; or

(4) an act or failure to act that constitutes bad faith, intentional misconduct, or gross negligence.

[Sections 2210.107-2210.150 reserved for expansion]

SUBCHAPTER D. PLAN OF OPERATION

Revised Law

Sec. 2210.151. ADOPTION OF PLAN OF OPERATION. With the advice of the board of directors, the commissioner by rule shall adopt the plan of operation to provide:

(1) Texas windstorm and hail insurance in a catastrophe area; and

(2) Texas fire and explosion insurance in an inadequate fire insurance area. (V.T.I.C. Art. 21.49, Secs. 3(c) (part), 5(c) (part).)

Source Law

[Sec. 3]
(c) ["Plan of Operation" means the] plan for providing Texas windstorm and hail insurance in a catastrophe area and Texas fire and explosion insurance in an inadequate fire insurance area which plan has been adopted by the Board . . . .

[Sec. 5]
(c) . . . The Board by rule shall adopt the plan of operation with the advice of the board of directors of the Association. . . .

Revised Law

Sec. 2210.152. CONTENTS OF PLAN OF OPERATION. (a) The plan of operation must:

(1) provide for the efficient, economical, fair, and nondiscriminatory administration of the association; and

(2) include:

(A) a plan for the equitable assessment of the members of the association to defray losses and expenses;

(B) underwriting standards;

(C) procedures for accepting and ceding reinsurance;

(D) procedures for determining the amount of insurance to be provided to specific risks;

(E) time limits and procedures for processing applications for insurance; and

(F) other provisions as considered necessary by the department to implement the purposes of this chapter.

(b) The plan of operation may provide for liability limits for an insured structure and for the corporeal movable property located in the structure. (V.T.I.C. Art. 21.49, Secs. 3(c) (part), 5(c) (part), (d).)

Source Law

[Sec. 3]
(c) . . . [means the plan for providing Texas windstorm and hail insurance in a catastrophe area and Texas fire and explosion insurance in an inadequate fire insurance area which plan has been adopted by the Board for operation by the Association pursuant to the provisions of this Act,] which plan may, among other things, provide for limits of liability for each structure insured, and/or the corporeal movable property located therein.

[Sec. 5]

(c) The plan of operation of the Association shall provide for the efficient, economical, fair, and nondiscriminatory administration of the Association. . . .

(d) The plan of operation must include:

(1) a plan for the equitable assessment of the members of the Association to defray losses and expenses;

(2) underwriting standards;

(3) procedures for the acceptance and cession of reinsurance;

(4) procedures for determining the amount of insurance to be provided to specific risks;

(5) time limits and procedures for processing applications for insurance; and

(6) other provisions as deemed necessary by the Board to carry out the purposes of this Act.

Revised Law

Sec. 2210.153. AMENDMENTS TO PLAN OF OPERATION. (a) The association may present a recommendation for a change in the plan of operation to the department at:

(1) periodic hearings conducted by the department for that purpose; or

(2) hearings relating to property and casualty insurance rates.

(b) The association must present a proposed change to the department in writing in the manner prescribed by the commissioner. A proposed change does not take effect unless adopted by the commissioner by rule.

(c) An interested person may, in accordance with Chapter 2001, Government Code, petition the commissioner to modify the plan of operation. (V.T.I.C. Art. 21.49, Secs. 5(c) (part), (f).)

Source Law

(c) . . . The Association may present recommended changes in the plan of operation to the Board at periodic hearings conducted by the Board for that purpose, or at hearings relating to property and casualty insurance rates. The Association must present a proposed change to the Board in writing in the manner prescribed by the Board. A change proposed by the Association does not take effect unless adopted by the Board by rule.

(f) Any interested person may petition the Board to modify the plan of operation in accordance with the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes).

Revisor's Note

Section 5(f), V.T.I.C. Article 21.49, refers to the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes). The relevant provisions of that statute were codified in 1993 as Chapter 2001, Government Code. The revised law is drafted accordingly.

[Sections 2210.154-2210.200 reserved for expansion]

SUBCHAPTER E. INSURANCE COVERAGE

Revised Law

Sec. 2210.201. DEFINITION OF INSURABLE INTEREST. In this subchapter, "insurable interest" includes any lawful and substantial economic interest in the safety or preservation of property from loss, destruction, or pecuniary damage. (V.T.I.C. Art. 21.49, Sec. 6(a) (part).)

Source Law

Sec. 6. (a) . . . The term "insurable interest" as used in this subsection shall be deemed to include any lawful and substantial economic interest in the safety or preservation of property from loss, destruction or pecuniary damage. . . .

Revisor's Note

Section 6(a), V.T.I.C. Article 21.49, refers to the term "insurable interest" as used "in this subsection," meaning Section 6(a). The same term is also used in Section 6(b), V.T.I.C. Article 21.49, revised in relevant part in this subchapter as Section 2210.204. Because it is clear from the context that the definition of "insurable interest" set forth in Section 6(a) also applies to the use of that term in Section 6(b), the revised law applies the definition to the entire subchapter and does not limit the application of the term to the parts of the revised law derived from Section 6(a), V.T.I.C. Article 21.49.

Revised Law

Sec. 2210.202. APPLICATION FOR COVERAGE. (a) A person

who has an insurable interest in insurable property may apply to the association for insurance coverage provided under the plan of operation and an inspection of the property, subject to any rules, including any inspection fee, established by the board of directors and approved by the commissioner.

(b) A general property and casualty agent must submit an application for the insurance coverage on behalf of the applicant on forms prescribed by the association. The application must contain a statement as to whether the applicant has submitted or will submit the premium in full from personal funds or, if not, to whom a balance is or will be due. (V.T.I.C. Art. 21.49, Sec. 6(a) (part).)

Source Law

> (a) Any person having an insurable interest in insurable property located in an area designated by the Board shall be entitled to apply to the Association for insurance provided for under the plan of operation and for an inspection of the property under such rules and regulations, including an inspection fee, if any, as determined by the Board of Directors of the Association and approved by the State Board of Insurance. . . . Application shall be made on behalf of the applicant by a Local Recording Agent and shall be submitted on forms prescribed by the Association. The application shall contain a statement as to whether or not the applicant has or will submit the premium in full from personal funds, or if not, to whom a balance is or will be due.

Revisor's Note

(1) Section 6(a), V.T.I.C. Article 21.49, refers to insurable property "located in an area designated by the Board," meaning the commissioner of insurance. The revised law omits the quoted language as unnecessary. Under Section 3(f), Article 21.49, revised in this chapter as Section 2210.004, "insurable property" means, in part, property at a fixed location in a catastrophe area. Under Section 3(h), Article 21.49, revised in pertinent part in this chapter in Section 2210.005, the commissioner of insurance designates a defined territory as a catastrophe area. Because property must be located in

a catastrophe area to be "insurable property" for purposes of Article 21.49, revised as this chapter, and because a catastrophe area is an area designated by the commissioner, the revised law omits the reference to "located in an area designated by the Board" as unnecessary.

(2) Section 6(a), V.T.I.C. Article 21.49, 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), applicable to the revised law, a rule is defined to include a regulation.

Revised Law

Sec. 2210.203. ISSUANCE OF COVERAGE; TERM; RENEWAL. (a) If the association determines that the property for which an application for insurance coverage is made is insurable property, the association, on payment of the premium, shall direct the issuance of an insurance policy as provided by the plan of operation.

(b) A policy issued under this section is for a one-year term.

(c) A policy may be renewed annually on application for renewal as long as the property continues to be insurable property. (V.T.I.C. Art. 21.49, Secs. 6(b) (part), (c).)

Source Law

> (b) If the Association determines that the property is insurable, the Association, upon payment of the premium, shall cause to be issued a policy of insurance as may be provided in the plan for a term of one year. . . .
>
> (c) Any policy issued pursuant to the provisions of this Act may be renewed annually, upon application therefor, so long as the property continues to meet the definition of "insurable property" set forth in Section 3 of this Act.

Revised Law

Sec. 2210.204. CANCELLATION OF CERTAIN COVERAGE. (a) Subsections (b) and (c) apply if:

(1) an agent or another person, firm, or corporation finances the payment of all or a portion of the premium for insurance coverage;

(2) there is an outstanding balance for the financing of the premium; and

(3) that balance, or an installment of that balance, is not paid before the expiration of the 10th day after the due date.

(b) The agent or other person, firm, or corporation to whom the balance described by Subsection (a) is due may request cancellation of the insurance coverage by:

(1) returning the policy, with proof that the insured was notified of the return; or

(2) requesting the association to cancel the insurance coverage by a notice mailed to the insured and to any others shown in the policy as having an insurable interest in the property.

(c) On completion of cancellation under Subsection (b), the association shall refund the unearned premium, less any minimum retained premium set forth in the plan of operation, to the person, firm, or corporation to whom the unpaid balance is due.

(d) If an insured requests cancellation of the insurance coverage, the association shall refund the unearned premium payable to the insured and the holder of an unpaid balance. The general property and casualty agent who submitted the application shall refund the agent's commission on any unearned premium in the same manner. (V.T.I.C. Art. 21.49, Sec. 6(b) (part).)

Source Law

> (b) . . . In the event an agent or some other person, firm, or corporation shall finance the payment of all or a portion of the premium and there is a balance due for the financing of such premium and such balance, or any installment thereof, is not paid within 10 days after the due date, the agent or other person, firm, or corporation to whom such balance is due may request cancellation of the insurance by returning the policy, with proof that the insured was notified of such return, or by requesting the Association to cancel such insurance by notice mailed to the insured and any others shown in the policy as having an insurable interest in the property. Upon

completion of cancellation, the Association shall refund the unearned premium, less any minimum retained premium set forth in the plan of operation, to the person, firm, or corporation to whom the unpaid balance is due. In the event an insured requests cancellation of insurance, the Association shall make refund of such unearned premium payable to the insured and the holder of an unpaid balance. The Local Recording Agent, who submitted the application, shall refund the commission on any unearned premium in the same manner.

Revised Law

Sec. 2210.205. DELETION OF INSURANCE COVERAGE FROM OTHER POLICIES. The department shall prepare endorsements and forms applicable to the standard prescribed policies that delete insurance coverages available through the association, and the commissioner shall promulgate the applicable reduction of premiums and rates for the use of the endorsement or form. (V.T.I.C. Art. 21.49, Sec. 7.)

Source Law

Sec. 7. The Board shall prepare endorsements and forms applicable to the standard policies which it has promulgated providing for the deletion of coverages available through the Association and shall promulgate the applicable reduction of premiums and rates for the use of such endorsements and forms.

Revised Law

Sec. 2210.206. INSURANCE COVERAGE FOR CERTAIN GOVERNMENTAL ENTITIES. (a) In insuring property of this state or property of a political subdivision of this state, the association may not direct an insurer to issue the policy if the insurer's organizational plan precludes the insurer from writing insurance coverage for this state or a political subdivision of this state.

(b) An insurer described by Subsection (a) may not act as a reinsurer with respect to an insurance policy described by Subsection (a). (V.T.I.C. Art. 21.49, Sec. 4(b).)

Source Law

(b) The organizational plan of certain types of insurers precludes such insurers from writing insurance coverage for the State of Texas, any city, political subdivision or agency of the State. When insuring property of the State of Texas, any city, political subdivision or agency of the State, the Association shall not cause such policies to be issued in such companies, nor shall such companies be included as reinsurers for any policies of insurance

in this category.

Revisor's Note

(1) Section 4(b), V.T.I.C. Article 21.49, refers to "any city, political subdivision or agency of the State." The revised law omits the references to "city" because that term is included within the meaning of "political subdivision."

(2) Section 4(b), V.T.I.C. Article 21.49, refers to "property of the State of Texas, . . . or agency of the State." The revised law omits the reference to property of an agency of this state because that property is included within the meaning of "property of this state."

Revised Law

Sec. 2210.207. WINDSTORM AND HAIL INSURANCE: REPLACEMENT COST COVERAGE. (a) In this section, "roof covering" means:

(1) the roofing material exposed to the weather;

(2) the underlayments applied for moisture protection; and

(3) all flashings required in the replacement of a roof covering.

(b) Subject to any applicable deductibles and the limits for the coverage purchased by the insured, a windstorm and hail insurance policy issued by the association may include replacement cost coverage for one- and two-family dwellings, including outbuildings, as provided under the dwelling extension coverage in the policy.

(c) If, at the time of loss, the total amount of insurance applicable to a dwelling is equal to 80 percent or more of the full replacement cost of the dwelling or equal to the maximum amount of insurance otherwise available through the association, coverage applicable to the dwelling under the policy is extended to include the full cost of repair or replacement, without a deduction for depreciation.

(d) If, at the time of loss, the total amount of insurance applicable to a dwelling is equal to less than 80 percent of the full replacement cost of the dwelling and less than the maximum amount of insurance available through the association, liability for loss under the policy may not exceed the replacement cost of the part of the dwelling that is damaged or destroyed, less depreciation.

(e) Notwithstanding this chapter or any other law, the commissioner, after notice and hearing, may adopt rules to:

(1) authorize the association to provide actual cash value coverage instead of replacement cost coverage on the roof covering of a building insured by the association; and

(2) establish:

(A) the conditions under which the association may provide that actual cash value coverage;

(B) the appropriate premium reductions when coverage for the roof covering is provided on an actual cash value basis; and

(C) the disclosure that must be provided to the policyholder, prominently displayed on the face of the windstorm and hail insurance policy.

(f) Notwithstanding Chapter 40, a hearing under Subsection (e) shall be held before the commissioner or the commissioner's designee.

(g) The commissioner may adopt rules as necessary to implement this section. (V.T.I.C. Art. 21.49, Sec. 8A.)

Source Law

Sec. 8A. (a) A policy of windstorm and hail insurance issued by the Association may include replacement cost coverage for one and two-family dwellings, including outbuildings, as provided under the dwelling extension coverage in the policy, subject to any applicable deductibles and the limits for the coverage purchased by the insured.

(b) If, at the time of loss, the total amount of insurance applicable to the dwelling is equal to 80 percent or more of the full replacement cost of the dwelling or equal to the maximum amount of insurance otherwise available through the Association, coverage applicable to the dwelling under the policy is

extended to include the full cost of repair or replacement, without a deduction for depreciation. If, at the time of loss, the total amount of insurance applicable to the dwelling is equal to less than 80 percent of the full replacement cost of the dwelling and less than the maximum amount of insurance available through the Association, liability for loss under the policy may not exceed the replacement cost of that part of the dwelling damaged or destroyed, less depreciation. Notwithstanding any other provision of this Act or other law, the commissioner, after notice and hearing, may adopt rules to:

(1) authorize the Association to provide actual cash value coverage instead of replacement cost coverage on the roof covering of a building insured by the Association; and

(2) determine:

(A) the conditions under which the Association may provide that actual cash value coverage;

(B) the appropriate premium reductions when coverage for the roof covering is provided on an actual cash value basis; and

(C) the disclosure that must be provided to the policyholder, prominently displayed on the face of the windstorm and hail insurance policy.

(c) The Commissioner may promulgate such rules and regulations as necessary to implement this section.

(d) Notwithstanding Article 1.33B of this code, a hearing under Subsection (b) of this section shall be held before the commissioner or the commissioner's designee.

(e) For purposes of this section, "roof covering" means:

(1) the roofing material exposed to the weather;

(2) the underlayments applied for moisture protection; and

(3) all flashings required in the replacement of a roof covering.

Revisor's Note

Section 8A(c), V.T.I.C. Article 21.49, authorizes the commissioner of insurance to adopt "rules and regulations" necessary to implement Section 8A, V.T.I.C. Article 21.49. The revised law omits the reference to "regulations" for the reason stated in Revisor's Note (2) to Section 2210.202.

Revised Law

Sec. 2210.208. WINDSTORM AND HAIL INSURANCE: COVERAGE FOR CERTAIN INDIRECT LOSSES. (a) Except as provided by Subsections (e) and (f), a windstorm and hail insurance policy issued by the association for a dwelling, as that term is defined by the department or a successor to the department, must include coverage

for:

(1) wind-driven rain damage, regardless of whether an opening is made by the wind;

(2) loss of use; and

(3) consequential losses.

(b) A windstorm and hail insurance policy issued by the association for tenant contents of a dwelling or other residential building must include coverage for loss of use and consequential losses.

(c) The coverage required under Subsection (a) or (b) must be made:

(1) according to forms approved by the commissioner; and

(2) for a premium paid by the insured based on rates established by commissioner rule.

(d) The association shall provide coverage under this section as directed by commissioner rule.

(e) The association is not required to offer coverage for indirect losses as provided by Subsection (a) or (b) unless that coverage was excluded from a companion policy in the voluntary market.

(f) The association is not required to provide coverage for:

(1) loss of use, if the loss is loss of rent or loss of rental value; or

(2) additional living expenses, if the insured property is a secondary or a nonprimary residence. (V.T.I.C. Art. 21.49, Sec. 8B.)

Source Law

Sec. 8B. (a) Except as provided by Subsections (b) and (c) of this section, a policy of windstorm and hail insurance issued by the association for a dwelling, as that term is defined by the Texas Department of Insurance or its successor, must include coverage for wind-driven rain damage, regardless of whether an opening is made by the wind, loss of use, and consequential losses, according to forms approved by the commissioner and for a premium paid by the insured based on rates established by rule adopted by the commissioner. A policy of windstorm and hail

insurance issued by the association for tenant contents of a dwelling or other residential building must include coverage for loss of use and consequential losses, according to forms approved by the board and for a premium paid by the insured based on rates established by rule adopted by the commissioner. The association shall provide coverage under this section as directed by rule of the commissioner.

(b) The association is not required to offer coverage for indirect losses as provided by Subsection (a) of this section unless that coverage was excluded from a companion policy in the voluntary market.

(c) The association is not required to provide coverage for (1) "loss of use" if such "loss of use" is loss of rents or loss of rental value; or (2) "additional living expenses" when the property insured is a secondary or a non-primary residence.

[Sections 2210.209-2210.250 reserved for expansion]

SUBCHAPTER F. PROPERTY INSPECTIONS FOR WINDSTORM AND HAIL INSURANCE

Revised Law

Sec. 2210.251. INSPECTION REQUIREMENTS. (a) Except as provided by this section, to be considered insurable property eligible for windstorm and hail insurance coverage from the association, a structure that is constructed or repaired or to which additions are made on or after January 1, 1988, must be inspected or approved by the department for compliance with the plan of operation.

(b) After January 1, 2004, for geographic areas specified by the commissioner, the commissioner by rule shall adopt the 2003 International Residential Code for one- and two-family dwellings published by the International Code Council. For those geographic areas, the commissioner by rule may adopt a subsequent edition of that code and may adopt any supplements published by the International Code Council and amendments to that code.

(c) After January 1, 2004, a person must submit a notice of a windstorm inspection to the unit responsible for certification of windstorm inspections at the department before beginning to construct, alter, remodel, enlarge, or repair a structure.

(d) A structure constructed or repaired or to which additions were made before January 1, 1988, that is located in an area that was governed at the time of the construction, repair, or

addition by a building code recognized by the association is insurable property eligible for windstorm and hail insurance coverage from the association without compliance with the inspection or approval requirements of this section or the plan of operation.

(e) A structure constructed or repaired or to which additions were made before January 1, 1988, that is located in an area not governed by a building code recognized by the association is insurable property eligible for windstorm and hail insurance coverage from the association without compliance with the inspection or approval requirements of this section or the plan of operation if the structure was previously insured by an insurer authorized to engage in the business of insurance in this state and the structure is in essentially the same condition as when previously insured, except for normal wear and tear, and is without any structural change other than a change made according to code. For purposes of this subsection, evidence of previous insurance coverage includes:

(1) a copy of a previous insurance policy;

(2) copies of canceled checks or agent's records that show payments for previous policies; and

(3) a copy of the title to the structure or mortgage company records that show previous policies.

(f) The department shall issue a certificate of compliance for each structure that qualifies for coverage. The certificate is evidence of insurability of the structure by the association.

(g) The department may enter into agreements and contracts as necessary to implement this section.

(h) The department may charge a reasonable fee to cover the cost of making building requirements and inspection standards available to the public. (V.T.I.C. Art. 21.49, Secs. 6A(a), (b), (g), (h).)

Source Law

Sec. 6A. (a) Except as otherwise provided by

this Subsection, all structures that are constructed or repaired or to which additions are made on or after January 1, 1988, to be considered insurable property for windstorm and hail insurance from the Association, must be inspected or approved by the Board for compliance with the plan of operation. After January 1, 2004, for geographic areas specified by the commissioner, the commissioner by rule shall adopt the 2003 International Residential Code for one- and two-family dwellings published by the International Code Council. For those geographic areas, the commissioner by rule may adopt a subsequent edition of that code and may adopt any supplements published by the International Code Council and amendments to the code. A structure constructed, repaired, or to which additions were made before January 1, 1988, that is located in an area covered at the time by a building code recognized by the Association shall be considered an insurable property for windstorm and hail insurance from the Association without compliance with the inspection or approval requirements of this Section or the plan of operation. A structure constructed, repaired, or to which additions were made before January 1, 1988, that is located in an area not covered by a building code recognized by the Association shall be considered an insurable property for windstorm and hail insurance from the Association without compliance with the inspection or approval requirements of this Section or the plan of operation if that structure has been previously insured by a licensed insurance company authorized to do business in this State and the risk is in essentially the same condition as when previously insured, except for normal wear and tear, and without any structural change other than a change made according to code. Evidence of previous insurance includes a copy of a previous policy, copies of canceled checks or agent's records that show payments for previous policies, and a copy of the title to the structure or mortgage company records that show previous policies. After January 1, 2004, a person must submit a notice of a windstorm inspection to the unit responsible for certification of windstorm inspections at the department before beginning to construct, alter, remodel, enlarge, or repair a structure.

(b) The Board shall issue for each structure that qualifies a certificate of compliance that is evidence of insurability of the structure by the Association.

(g) The Board may make agreements and contracts as necessary to effect the provisions of this Section.

(h) The department may charge a reasonable fee to cover the cost of making building requirements and inspection standards available to the public.

Revisor's Note

Section 6A(a), V.T.I.C. Article 21.49, refers to a "licensed insurance company authorized to do business in this State." The revised law omits the reference to "licensed" as redundant because "certificate of authority" is the term used throughout

this code in relation to an entity's authority to engage in business, and an insurer that is "authorized" necessarily holds a certificate of authority.

Revised Law

Sec. 2210.252. INTERNATIONAL RESIDENTIAL CODE BUILDING SPECIFICATIONS. (a) After January 1, 2004, for geographic areas specified by the commissioner, the commissioner by rule may supplement the plan of operation building specifications with the structural provisions of the International Residential Code for one- and two-family dwellings, as published by the International Code Council or an analogous entity recognized by the department.

(b) For a geographic area specified under Subsection (a), the commissioner by rule may adopt a subsequent edition of the International Residential Code for one- and two-family dwellings and may adopt a supplement published by the International Code Council or an amendment to that code. (V.T.I.C. Art. 21.49, Sec. 5(m).)

Source Law

(m) After January 1, 2004, for geographic areas specified by the commissioner, the commissioner by rule may supplement the building specifications in the plan of operation with the structural provisions of the International Residential Code for one- and two-family dwellings, as published by the International Code Council, or by an analogous entity recognized by the department. For those specified geographic areas, the commissioner by rule may adopt subsequent editions of that code and may adopt any supplements published by the International Code Council and amendments to that code.

Revised Law

Sec. 2210.253. INSURER ASSESSMENT: FIRST TIER COASTAL COUNTY. (a) In this section, "property insurance" means a commercial or residential insurance policy prescribed or approved by the department that provides coverage for windstorm and hail damage, including a Texas windstorm and hail insurance policy.

(b) The department shall assess each insurer that provides property insurance in a first tier coastal county in accordance

with this section.

(c) The total assessment under this section in a state fiscal year must be in the amount estimated by the department as necessary to cover the administrative costs of the windstorm inspection program under Section 2210.251 to be incurred in the first tier coastal counties in that fiscal year.

(d) The assessment must be based on each insurer's proportionate share of the total extended coverage and other allied lines premium received by all insurers for property insurance in the first tier coastal counties in the calendar year preceding the year in which the assessment is made.

(e) The commissioner shall adopt rules to implement the assessment of insurers under this section. (V.T.I.C. Art. 21.49, Secs. 6B(a), (b) (part), (c), (d).)

Source Law

> Sec. 6B. (a) The board shall assess each insurer who provides property insurance in a first tier coastal county in accordance with this section.
>
> (b) The total assessment under this section must be in the amount the board estimates is necessary to cover the cost of administration of the windstorm inspection program in the first tier coastal counties under Section 6A of this article in the state fiscal year in which the assessment is made, . . . .
>
> (c) The assessment must be based on each insurer's proportionate share of the total extended coverage and other allied lines premium received by all insurers for property insurance in the first tier coastal counties in the calendar year preceding the year in which the assessment is made. The board shall adopt rules to implement the assessment of insurers under this section.
>
> (d) For purposes of this section, "property insurance" means any commercial or residential policy promulgated or approved by the board that provides coverage for the perils of windstorm and hail, including a Texas Windstorm and Hail Insurance Policy.

Revisor's Note

Section 6B(b), V.T.I.C. Article 21.49, in part provides that the assessment made under Section 6B is reduced by certain fees collected "under Section 6A(c) of this article." The revised law omits the reference to Section 6A(c) as inaccurate. Section 6A(c) in current law does not relate to the collection of fees.

A former Section 6A(c) did relate to the collection of fees, but was repealed by Section 9.06, Chapter 206, Acts of the 78th Legislature, Regular Session, 2003. The omitted law reads:

> [(b) The total assessment under this section must be in the amount the board estimates is necessary to cover the cost of administration of the windstorm inspection program in the first tier coastal counties under Section 6A of this article in the state fiscal year in which the assessment is made,] reduced by the total amount of fees the department estimates will be collected for that year under Section 6A(c) of this article.

Revised Law

Sec. 2210.254. QUALIFIED INSPECTORS. (a) For purposes of this chapter, a "qualified inspector" includes:

(1) a person determined by the department to be qualified because of training or experience to perform building inspections;

(2) a licensed professional engineer who meets the requirements specified by commissioner rule for appointment to conduct windstorm inspections; and

(3) an inspector who:

(A) is certified by the International Code Council, the Building Officials and Code Administrators International, Inc., the International Conference of Building Officials, or the Southern Building Code Congress International, Inc.;

(B) has certifications as a buildings inspector and coastal construction inspector; and

(C) complies with other requirements specified by commissioner rule.

(b) A windstorm inspection may be performed only by a qualified inspector.

(c) Before performing building inspections, a qualified inspector must be approved and appointed or employed by the department.

(d) The department may charge a reasonable fee for the filing of applications by and determining the qualifications of persons for appointment as qualified inspectors. (V.T.I.C. Art. 21.49, Sec. 6A(d).)

Source Law

> (d) A windstorm inspection may only be performed by a qualified inspector. For purposes of this article, a "qualified inspector" includes:
>
> (1) a person determined by the department to be qualified to perform building inspections because of training or experience;
>
> (2) a licensed professional engineer meeting the requirements of the rules adopted by the commissioner for appointment to conduct windstorm inspections; and
>
> (3) an inspector who is certified by the International Code Council, the Building Officials and Code Administrators International, Inc., the International Conference of Building Officials, or the Southern Building Code Congress International, Inc., who has certifications as a buildings inspector and coastal construction inspector, and who also complies with other requirements specified by rule by the commissioner. A qualified inspector must be approved and appointed or employed by the department to perform building inspections. The department may charge a reasonable fee for the filing of applications and determining the qualifications of persons for appointment as qualified inspectors.

Revised Law

Sec. 2210.255. APPOINTMENT OF LICENSED ENGINEER AS INSPECTOR. (a) On request of an engineer licensed by the Texas Board of Professional Engineers, the commissioner shall appoint the engineer as an inspector under this subchapter not later than the 10th day after the date the engineer delivers to the commissioner information demonstrating that the engineer is qualified to perform windstorm inspections under this subchapter.

(b) The commissioner shall adopt rules establishing the information to be considered in appointing engineers under this section. (V.T.I.C. Art. 21.49, Sec. 6D.)

Source Law

> Sec. 6D. (a) The commissioner, on the request of an engineer licensed by the Texas Board of Professional Engineers, shall appoint the engineer under this article not later than the 10th day after the date of the engineer's delivery to the commissioner of information demonstrating that the engineer is qualified to perform windstorm inspections under this article.

(b) The commissioner shall adopt rules to determine the information the commissioner will consider in appointing engineers under Subsection (a) of this section.

Revised Law

Sec. 2210.256. DISCIPLINARY PROCEEDINGS REGARDING APPOINTED INSPECTORS. (a) After notice and hearing, the department may revoke an appointment made under Section 2210.254 if the appointee is found to be in violation of this subchapter or a rule of the commissioner adopted under this subchapter.

(b) The commissioner, instead of revocation, may impose one or more of the following sanctions if the commissioner determines from the facts that the sanction would be fair, reasonable, or equitable:

(1) suspension of the appointment for a specific period, not to exceed one year;

(2) issuance of an order directing the appointee to cease and desist from the specified activity or failure to act determined to be in violation of this subchapter or rules of the commissioner adopted under this subchapter; or

(3) if the commissioner finds that the appointee knowingly, wilfully, fraudulently, or with gross negligence signed or caused to be prepared an inspection report that contains a false or fraudulent statement, issuance of an order directing the appointee to pay within a specified time, not to exceed 60 days, a fine not to exceed $5,000 for the violation.

(c) A fine paid as a result of an order issued under Subsection (b)(3) shall be deposited in the general revenue fund.

(d) If it is found after a hearing that an appointee has failed to comply with an order issued under Subsection (b), the department shall, unless the order is stayed, revoke the appointment of the person.

(e) The department may informally dispose of any matter under Subsection (a) or (b) by consent order or default.

(f) If an appointee is an engineer licensed by the Texas Board of Professional Engineers who is found by the department to

have knowingly, wilfully, fraudulently, or with gross negligence signed or caused to be prepared an inspection report that contains a false or fraudulent statement, the commissioner may take action against the appointee in the manner provided by Subsections (a) and (b) but may not assess a fine against the appointee. The commissioner shall notify the Texas Board of Professional Engineers of an order issued by the commissioner against an appointee who is an engineer licensed by that board, including an order suspending or revoking the appointment of the person. (V.T.I.C. Art. 21.49, Secs. 6A(j), (j-1), (k), (k-1).)

Source Law

(j) After notice and hearing, the department may cancel or revoke an appointment made under this Section if the holder of the appointment is found to be in violation of, or to have failed to comply with, specific provisions of this Section or any rule or regulation of the commissioner made under this Section. In lieu of cancellation or revocation, the commissioner may order one or more of the following sanctions, if the commissioner determines from the facts that it would be fair, reasonable, or equitable:

(1) suspending the appointment for a specific period, not to exceed one year;

(2) an order directing the holder of the appointment to cease and desist from the specified activity determined to be in violation of specific provisions of this Section or rules and regulations of the commissioner made pursuant to this Section or from failing to comply with those provisions of this Section or the rules and regulations promulgated under this Section; or

(3) if the appointed person is found by the commissioner to have knowingly, wilfully, fraudulently, or with gross negligence signed or caused to be prepared an inspection report that contains a false, fictitious, or fraudulent statement or entry, directing the appointed person to remit within a specified time, not to exceed 60 days, a specified monetary forfeiture not to exceed $5,000 for the violation or failure to comply.

(j-1) If an appointed person is an engineer licensed by the Texas Board of Professional Engineers who is found by the department to have knowingly, wilfully, fraudulently, or with gross negligence signed or caused to be prepared an inspection report that contains a false or fraudulent statement or entry, the commissioner may take action against the appointed person in the manner provided by Subsection (j) of this Section, but may not levy any monetary fine against an appointed person who is a licensed engineer.

(k) A monetary forfeiture paid as a result of an order issued under Subsection (j)(3) of this Section shall be deposited to the credit of the general revenue fund. If it is found after hearing that any appointed person has failed to comply with an order issued under

Subsection (j) of this Section, the department shall, unless the order is lawfully stayed, cancel the appointment of the person. The department may informally dispose of any matter under Subsection (j) of this Section by consent order or default.

(k-1) The commissioner shall notify the Texas Board of Professional Engineers of each order issued by the commissioner against an appointed person who is an engineer licensed by the Texas Board of Professional Engineers, including an order suspending, canceling, or revoking the appointment of that person.

Revisor's Note

(1) Section 6A(j), V.T.I.C. Article 21.49, authorizes the department to "cancel" or "revoke" an appointment to serve as an inspector and contains other similar references. The revised law omits the reference to "cancel" and other similar references because, in context, the terms are included within the meaning of the term "revoke."

(2) Section 6A(j), V.T.I.C. Article 21.49, refers to an appointee who "is found to be in violation of, or to have failed to comply with" certain requirements and contains other similar references. The revised law omits the references because, in context, a failure to comply constitutes a violation.

(3) Section 6A(j)(3), V.T.I.C. Article 21.49, refers to "a false, fictitious, or fraudulent statement or entry" and Section 6A(j-1), V.T.I.C. Article 21.49, refers to a "statement or entry." The revised law omits the reference to "fictitious" because, in context, "fictitious" is included within the meaning of "false." The revised law omits the references to "entry" because, in context, "entry" is included within the meaning of "statement."

(4) Section 6A(k), V.T.I.C. Article 21.49, refers to an order that is "lawfully" stayed. The revised law omits the reference to "lawfully" as unnecessary because the word does not add to the clear meaning of the law. An order is not stayed unless the

order is stayed in compliance with applicable law.

Revised Law

Sec. 2210.257. DEPOSIT OF FEES. All fees collected by the department under this subchapter shall be deposited to the credit of the Texas Department of Insurance operating account. (V.T.I.C. Art. 21.49, Sec. 6A(i).)

Source Law

(i) All fees collected by the Board under this Section shall be deposited in the State Treasury to the credit of the State Board of Insurance operating fund.

Revisor's Note

Section 6A(i), V.T.I.C. Article 21.49, requires 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.

[Sections 2210.258-2210.300 reserved for expansion]

SUBCHAPTER G. WINDSTORM BUILDING CODE ADVISORY COMMITTEE

Revised Law

Sec. 2210.301. DEFINITION. In this subchapter, "advisory committee" means the Windstorm Building Code Advisory Committee on Specifications and Maintenance. (V.T.I.C. Art. 21.49, Sec. 6C(a).)

Source Law

Sec. 6C. (a) In this section, "advisory committee" means the Windstorm Building Code Advisory Committee on Specifications and Maintenance.

Revised Law

Sec. 2210.302. ADVISORY COMMITTEE. (a) The advisory committee shall advise and make recommendations to the commissioner on building and maintenance requirements under the plan of operation.

(b) The advisory committee is composed of nine voting members appointed by the commissioner without regard to the race, color, disability, sex, religion, age, or national origin of the appointee.

(c) The commissioner or the commissioner's designee shall serve as an ex officio, nonvoting member of the advisory committee.

(d) The commissioner shall appoint the voting members of the advisory committee as follows:

(1) three members who are representatives of the building industry who reside in catastrophe areas:

(A) two of whom are residential builders; and

(B) one of whom is a representative of the building supply industry;

(2) three members who are representatives of the insurance industry:

(A) one of whom is a member of the board of directors; and

(B) two of whom are full-time employees of an insurer authorized to engage in the business of property and casualty insurance in this state that writes insurance in a catastrophe area; and

(3) three members who are representatives of the public who reside in a catastrophe area, one of whom is a professional engineer licensed in this state. (V.T.I.C. Art. 21.49, Secs. 6C(b), (c).)

Source Law

(b) The Windstorm Building Code Advisory Committee on Specifications and Maintenance is established as an advisory committee to the commissioner to advise and make recommendations to the commissioner on building requirements and maintenance in the plan of operation.

(c) The advisory committee is composed of nine members appointed by the commissioner without regard to the race, color, disability, sex, religion, age, or national origin of the appointee. The commissioner or the commissioner's designated representative shall serve as an ex officio, nonvoting member of the advisory committee. The voting members of the advisory committee shall be appointed as follows:

(1) three members must be representatives

of the building industry who reside in designated catastrophe areas:

(A) two of whom are residential builders; and

(B) one of whom is a representative of the building supply industry;

(2) three members must be representatives of the insurance industry:

(A) one of whom is a member of the board of directors of the Association; and

(B) two of whom are full-time employees of an insurance company authorized to engage in the business of property and casualty insurance in this state that writes insurance in the designated catastrophe area; and

(3) three members must be representatives of the public who reside in a designated catastrophe area, one of whom is a professional engineer licensed in this state.

Revisor's Note

Section 6C(b), V.T.I.C. Article 21.49, provides that the Windstorm Building Code Advisory Committee on Specifications and Maintenance "is established." The revised law omits the reference to the establishment of the advisory committee as executed.

Revised Law

Sec. 2210.303. TERMS. A member of the advisory committee serves a three-year term. (V.T.I.C. Art. 21.49, Sec. 6C(d) (part).)

Source Law

(d) A member of the advisory committee serves a three-year term. . . .

Revised Law

Sec. 2210.304. COMPENSATION. A member of the advisory committee is not entitled to compensation but is entitled to reimbursement for actual and necessary expenses incurred in performing duties as an advisory committee member, subject to any applicable limitation on reimbursement provided by the General Appropriations Act. (V.T.I.C. Art. 21.49, Sec. 6C(d) (part).)

Source Law

(d) . . . A member of the advisory committee is not entitled to compensation but is entitled to reimbursement for actual and necessary expenses incurred in performing duties as an advisory committee member, subject to any applicable limitation on reimbursement provided by the General Appropriations Act.

Revised Law

Sec. 2210.305. PRESIDING OFFICER. The advisory committee shall elect a presiding officer from the committee members. (V.T.I.C. Art. 21.49, Sec. 6C(e) (part).)

Source Law

> (e) The advisory committee shall elect a presiding officer from its members. . . .

Revised Law

Sec. 2210.306. MEETINGS. (a) The advisory committee shall meet at least two times each year at the call of the presiding officer with the approval of the commissioner. The advisory committee shall publish the date and location of the meeting not later than the 45th day before the date on which the meeting is scheduled to occur.

(b) The commissioner or the commissioner's designee must be present at each meeting of the advisory committee. (V.T.I.C. Art. 21.49, Sec. 6C(e) (part).)

Source Law

> (e) . . . The advisory committee shall meet at the call of the presiding officer with the approval of the commissioner, but at least two times each year. The advisory committee shall publish the date and location of the meeting not later than the 45th day before the date on which the meeting is scheduled to occur. The commissioner or the commissioner's designee must be present at each meeting of the advisory committee.

Revised Law

Sec. 2210.307. RECOMMENDATIONS FOR CHANGES IN PLAN OF OPERATION PROCEDURES. (a) The advisory committee shall analyze and make recommendations for changes regarding procedures described under Section 2210.152(a)(2) that are adopted by the commissioner in the plan of operation. In making recommendations, the advisory committee shall seek to balance the concerns of all affected parties, including consumers, builders, and the association.

(b) Each proposal for a change in an applicable procedure must be submitted to the commissioner. Each proposal must be

submitted separately in writing and must contain:

(1) the name, mailing address, and telephone number of the proponent, or, if the proponent is a group or organization, the name of the group or organization and the mailing address and telephone number of the group or organization;

(2) a citation of any applicable statute or rule;

(3) the text of the proposed change, with deletions from current language struck through with a single line and new language underlined; and

(4) a statement of the purpose of the proposed change, with supporting written or printed information.

(c) The commissioner by rule shall adopt a form to be used by a person in presenting to the commissioner a proposal for a change in an applicable procedure.

(d) To be considered at a scheduled advisory committee meeting, a proposal must be submitted not later than the 30th day before the date of that meeting and must meet the requirements of Subsection (b).

(e) The department shall review and organize each proposal submitted and shall allow the advisory committee and interested parties to view the proposals to be considered within a reasonable time before the meeting of the advisory committee. If requested by a majority of the advisory committee, the department shall make recommendations regarding each proposal submitted and provide to the advisory committee any necessary technical information.

(f) At an advisory committee meeting, any interested person may present the person's views on a proposal for a change in an applicable procedure that is included on the advisory committee's published agenda. The advisory committee shall consider each comment presented in acting on the disposition of each proposal.

(g) After consideration of a proposal for a change in an applicable procedure, the advisory committee by vote shall:

(1) recommend adoption of the proposal as initially submitted;

(2) recommend adoption of the proposal with modifications;

(3) recommend rejection of the proposal; or

(4) suspend consideration of the proposal and request additional evaluation and study of the proposal.

(h) The advisory committee shall submit to the commissioner the committee's recommendation on each proposal. The commissioner shall notify the advisory committee of the acceptance or rejection of each recommendation not later than the 30th day after the date of receipt by the commissioner. Acceptance of a recommendation by the commissioner means that the commissioner will consider adoption of that recommendation at a rulemaking hearing. Before adopting a recommendation, the commissioner must determine that the proposal, if adopted, will not weaken the integrity or diminish the effectiveness of a procedure. (V.T.I.C. Art. 21.49, Secs. 6C(f), (g), (h), (i), (j), (k), (l), (m).)

Source Law

(f) The advisory committee shall analyze and make recommendations for changes regarding procedures described under Section 5(d) of this article that are adopted by the commissioner in the plan of operation. In making recommendations, the advisory committee shall seek to balance the concerns of all affected parties, including consumers, builders, and the Association.

(g) Each proposal for a change in an applicable procedure must be submitted to the commissioner. Each proposal must be submitted separately in writing and must contain:

(1) the name, mailing address, and telephone number of the proponent, or, if the proponent is a group or organization, the name of the group or organization and the mailing address and telephone number of the group or organization;

(2) a citation of any applicable statute or rule;

(3) the text of the proposed change, with deletions from current language struck through with a single line and new language underlined; and

(4) a statement of the purpose of the proposed change, with supporting written or printed information.

(h) The commissioner by rule shall adopt a form to be used by a person in presenting a proposal for a change in an applicable procedure to the commissioner.

(i) Each proposal shall be submitted not later than the 30th day before the date of a scheduled advisory committee meeting. A proposal that does not comply with the requirements adopted under Subsection (g) of this section and is not submitted within the

time specified in this subsection may not be considered at that scheduled meeting.

(j) The department shall review and organize each proposal submitted and shall allow the advisory committee and interested parties to view the proposals to be considered within a reasonable time before the meeting of the advisory committee. If requested by a majority of the advisory committee, the department shall make recommendations regarding each proposal submitted and provide to the advisory committee any necessary technical information.

(k) At an advisory committee meeting, any interested person may present the person's views on a proposal for a change in an applicable procedure that is included on the advisory committee's published agenda. The advisory committee shall consider each comment presented in its action on the disposition of each proposal.

(l) After consideration of a proposal for a change in an applicable procedure, the advisory committee by vote shall:

(1) recommend adoption of the proposal as initially submitted;

(2) recommend adoption of the proposal with modifications;

(3) recommend rejection of the proposal; or

(4) suspend consideration of the proposal and request additional evaluation and study of the proposal.

(m) The advisory committee shall submit its recommendation on each proposal to the commissioner. The commissioner shall notify the advisory committee of the acceptance or rejection of each recommendation not later than the 30th day after the date of receipt by the commissioner. Acceptance of a recommendation by the commissioner means that the commissioner will consider adoption of that recommendation at a rulemaking hearing. Before adopting a recommendation, the commissioner must determine that the proposal, if adopted, will not weaken the integrity or diminish the effectiveness of a procedure.

Revised Law

Sec. 2210.308. RULES. In addition to any other rulemaking authority granted under this chapter, the commissioner may adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 21.49, Sec. 6C(n).)

Source Law

(n) In addition to any other rulemaking authority granted under this article, the commissioner may adopt rules as necessary to implement this section.

[Sections 2210.309-2210.350 reserved for expansion]

SUBCHAPTER H. RATES

Revised Law

Sec. 2210.351. ASSOCIATION FILINGS. (a) The association

must file with the department each manual of classifications, rules, rates, including condition charges, and each rating plan, and each modification of those items that the association proposes to use.

(b) A filing under this section must indicate the character and the extent of the coverage contemplated and must be accompanied by the policy and endorsement forms proposed to be used. The forms may be designed specifically for use by the association without regard to other forms filed with, approved by, or prescribed by the department for use in this state.

(c) As soon as reasonably possible after the filing has been made, the commissioner in writing shall approve, modify, or disapprove the filing. A filing is considered approved unless modified or disapproved on or before the 30th day after the date of the filing.

(d) If at any time the commissioner determines that a filing approved under Subsection (c) no longer meets the requirements of this chapter, the commissioner may, after a hearing held on at least 20 days' notice to the association that specifies the matters to be considered at the hearing, issue an order withdrawing approval of the filing. The order must specify in what respects the commissioner determines that the filing no longer meets the requirements of this chapter. An order issued under this subsection may not take effect before the 30th day after the date of issuance of the order.

(e) The department shall value the loss and loss adjustment expense data to be used for a filing not earlier than March 31 of the year before the year in which the filing is to be made. (V.T.I.C. Art. 21.49, Secs. 8(a) (part), (c), (d), (h)(15).)

Source Law

> Sec. 8. (a) The Association shall file with the Commissioner every manual of classifications, rules, rates which shall include condition charges, every rating plan, and every modification of any of the foregoing which it proposes to use. Every such filing shall indicate the character and the extent of the coverage contemplated and shall be accompanied by the

policies and endorsements forms proposed to be used, which said forms and endorsements may be designed specifically for use by the Association and without regard to other forms filed with, approved by, or promulgated by the Board for use in this State. . . .

(c) Any filing made by the Association pursuant hereto shall be submitted to the Board and as soon as reasonably possible after the filing has been made the Board shall, in writing, approve, modify, or disapprove the same; provided that any filing shall be determined approved unless modified or disapproved within 30 days after date of filing.

(d) If at any time the Board finds that a filing so approved no longer meets the requirements of this Act, it may, after a hearing held on not less than 20 days' notice to the Association specifying the matters to be considered at such hearing, issue an order withdrawing its approval thereof. Said order shall specify in what respects the Board finds that such filing no longer meets the requirements of this Act and shall be effective not less than 30 days after its issuance.

[(h)]

(15) Not earlier than March 31 of the year before the year in which a filing is to be made, the department shall value the loss and loss adjustment expense data to be used for the filing.

Revisor's Note

Section 8(a), V.T.I.C. Article 21.49, refers to certain filings made "with the Commissioner." Section 8(c), V.T.I.C. Article 21.49, refers to the submission of those filings "to the Board," meaning the State Board of Insurance, and requires "the Board" to "approve, modify, or disapprove the same." For the reason stated in Revisor's Note (3) to Section 2210.003, the commissioner of insurance and the Texas Department of Insurance have the authority formerly granted to the board. The revised law substitutes references to filings made with the department and approval of those filings by the commissioner to accurately reflect the organizational structure of the department and the authority of the commissioner and department.

Revised Law

Sec. 2210.352. MANUAL RATE FILINGS: ANNUAL FILING. (a) Not later than August 15 of each year, the association shall file

with the department for approval by the commissioner a proposed manual rate for all types and classes of risks written by the association. Chapter 40 does not apply to:

(1) a filing made under this subsection; or

(2) a department action with respect to the filing.

(b) Before approving, disapproving, or modifying a filing, the commissioner shall provide all interested persons a reasonable opportunity to:

(1) review the filing;

(2) obtain copies of the filing on payment of any legally required copying cost; and

(3) submit to the commissioner written comments or information related to the filing.

(c) The commissioner shall schedule an open meeting not later than the 45th day after the date the department receives a filing at which interested persons may present written or oral comments relating to the filing.

(d) An open meeting under Subsection (c) is subject to Chapter 551, Government Code, but is not a contested case hearing under Chapter 2001, Government Code.

(e) The department shall file with the secretary of state for publication in the Texas Register notice that a filing has been made under Subsection (a) not later than the seventh day after the date the department receives the filing. The notice must include information relating to:

(1) the availability of the filing for public inspection at the department during regular business hours and the procedures for obtaining copies of the filing;

(2) procedures for making written comments related to the filing; and

(3) the time, place, and date of the open meeting scheduled under Subsection (c) at which interested persons may present written or oral comments relating to the filing.

(f) After the conclusion of the open meeting, the

commissioner shall approve, disapprove, or modify the filing in writing not later than November 15 of the year in which the filing was made. If the filing is not approved, disapproved, or modified on or before that date, the filing is considered approved.

(g) If the commissioner disapproves a filing, the commissioner shall state in writing the reasons for the disapproval and the criteria the association is required to meet to obtain approval. (V.T.I.C. Art. 21.49, Secs. 8(h)(2), (3), (4), (5), (6) (part).)

Source Law

(2) Not later than August 15 of each year, the Association shall file with the department for approval by the commissioner a proposed manual rate for all types and classes of risks written by the Association. Chapter 40 of this code does not apply to a filing made under this subsection or a department action with respect to the filing.

(3) Before approving or disapproving a filing, or modifying a filing, the commissioner shall provide all interested persons a reasonable opportunity to review the filing, obtain copies of the filing on payment of any legally required copying cost, and submit to the commissioner written comments or information related to the filing.

(4) The commissioner shall schedule an open meeting not later than the 45th day after the date on which the department receives the filing at which interested persons may present written or oral comments relating to the filing. An open meeting under this subdivision is subject to Chapter 551, Government Code, but is not a contested case hearing under Chapter 2001, Government Code.

(5) The department shall file with the Texas Register notice that a filing has been made under Subdivision (2) of this subsection not later than the seventh day after the date the filing is received by the department. The notice must include information relating to:

(A) the availability of the filing for public inspection at the department during regular business hours and the procedures for obtaining copies of the filing;

(B) procedures for making written comments related to the filing; and

(C) the time, place, and date of the open meeting scheduled under Subdivision (4) of this subsection at which an interested person may submit either written or oral comments relating to the filing.

(6) After the conclusion of the open meeting, the commissioner shall approve or disapprove or modify the filing in writing on or before November 15 of the year in which the filing is made or the filing is deemed approved. If the commissioner disapproves a filing, the commissioner shall state in writing the reasons for the disapproval and the criteria to be met by the Association to obtain approval. . . .

Revisor's Note

Section 8(h)(5), V.T.I.C. Article 21.49, refers to making a filing "with the Texas Register." Under Section 2002.016, Government Code, information to be published in the Texas Register is filed with the secretary of state for publication in the Texas Register. The revised law is drafted accordingly.

Revised Law

Sec. 2210.353. MANUAL RATE FILINGS: AMENDED FILING. (a) Not later than the 30th day after the date the association receives the commissioner's written disapproval under Section 2210.352(f), the association may file with the commissioner an amended filing that conforms to all criteria stated in that written disapproval.

(b) Not later than the 30th day after the date an amended filing made under Subsection (a) is received, the commissioner shall approve the amended filing with or without modifications or disapprove the amended filing. If the filing is not modified or disapproved on or before the 30th day after the date of receipt, the filing is considered approved without modification.

(c) Before approving or disapproving an amended filing, the commissioner shall, in the manner provided by Section 2210.352(b), provide all interested persons a reasonable opportunity to:

(1) review the amended filing;

(2) obtain copies of the amended filing on payment of any legally required copying cost; and

(3) submit to the commissioner written comments or information related to the amended filing.

(d) The commissioner may, in the manner provided by Sections 2210.352(c) and (d), hold a hearing regarding an amended filing not later than the 20th day after the date the department receives the amended filing.

(e) Not later than the 10th day after the date the hearing is concluded, the commissioner shall approve or disapprove the amended filing.

(f) The requirements imposed under Subsection (a) and under Sections 2210.352(e), (f), and (g) apply to a hearing conducted under this section and the commissioner's decision resulting from that hearing. (V.T.I.C. Art. 21.49, Secs. 8(h)(6) (part), (7).)

Source Law

> (6) . . . The Association may file with the commissioner, not later than 30 days after the date on which the Association receives the commissioner's written disapproval, an amended filing bringing the filing into conformity with all criteria stated in the commissioner's written disapproval.
>
> (7) Before approving or disapproving an amended filing, the commissioner shall provide all interested persons a reasonable opportunity to review the amended filing, obtain copies of the amended filing on payment of any legally required copying cost, and submit to the commissioner written comments or information related to the amended filing in the manner provided by Subdivision (3) of this subsection, and may hold a hearing not later than the 20th day after the date on which the department receives the amended filing in the manner provided by Subdivision (4) of this subsection. Not later than the 10th day after the date on which the hearing on the amended filing is concluded, the commissioner shall approve or disapprove the amended filing. Within 30 days after the amended filing is received, the commissioner shall approve without changes, approve as modified by the commissioner, or disapprove an amended filing or it is deemed approved. The requirements imposed under Subdivisions (5) and (6) of this subsection apply to a hearing conducted under this subdivision.

Revised Law

Sec. 2210.354. MANUAL RATE FILINGS: ADDITIONAL SUPPORTING INFORMATION. (a) In conjunction with the review of a filing under Section 2210.352 or 2210.353:

(1) the commissioner may request the association to provide additional supporting information relating to the filing; and

(2) any interested person may file a written request with the commissioner for additional supporting information relating to the filing.

(b) A request under this section must be reasonable and must be directly related to the filing.

(c) The commissioner shall submit to the association all requests for additional supporting information made under this section for the commissioner's use and the use of any interested

person.

(d) Unless a different period is requested by the association and approved by the commissioner, the association shall provide the information to the commissioner not later than the fifth day after the date the written request for additional supporting information is delivered to the association. The department shall notify an interested person who has requested additional information of the availability of the information not later than one business day after the date the commissioner receives the information from the association. (V.T.I.C. Art. 21.49, Sec. 8(h)(8).)

Source Law

> (8) In conjunction with the review of a filing or amended filing, the commissioner may request the Association to provide additional supporting information relating to the filing or amended filing, and any interested person may file a written request with the commissioner for additional supporting information relating to the filing or amended filing. A request under this subdivision must be reasonable and must be directly related to the filing or amended filing. The commissioner shall submit to the Association all requests for additional supporting information made under this subdivision for the commissioner's use and the use of any interested person. Unless a different period is requested by the Association and approved by the commissioner, the Association shall provide the information to the commissioner not later than the fifth day after the date on which the written request for additional supporting information is delivered to the Association. The department shall notify an interested person who has requested additional information of the availability of the information not later than one business day after the date on which the commissioner receives the information from the Association.

Revised Law

Sec. 2210.355. GENERAL RATE REQUIREMENTS; RATE STANDARDS. (a) Rates for coverage under this chapter must be made in accordance with this section.

(b) In adopting rates under this chapter, the following must be considered:

(1) the past and prospective loss experience within and outside this state of hazards for which insurance is made available through the plan of operation, if any;

(2) expenses of operation, including acquisition costs;

(3) a reasonable margin for profit and contingencies; and

(4) all other relevant factors, within and outside this state.

(c) Rates must be reasonable, adequate, not unfairly discriminatory, and nonconfiscatory as to any class of insurer.

(d) For the establishment of rates and minimum premiums, the risks may be grouped by classification.

(e) Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in those risks on the basis of any or all of the factors described by Subsection (b). The classification rates may include rules for classification of risks insured under this chapter and rate modifications to those classifications.

(f) Each provision regarding a rate, classification, standard, or premium must be made without prejudice to, or prohibition of, provision by the association for consent rates on individual risks if the rate and risk are acceptable to the association, and are analogous to the rate provided for under Article 5.26(a). This subsection applies regardless of whether such a risk would otherwise be subject to or the subject of a rate classification provision or eligibility provision.

(g) A commission paid to an agent must be reasonable, adequate, not unfairly discriminatory, and nonconfiscatory. (V.T.I.C. Art. 21.49, Sec. 8(e).)

Source Law

(e) All rates shall be made in accordance with the following provisions:

(1) Due consideration shall be given to the past and prospective loss experience within and outside the State of hazards for which insurance is made available through the plan of operation, if any, to expenses of operation including acquisition costs, to a reasonable margin for profit and contingencies, and to all other relevant factors, within and outside

the State.

(2) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in such risks on the basis of any or all of the factors mentioned in the preceding paragraph. Such rates may include rules for classification of risks insured hereunder and rate modifications thereof. All such provisions, however, as respects rates, classifications, standards and premiums shall be without prejudice to or prohibition of provision by the Association for consent rates on individual risks if the rate and risk are acceptable to the Association and as is similarly provided for, or as is provided for, in Article 5.26(a), Texas Insurance Code, and this provision or exception on consent rates is irrespective of whether or not any such risk would otherwise be subject to or the subject of a provision of rate classification or eligibility.

(3) Rates shall be reasonable, adequate, not unfairly discriminatory, and nonconfiscatory as to any class of insurer.

(4) Commissions paid to agents shall be reasonable, adequate, not unfairly discriminatory and nonconfiscatory.

Revisor's Note

Section 8(e)(2), V.T.I.C. Article 21.49, refers to certain provisions relating to consent rates analogous to provisions contained in Section (a), V.T.I.C. Article 5.26. Section (i), V.T.I.C. Article 5.26, as added by Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, provided that rate requirements for residential property insurance under Article 5.26 were superseded by the flexible rating program adopted under V.T.I.C. Article 5.101, and that rate requirements for commercial property insurance under Article 5.26 were superseded by V.T.I.C. Article 5.13-2. Article 5.26, as amended by Section 21.15, Chapter 206, Acts of the 78th Legislature, Regular Session, 2003, provides that "rates for all lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code." As a result, Section (a), V.T.I.C. Article 5.26, is no longer generally applicable to the setting of rates. However, Section (a) contains provisions applicable to the

establishment of consent rates, and it is therefore appropriate to retain the reference to that section. The revised law is drafted accordingly.

Revised Law

Sec. 2210.356. UNIFORM RATE REQUIREMENTS; INFORMATION USED IN DEVELOPING RATES. (a) Each rate approved by the commissioner in accordance with this subchapter must be uniform throughout the first tier coastal counties.

(b) The catastrophe element used to develop rates under this subchapter applicable to risks written by the association must be uniform throughout the seacoast territory. The catastrophe element of the rates must be developed using:

(1) 90 percent of both the monoline extended coverage loss experience and related premium income for all insurers, other than the association, for covered property located in the seacoast territory, using not less than the most recent 30 years of experience available; and

(2) 100 percent of both the loss experience and related premium income for the association for covered property, using not less than the most recent 30 years of experience available.

(c) The noncatastrophe element of the noncommercial rates must be developed using:

(1) 90 percent of both the monoline extended coverage loss experience and related premium income for all insurers, other than the association, for covered property located in the catastrophe area of the seacoast territory, using the most recent 10 years of experience available; and

(2) 100 percent of both the loss experience and related premium income for the association for covered property, using the most recent 10 years of experience available.

(d) The noncatastrophe element of the commercial rates must be developed using 100 percent of both the loss experience and related premium income for the association for covered property,

using the most recent 10 years of experience available. (V.T.I.C. Art. 21.49, Secs. 8(h)(1), (11), (12), (13).)

Source Law

(h)(1) Each rate established by the commissioner in accordance with this section must be uniform throughout the first tier of coastal counties.

(11) The catastrophe element used to develop rates under this Act applicable to risks written by the Association shall be uniform throughout the seacoast territory. The catastrophe element of the rates must be developed using:

(A) 90 percent of both the monoline extended coverage loss experience and related premium income for all insurers, other than the Association, for covered property located in the seacoast territory using not less than the most recent 30 years of experience available; and

(B) 100 percent of both the loss experience and related premium income for the Association for covered property using not less than the most recent 30 years of experience available.

(12) The noncatastrophe element of the noncommercial rates must be developed using:

(A) 90 percent of both the monoline extended coverage loss experience and related premium income for all insurers, other than the Association, for covered property located in the catastrophe area of the seacoast territory using the most recent 10 years of experience available; and

(B) 100 percent of both the loss experience and related premium income for the Association for covered property using the most recent 10 years of experience available.

(13) The noncatastrophe element of the commercial rates must be developed using 100 percent of both the loss experience and related premium income for the Association for covered property using the most recent 10 years of experience available.

Revisor's Note

Section 8(h)(1), V.T.I.C. Article 21.49, refers to rates "established by the commissioner." The revised law substitutes "approved by the commissioner" for "established by the commissioner" because under Section 8(c), V.T.I.C. Article 21.49, revised as Section 2210.351(c), the commissioner of insurance reviews and may approve rates filed by the association.

Revised Law

Sec. 2210.357. RATE CLASSIFICATIONS. All premiums written and losses paid under this chapter, as appropriate, must be

included in applicable classifications for general ratemaking purposes. (V.T.I.C. Art. 21.49, Sec. 8(g).)

Source Law

> (g) All premiums written and losses paid under this Act as appropriate shall be included in applicable classifications for general rate making purposes.

Revised Law

Sec. 2210.358. EXPERIENCE DATA. (a) Not later than June 1 of each year, the department shall provide to the association and other interested persons the experience data to be used in establishing the rates under this subchapter in that year.

(b) On request from the department, an insurer shall provide the data to the department or the department may obtain the data from a designated statistical agent, as defined by Section 38.201. (V.T.I.C. Art. 21.49, Sec. 8(h)(16).)

Source Law

> (16) Not later than June 1 of each year, the department shall provide the experience data to be used in establishing the rates under this subsection in that year to the Association and other interested persons. On request from the department, an insurer shall provide the data to the department or the department may obtain the data from a designated statistical agent, as defined by Section 38.201 of this code.

Revised Law

Sec. 2210.359. LIMITATION ON CERTAIN RATE CHANGES. (a) A rate approved by the commissioner under this subchapter may not reflect an average rate change that is more than 10 percent higher or lower than the rate for commercial windstorm and hail insurance or 10 percent higher or lower than the rate for noncommercial windstorm and hail insurance in effect on the date the filing is made. The rate may not reflect a rate change for an individual rating class that is 15 percent higher or lower than the rate for that individual rating class in effect on the date the filing is made.

(b) The commissioner may, after notice and hearing, suspend this section on a finding that a catastrophe loss or series of

occurrences resulting in losses in the catastrophe area justify a need to ensure:

(1) rate adequacy in the catastrophe area; and

(2) availability of insurance outside the catastrophe area. (V.T.I.C. Art. 21.49, Sec. 8(h)(9).)

Source Law

(9) A rate established and authorized by the commissioner under this subsection may not reflect an average rate change that is more than 10 percent higher or lower than the rate for commercial or 10 percent higher or lower than the rate for noncommercial windstorm and hail insurance in effect on the date the filing is made. The rate may not reflect a rate change for an individual rating class that is 15 percent higher or lower than the rate for that individual class in effect on the date the filing is made. The commissioner may, after notice and hearing, suspend this subdivision upon a finding that a catastrophe loss or series of occurrences resulting in losses in the catastrophe area justify a need to assure rate adequacy in the catastrophe area and also justify a need to assure availability of insurance outside the catastrophe area.

Revisor's Note

Section 8(h)(9), V.T.I.C. Article 21.49, refers to rates "established and authorized by the commissioner." The revised law substitutes "approved by the commissioner" for "established and authorized by the commissioner" for the reason stated in the revisor's note to Section 2210.356.

Revised Law

Sec. 2210.360. USE OF CERTAIN SURCHARGES IN DEVELOPING RATES. Surcharges previously collected and used in the development of current rates may not be excluded from future rate development if those surcharges were collected during the experience period considered by the commissioner. (V.T.I.C. Art. 21.49, Sec. 8(h)(14).)

Source Law

(14) Surcharges collected in the past and used in the development of current rates may not be excluded from future rate development as long as those surcharges were collected during the experience period considered by the commissioner.

Revised Law

Sec. 2210.361. ASSOCIATION RECOMMENDATIONS REGARDING REDUCTIONS IN COVERAGES OR INCREASES IN DEDUCTIBLES. (a) The association may make recommendations to the commissioner that would result in a reduction of coverages or an increase in an applicable deductible if the resultant reduction in coverages or increase in deductibles is accompanied by proposed rate credits.

(b) After notice and hearing, the commissioner may accept, modify, or reject a recommendation made by the association under this section. Chapter 40 does not apply to an action taken under this section. (V.T.I.C. Art. 21.49, Sec. 8(a) (part).)

Source Law

> (a) . . . The Association may make recommendations to the Commissioner that would result in a reduction of coverages or an increase in an applicable deductible if any resultant reduction in coverages or increase in deductibles is accompanied by proposed rate credits. After notice and hearing, the Commissioner may accept, modify, or reject a recommendation made by the Association under this subsection. Article 1.33B of this code does not apply to an action taken under this subsection.

Revised Law

Sec. 2210.362. IMPLIED CONSENT BY APPLICANT FOR INSURANCE COVERAGE. For purposes of this chapter, an applicant for insurance coverage is considered to have consented to the appropriate rates and classifications authorized by this chapter regardless of any other rates or classifications. (V.T.I.C. Art. 21.49, Sec. 8(f).)

Source Law

> (f) For the purpose of this Act the applicant under Section 6(a) hereof shall be considered to have consented to the appropriate rates and classifications authorized by this Act irrespective of any and all other rates or classifications.

Revised Law

Sec. 2210.363. EFFECT ON RATES OF CERTAIN OTHER INSURANCE COVERAGE. The commissioner may provide for an appropriate premium rate or reduction in premium rate if flood or rising water insurance coverage exists and is maintained on a risk insured by the association. (V.T.I.C. Art. 21.49, Sec. 8(h)(10).)

Source Law

(10) If valid flood or rising water insurance coverage exists and is maintained on any risk being insured in the pool, the commissioner may provide for a rate and reduction in rate of premium as may be appropriate.

Revisor's Note

(1) Section 8(h)(10), V.T.I.C. Article 21.49, refers to "valid" flood or rising water insurance. The revised law omits the reference to "valid" as unnecessary because the word does not add to the clear meaning of the law. Flood insurance that is not effective or does not provide coverage is not "insurance."

(2) Section 8(h)(10), V.T.I.C. Article 21.49, refers to "any risk being insured in the pool." The revised law substitutes "association" for "pool" for the reason stated in Revisor's Note (1) to Section 2210.051.

[Sections 2210.364-2210.400 reserved for expansion]

SUBCHAPTER I. RATE ROLLBACK

Revised Law

Sec. 2210.401. RATE ROLLBACK FOR CERTAIN RESIDENTIAL CONSTRUCTION. (a) This section applies only to insurance coverage issued by the association to cover new residential construction, excluding an addition or repair to an existing structure, built to the standards of a new building code.

(b) The commissioner shall hold a rulemaking hearing under Chapter 2001, Government Code, to determine the percentage of equitable across-the-board reductions in insurance rates required for Texas windstorm and hail insurance coverage written by the association.

(c) Not later than the 180th day after the date a building code is implemented, the commissioner shall issue an order mandating the appropriate rate reductions.

(d) The commissioner shall require a six percent

across-the-board reduction if, before the 181st day after the date a new building code is implemented:

(1) the commissioner has not issued an order establishing rate reductions for Texas windstorm and hail insurance on new residential construction built to the standards of a new building code; or

(2) the order has not become final because of judicial intervention or any other reason.

(e) Notwithstanding Chapter 40, a hearing under this section shall be held before the commissioner or the commissioner's designee. (V.T.I.C. Art. 21.49, Sec. 8E, as added Acts 75th Leg., R.S., Ch. 1000.)

Source Law

Sec. 8E. (a) This section applies only to policies or coverages that are issued by the association to cover new residential construction, excluding additions or repairs to existing structures, built to the standards of a new building code.

(b) The commissioner shall hold a rulemaking hearing under Chapter 2001, Government Code, to determine the percentage of equitable across-the-board reductions in insurance rates required for Texas windstorm and hail insurance coverage written by the association.

(c) Not later than the 180th day after the date a building code is implemented, the commissioner shall issue an order mandating the appropriate rate reductions.

(d) If, before the 181st day after the date a new building code is implemented, the commissioner has not issued an order establishing rate reductions for Texas windstorm and hail insurance on new residential construction built to the standards of a new building code, or the order has not become final because of judicial intervention or any other reason, the commissioner shall require a six percent across-the-board reduction.

(e) Notwithstanding Article 1.33B of this code, a hearing under this section shall be held before the commissioner or the commissioner's designee.

Revisor's Note

Section 8E(a), V.T.I.C. Article 21.49, refers to "policies or coverages." The revised law substitutes "insurance coverage" for the reference to "policies or coverages" because, in context, a "policy" is included within the meaning of "insurance coverage."

[Sections 2210.402-2210.450 reserved for expansion]

SUBCHAPTER J. CATASTROPHE RESERVE TRUST FUND AND REINSURANCE PROGRAM

Revised Law

Sec. 2210.451. DEFINITION. In this subchapter, "trust fund" means the catastrophe reserve trust fund. (V.T.I.C. Art. 21.49, Sec. 8(i)(1) (part).)

Source Law

> (i)(1) [The commissioner shall adopt rules under which the association members relinquish their net equity . . . by making payments to] a fund known as the catastrophe reserve trust fund . . . .

Revised Law

Sec. 2210.452. ESTABLISHMENT AND USE OF TRUST FUND. (a) The commissioner shall adopt rules under which association members relinquish their net equity on an annual basis as provided by those rules by making payments to the catastrophe reserve trust fund. The trust fund may be used only to fund:

(1) the obligations of the trust fund under Section 2210.058(a); and

(2) the mitigation and preparedness plan established under Section 2210.454 to reduce the potential for payments by association members that give rise to tax credits in the event of loss.

(b) All money, including investment income, deposited in the trust fund constitutes state funds until disbursed as provided by this chapter and commissioner rules. The comptroller shall hold the money outside the state treasury on behalf of, and with legal title in, the department. The department shall keep and maintain the trust fund in accordance with this chapter and commissioner rules. The comptroller, as custodian of the trust fund, shall administer the trust fund strictly and solely as provided by this chapter and commissioner rules.

(c) At the end of each calendar year or policy year, the association shall pay the net equity of a member, including all premium and other revenue of the association in excess of incurred

losses and operating expenses, to the trust fund or a reinsurance program approved by the commissioner.

(d) The commissioner by rule shall establish the procedure relating to the disbursement of money from the trust fund to policyholders in the event of an occurrence or series of occurrences within a catastrophe area that results in a disbursement under Section 2210.058(a).

(e) The trust fund may be terminated only by law. On termination of the trust fund, all assets of the trust fund revert to the state to provide funding for the mitigation and preparedness plan established under Section 2210.454. (V.T.I.C. Art. 21.49, Secs. 8(i)(1) (part), (2), (3), (4).)

Source Law

(i)(1) The commissioner shall adopt rules under which the association members relinquish their net equity on an annual basis as provided by those rules by making payments to . . . to fund the obligations of that fund under Section 19(a) of this Act and to fund the mitigation and preparedness plan established under this subsection to reduce the potential for payments by members of the association giving rise to tax credits in the event of loss or losses. Until disbursements are made as provided by this Act and rules adopted by the commissioner, all money, including investment income, deposited in the catastrophe reserve trust fund are state funds to be held by the comptroller outside the state treasury on behalf of, and with legal title in, the department. The fund may be terminated only by law. On termination of the fund, all assets of the fund revert to the state to be used to provide funding for the annual loss mitigation and preparedness plan developed and implemented by the commissioner under Subdivision (5) of this subsection.

(2) The catastrophe reserve trust fund shall be kept and maintained by the Texas Department of Insurance pursuant to this Act and rules adopted by the commissioner. The comptroller, as custodian, shall administer the funds strictly and solely as provided by this Act and the commissioner's rules.

(3) At the end of either each calendar year or policy year, the association shall pay the net equity of a member, including all premium and other revenue of the association in excess of incurred losses and operating expenses to the catastrophe reserve trust fund or a reinsurance program approved by the commissioner.

(4) The commissioner's rules shall establish the procedure relating to the disbursement of money from the catastrophe reserve trust fund to policyholders in the event of an occurrence or series of occurrences within the defined catastrophe area that results in a disbursement under Section 19(a) of this Act.

Revised Law

Sec. 2210.453. REINSURANCE PROGRAM. (a) The association shall:

(1) make payments into the trust fund; or

(2) establish a reinsurance program approved by the department.

(b) With the approval of the department, the association may establish a reinsurance program that operates in addition to or in concert with the trust fund. (V.T.I.C. Art. 21.49, Sec. 8(h)(17).)

Source Law

(17) The association shall either establish a reinsurance program approved by the Texas Department of Insurance or make payments into the catastrophe reserve trust fund established under Subsection (i) of this section. With the approval of the Texas Department of Insurance, the association may establish a reinsurance program that operates in addition to or in concert with the catastrophe reserve trust fund established under Subsection (i) of this section.

Revised Law

Sec. 2210.454. MITIGATION AND PREPAREDNESS PLAN. (a) The commissioner shall annually develop and implement a mitigation and preparedness plan.

(b) Each state fiscal year, the department may fund the mitigation and preparedness plan using the investment income of the trust fund in an amount not less than $1 million and not more than 10 percent of the investment income of the prior fiscal year. From that amount and as part of that plan, the department may use in each fiscal year $1 million for the windstorm inspection program established under Section 2210.251.

(c) The mitigation and preparedness plan must provide for actions to be taken in the seacoast territory by the commissioner, or by a local government, state agency, educational institution, or nonprofit organization designated by the commissioner in the plan, to implement programs to:

(1) improve preparedness for windstorm and hail catastrophes;

(2) reduce potential losses in the event of such a catastrophe; and

(3) provide research into the means to:

(A) reduce those losses;

(B) educate or inform the public in determining the appropriateness of particular upgrades to structures; or

(C) protect infrastructure from potential damage from those catastrophes.

(d) Money in excess of $1 million may not be used under this section if the commissioner determines that an expenditure of investment income from the trust fund would jeopardize the actuarial soundness of the fund or materially impair the ability of the fund to serve the state purposes for which the fund was established. (V.T.I.C. Art. 21.49, Sec. 8(i)(5).)

Source Law

(5) Each state fiscal year, beginning with fiscal year 2002, the department may use from the investment income of the fund an amount equal to not less than $1 million and not more than 10 percent of the investment income of the prior fiscal year to provide funding for an annual mitigation and preparedness plan to be developed and implemented each year by the commissioner. From that amount and as part of that plan, the department may use in each fiscal year $1 million for the windstorm inspection program established under Section 6A of this Act. The mitigation and preparedness plan shall provide for steps to be taken in the seacoast territory by the commissioner or by a local government, state agency, educational institution, or nonprofit organization designated by the commissioner in the plan, to implement programs intended to improve preparedness for windstorm and hail catastrophes, reduce potential losses in the event of such a catastrophe, provide research into the means to reduce those losses, educate or inform the public in determining the appropriateness of particular upgrades to structures, or protect infrastructure from potential damage from those catastrophes. Money in excess of $1 million is not available for use under this subsection if the commissioner determines that an expenditure of investment income from the fund would jeopardize the actuarial soundness of the fund or materially impair the ability of the fund to serve the state purposes for which it was established.

Revisor's Note

Section 8(i)(5), V.T.I.C. Article 21.49, refers to funding for the mitigation and preparedness plan

"beginning with fiscal year 2002." State fiscal year 2002 expired August 31, 2002. The revised law omits the reference as executed.

[Sections 2210.455-2210.500 reserved for expansion]

SUBCHAPTER K. LIABILITY LIMITS

Revised Law

Sec. 2210.501. MAXIMUM LIABILITY LIMITS. (a) The board of directors shall propose the maximum liability limits under a windstorm and hail insurance policy issued by the association under this chapter. The maximum liability limits must be approved by the commissioner.

(b) Subject to Section 2210.502, the maximum liability limits for coverage on a single insurable property may not be less than:

(1) $350,000 for:

(A) a dwelling, including an individually owned townhouse unit; and

(B) the corporeal movable property located in or about the dwelling and, as an extension of coverage, away from those premises, as provided under the policy;

(2) $2,192,000 for a building, and the corporeal movable property located in the building, if the building is:

(A) owned by, and at least 75 percent of which is occupied by, a governmental entity; or

(B) not owned by, but is wholly and exclusively occupied by, a governmental entity;

(3) $125,000 for individually owned corporeal movable property located in an apartment unit, residential condominium unit, or townhouse unit that is occupied by the owner of that property and, as an extension of coverage, away from those premises, as provided under the policy; and

(4) $1,500,000 for:

(A) a structure other than a dwelling or a public building; and

(B) the corporeal movable property located in that structure and, as an extension of coverage, away from those premises, as provided under the policy.

(c) Maximum liability limits for insurable property not described by Subsection (b) are established by the plan of operation. (V.T.I.C. Art. 21.49, Secs. 8D(a), (c).)

Source Law

Sec. 8D. (a) The maximum limits of liability under a policy of windstorm and hail insurance issued by the Association under this Act shall be proposed by the board of directors of the Association and must be approved by the Commissioner. The maximum limits of liability for coverage on any one insurable property may not be less than:

(1) $350,000 for a dwelling, including an individually owned townhouse unit, and the corporeal movable property located in or about the dwelling, and as an extension of coverage, away from those premises, as provided under the policy;

(2) $2,192,000 for a building and the corporeal movable property located in the building that is owned by, and at least 75 percent of which is occupied by, a governmental entity, or that is not owned by, but is wholly and exclusively occupied by, a governmental entity;

(3) $125,000 for individually owned corporeal movable property located in an apartment unit, residential condominium unit, or townhouse unit that is occupied by the owner of that property, and as an extension of coverage, away from those premises, as provided under the policy; and

(4) $1,500,000 for a structure other than a dwelling or a public building and the corporeal movable property located in that structure and, as an extension of coverage, away from those premises, as provided under the policy.

(c) Liability limits for insurable property that is not covered under Subsection (a) of this section shall be established by the plan of operation.

Revisor's Note

Section 8D(a), V.T.I.C. Article 21.49, establishes certain maximum limits for liability insurance on windstorm and hail insurance issued by the Texas Windstorm Insurance Association. Section 8D(d), V.T.I.C. Article 21.49, revised in this chapter in Section 2210.502, authorizes modification of those limits under certain circumstances. The revised law adds a cross-reference to Section 2210.502 for the convenience of the reader.

Revised Law

Sec. 2210.502. ADJUSTMENTS TO MAXIMUM LIABILITY LIMITS. (a) Not later than September 30 of each year, the board of directors shall propose inflation adjustments to the maximum liability limits imposed under Section 2210.501 in increments of $1,000, rounded to the nearest $1,000, considering the limits imposed by Section 2210.501(b), at a rate that reflects any change in the BOECKH Index. If the BOECKH Index ceases to exist, the board of directors shall propose the adjustments in the same manner based on another index that the board of directors determines accurately reflects changes in the cost of construction or residential values in the catastrophe area.

(b) An adjustment to the maximum liability limits that is approved by the commissioner applies to each windstorm and hail insurance policy delivered, issued for delivery, or renewed on or after January 1 of the year following the date of the approval. The indexing of the limits shall adjust for changes occurring on and after January 1, 1997.

(c) The board of directors may propose additional increases in the maximum liability limits as the board determines necessary to implement the purposes of this chapter.

(d) Notwithstanding Section 2210.501(b), the maximum liability limit imposed under Section 2210.501(b)(2) is frozen, and the indexing and adjustments provided by this section do not apply to that limit, until the limit imposed on a structure subject to Section 2210.501(b)(4) and the corporeal property located in that structure reaches or exceeds $2,192,000, at which time the limit imposed under Section 2210.501(b)(2) shall be indexed and adjusted as provided for a risk under Section 2210.501(b)(4). (V.T.I.C. Art. 21.49, Secs. 8D(b), (d), (e).)

Source Law

(b) Notwithstanding Subsection (a) of this section, the liability limit imposed under Subsection (a)(2) of this section is frozen, and the indexing and adjustments provided by this section do not apply to that liability limit, until the liability limit

imposed on a structure subject to Subsection (a)(4) of this section and the corporeal property located in that structure reaches or exceeds $2,192,000, at which time the liability limit shall be indexed and adjusted as provided for a risk under Subsection (a)(4) of this section.

(d) Not later than September 30 of each year, the board of directors of the Association shall propose adjustments to the liability limits for inflation. The proposed adjustments shall be made in increments of $1,000, rounded to the nearest $1,000, considering the limits set by Subsection (a) of this section, at a rate that reflects any change in the BOECKH Index. If the BOECKH Index ceases to exist, the board of directors of the Association shall propose adjustments to the nearest $1,000 in round numbers to the liability limits for inflation based on any other index that the board determines accurately reflects changes in the cost of construction or residential values in the catastrophe area. An adjustment to the liability limits that is approved by the Commissioner applies to each policy of windstorm and hail insurance delivered, issued for delivery, or renewed on or after January 1 of the year following the approval by the Commissioner of the adjustment to the liability limits. The indexing of the liability limits shall adjust for changes occurring on and after January 1, 1997.

(e) The board of directors of the Association may propose additional increases in the liability limits as it determines necessary to implement the purposes of this Act.

Revised Law

Sec. 2210.503. FILING OF PROPOSED ADJUSTMENTS WITH COMMISSIONER. Not later than the 10th day after the date a proposed adjustment to the maximum liability limits is determined under Section 2210.501(a) or (b) or Section 2210.502, the association shall file the proposed adjustments with the commissioner in writing. The filing must include:

(1) a statement of the proposed adjusted limits;

(2) a statement of the limits in effect immediately preceding the effective date of the proposed adjustment;

(3) a brief summary of the changes to the BOECKH Index or other index on which the proposed adjustments are based; and

(4) a brief summary of the computations used in determining the proposed adjustments. (V.T.I.C. Art. 21.49, Sec. 8D(f).)

Source Law

(f) Not later than the 10th day after the date on which the proposed adjustment to the liability limits

is determined under Subsection (a), (b), (d), or (e) of this section, the Association shall file its proposed adjustments with the Commissioner in writing. The filing must include:

(1) a statement of the proposed adjusted liability limits;

(2) a statement of the liability limits in effect immediately preceding the effective date of the proposed adjustment;

(3) a brief summary of the changes to the BOECKH Index or other index on which the proposed adjustments are based; and

(4) a brief summary of the computations used in determining the proposed adjustments.

Revised Law

Sec. 2210.504. COMMISSIONER ACTION ON PROPOSED ADJUSTMENTS. (a) Not later than the 60th day after the date of receipt of a filing under Section 2210.503, and after notice and hearing, the commissioner by order shall approve, disapprove, or modify the proposed adjustment to the maximum liability limits.

(b) Notwithstanding Subsection (a) and Sections 2210.501(c), 2210.502(a)-(c), and 2210.503, the commissioner may not approve adjustments of maximum liability limits to amounts lower than the amounts prescribed under Section 2210.501(b). (V.T.I.C. Art. 21.49, Secs. 8D(g), (h).)

Source Law

(g) Not later than the 60th day after the date of receipt of the filing made under Subsection (f) of this section, and after notice and hearing, the Commissioner by order shall approve, disapprove, or modify the proposed adjustments to the liability limits.

(h) Notwithstanding Subsections (c)-(g) of this section, the Commissioner may not approve adjustments of liability limits to amounts lower than the amounts prescribed under Subsection (a) of this section.

Revised Law

Sec. 2210.505. REINSURED EXCESS LIMITS. (a) Notwithstanding any other law, the association may issue a windstorm and hail insurance policy that includes coverage for an amount in excess of a maximum liability limit established under Sections 2210.501-2210.504 if the association first obtains from a reinsurer approved by the commissioner reinsurance for the full amount of policy exposure above that limit.

(b) The premium charged by the association for the excess

coverage must equal the amount of the reinsurance premium charged to the association by the reinsurer, plus any payment to the association that is approved by the commissioner.

(c) The commissioner shall adopt rules as necessary to implement this section. (V.T.I.C. Art. 21.49, Secs. 8E(a), (b), (c), as added Acts 75th Leg., R.S., Ch. 642.)

Source Law

> Sec. 8E. (a) Notwithstanding any other law, the Association may issue a policy of windstorm and hail insurance that includes coverage for an amount in excess of a liability limit proposed by the Association and approved by the Commissioner under Section 8D of this Act if the Association first obtains, from a reinsurer approved by the Commissioner, reinsurance for the full amount of policy exposure above the limits approved by the Commissioner for any given type of risk.
>
> (b) The premium charged by the Association for the excess coverage shall be equal to the amount of the reinsurance premium charged to the Association by the reinsurer, plus any payment to the Association that is approved by the Commissioner.
>
> (c) The Commissioner shall adopt rules as necessary to implement this section. The Association may not issue excess coverage under this section until those rules are adopted.

Revisor's Note

Section 8E(c), V.T.I.C. Article 21.49, requires the commissioner of insurance to adopt rules, and provides that the Texas Windstorm Insurance Association may not issue excess coverage "until those rules are adopted." The revised law omits as executed the provision that the association may not issue excess coverage until the adoption of the applicable rules because those rules have been adopted.

Revised Law

Sec. 2210.506. EXCEPTION FROM CERTAIN ADMINISTRATIVE PROCEDURES. Chapter 40 does not apply to an action taken under this subchapter. (V.T.I.C. Art. 21.49, Secs. 8D(i), 8E(d), as added Acts 75th Leg., R.S., Ch. 642.)

Source Law

> [Sec. 8D]
>
> (i) Article 1.33B of this code does not apply to an action taken under this section.

[Sec. 8E]

(d) Article 1.33B of this code does not apply to an action taken under this section.

[Sections 2210.507-2210.550 reserved for expansion]

SUBCHAPTER L. APPEALS AND OTHER ACTIONS

Revised Law

Sec. 2210.551. APPEALS. (a) This section applies to:

(1) a person insured under this chapter or an authorized representative of the person; or

(2) an affected insurer.

(b) A person or entity described by Subsection (a) who is aggrieved by an act, ruling, or decision of the association may appeal to the commissioner not later than the 30th day after the date of that act, ruling, or decision.

(c) If the association is aggrieved by the action of the commissioner with respect to a ruling, order, or determination of the commissioner, the association may, not later than the 30th day after the date of the action, make a written request to the commissioner for a hearing on the action.

(d) On 10 days' written notice of the time and place of the hearing, the commissioner shall conduct a hearing on the association's request or the appeal from an act, ruling, or decision of the association, not later than the 30th day after the date of receipt of the request or appeal.

(e) A hearing on an act, ruling, or decision of the association relating to the payment of, the amount of, or the denial of a particular claim shall be held, at the request of the claimant, in the county in which the insured property is located or in Travis County.

(f) Not later than the 30th day after the date of the hearing, the commissioner shall affirm, reverse, or modify the commissioner's previous action or the act, ruling, or decision appealed to the commissioner. Pending the hearing and decision, the commissioner may suspend or postpone the effective date of the previous action or of the act, ruling, or decision appealed to the

commissioner.

(g) The association, or the person or entity aggrieved by the order or decision of the commissioner, may appeal to a district court in the county in which the covered property is located or a district court in Travis County.

(h) An action brought under this section is subject to the procedures established under Subchapter D, Chapter 36. (V.T.I.C. Art. 21.49, Sec. 9.)

Source Law

> Sec. 9. Any person insured pursuant to this Act, or his duly authorized representative, or any affected insurer who may be aggrieved by an act, ruling or decision of the Association, may, within 30 days after such act, ruling or decision, appeal to the commissioner. In the event the Association is aggrieved by the action of the commissioner with respect to any ruling, order, or determination of the commissioner, it may, within 30 days after such action, make a written request to the commissioner, for a hearing thereon. The commissioner shall hear the Association, or the appeal from an act, ruling or decision of the Association, within 30 days after receipt of such request or appeal and shall give not less than 10 days' written notice of the time and place of hearing to the Association making such request or the person, or his duly authorized representative, appealing from the act, ruling or decision of the Association. A hearing on an act, ruling or decision of the Association relating to the payment of, the amount of, or the denial of a particular claim shall be held, at the request of the claimant, in either the county in which the covered property is located or Travis County. Within 30 days after the hearing, the commissioner shall affirm, reverse or modify its previous action or the act, ruling or decision appealed to the commissioner. Pending such hearing and decision thereon, the commissioner may suspend or postpone the effective date of its previous rule or of the act, ruling or decision appealed to the commissioner. The Association, or the person aggrieved by any order or decision of the commissioner, may thereafter appeal to either a District Court of Travis County, Texas, or a District Court in the county in which the covered property is located. An action brought under this section is subject to the procedures established under Article 1.04 of this code.

Revised Law

Sec. 2210.552. CLAIM DISPUTES; VENUE. (a) Except as provided by Sections 2210.007 and 2210.106, a person insured under this chapter who is aggrieved by an act, ruling, or decision of the association relating to the payment of, the amount of, or the denial

of a claim may:

(1) bring an action against the association, including an action under Chapter 541; or

(2) appeal the act, ruling, or decision under Section 2210.551.

(b) A person may not proceed under both Section 2210.551 and this section for the same act, ruling, or decision.

(c) Except as provided by Subsection (d), venue in an action brought under this section, including an action under Chapter 541, against the association is in the county in which the insured property is located or in a district court in Travis County.

(d) Venue in an action, including an action under Chapter 541, brought under this section in which the claimant joins the department as a party to the action is only in a district court in Travis County. (V.T.I.C. Art. 21.49, Sec. 9A.)

Source Law

> Sec. 9A. (a) Except as provided by Section 10 of this Article, any person insured under this Act who is aggrieved by an act, ruling, or decision of the Association relating to the payment of, the amount of, or the denial of a claim may elect to bring an action, including an action under Article 21.21 of this code, against the Association in a court of competent jurisdiction or to appeal the act, ruling, or decision under Section 9 of this Article. A person may not proceed under both Section 9 of this Article and this section for the same act, ruling, or decision.
>
> (b) Except as otherwise provided by this subsection, venue in a proceeding action against the Association under this section, including an action under Article 21.21 of this code, is in the county in which the covered property is located or in a District Court of Travis County. Venue is only in the District Court of Travis County if the claimant joins the State Board of Insurance as a party to the action.

Revisor's Note

(1) Section 9A(a), V.T.I.C. Article 21.49, 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

24.007-24.0011, Government Code, for the general jurisdiction of district courts.

(2) Sections 9A(a) and (b), V.T.I.C. Article 21.49, refer to V.T.I.C. Article 21.21. That article was revised in various places in this code. The relevant provisions were revised as Chapter 541 of this code, and the revised law is drafted accordingly.

Revisor's Note
(End of Chapter)

(1) Section 13, V.T.I.C. Article 21.49, refers to the effective date of the legislation that enacted the article. The revised law omits the reference as executed. The omitted law reads:

> Sec. 13. This Act shall become effective from and after passage.

(2) Section 14, V.T.I.C. Article 21.49, repeals all laws in conflict with that article. The revised law omits the provision as executed. The omitted law reads:

> Sec. 14. All laws or parts of laws in conflict herewith are hereby repealed to the extent necessary to accomplish the purposes of this Act.

(3) Section 15, V.T.I.C. Article 21.49, provides that the article is severable. The revised law omits the reference to severability because the reference is unnecessary. Section 311.032, Government Code (Code Construction Act), and Section 312.013, Government Code, state that a provision of a statute is severable from each other provision of the statute that can be given effect. Those statutes apply to the revised law. The omitted law reads:

> Sec. 15. If any provision of this Act or the application thereof to any person or circumstance is held to be invalid, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are

declared to be severable.

(4) Section 17, V.T.I.C. Article 21.49, codifies Article 21.49 as an article of the Texas Insurance Code of 1951. The revised law omits the provision as executed. The omitted law reads:

> Sec. 17. This Act is hereby codified as Article 21.49 of the Texas Insurance Code.

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CHAPTER 2211. FAIR PLAN

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2211.001. DEFINITIONS. In this chapter:

(1) "Association" means the FAIR Plan Association established under this chapter.

(2) "FAIR Plan" means a Fair Access to Insurance Requirements Plan established under Section 2211.051.

(3) "Governing committee" means the governing committee of the association.

(4) "Inspection bureau" means the organization or organizations designated by the association under Section 2211.153.

(5) "Insurer" means an authorized insurer writing property insurance in this state, including:

(A) a Lloyd's plan; and

(B) a reciprocal or interinsurance exchange.

(6) "Net direct premiums" means gross direct written premiums less return premiums on canceled contracts, regardless of reinsurance assumed or ceded, written on residential property under this chapter.

(7) "Residential property insurance" means the coverage provided by a homeowners insurance policy, residential fire and allied lines insurance policy, or farm and ranch owners insurance policy against loss incurred to real or tangible personal property at a fixed location.

(8) "Underserved area" or "underserved areas" means an area or areas designated as underserved by the commissioner by rule. (V.T.I.C. Art. 21.49A, Secs. 2(1) (part), (2), (3), (4) (part), (5), (6) (part); Art. 21.49A-1, Sec. 2(1); New.)

Source Law

[Art. 21.49A]

Sec. 2. (1) "FAIR Plan Association" or "association" means a . . . association established pursuant to this Act . . . .

(2) "Insurer" means any licensed insurer

writing property and casualty insurance in this state, including:

(A) a Lloyd's plan company; and

(B) a reciprocal or interinsurance exchange.

(3) "Residential property insurance" means the coverage against loss to real or tangible personal property at a fixed location provided in a homeowners policy, residential fire and allied lines policy, or farm and ranch owners policy.

(4) "Inspection bureau" means the organization or organizations designated by the FAIR Plan Association . . . .

(5) "Net direct premiums" means gross direct written premiums less return premiums upon canceled contracts (irrespective of reinsurance assumed or ceded) written on residential property pursuant to this Act.

(6) "Underserved area(s)" means area(s) designated as underserved by the commissioner by rule. . . .

[Art. 21.49A-1]

Sec. 2. In this article:

(1) "Association" means the FAIR Plan Association established under Article 21.49A of this code.

Revisor's Note

(1) Section 2(2), V.T.I.C. Article 21.49A, refers to a "licensed insurer," meaning an insurer that holds a certificate of authority and is thus authorized to engage in business in this state. For consistency with the terminology used in this code, the revised law substitutes "authorized" for "licensed" throughout this chapter with respect to an insurer's authority to engage in business or to write specified insurance.

(2) Section 2(2), V.T.I.C. Article 21.49A, defines "insurer" to mean an insurer writing "property and casualty insurance" in this state. The revised law omits the reference to casualty insurance because only insurers writing property insurance are required under Article 21.49A, revised in this chapter, to participate in the FAIR Plan, and this chapter does not otherwise apply to insurers writing casualty insurance.

(3) Section 2(4), V.T.I.C. Article 21.49A,

defines "inspection bureau" as the organization or organizations designated by the FAIR Plan Association to perform certain functions as provided by that section. The part of Section 2(4), V.T.I.C. Article 21.49A, that provides for the designation of the inspection bureau is revised in this chapter as Section 2211.153. The revised law adds a cross-reference to that section for the reader's convenience.

(4) The revised law adds definitions of "FAIR Plan" and "governing committee" for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definitions.

Revised Law

Sec. 2211.002. IMMUNITY. Liability does not exist on the part of, and a cause of action does not arise against, an insurer, the inspection bureau, the association, the governing committee, the commissioner, an authorized representative of the commissioner, or an agent or employee of an insurer, the inspection bureau, the association, or the governing committee for:

(1) an inspection required by this chapter;

(2) an act or omission in connection with an inspection; or

(3) a statement made:

(A) in a report and communication concerning the insurability of property;

(B) in the determinations required by this subchapter or Subchapter B, C, D, or F; or

(C) at a hearing conducted in connection with an inspection. (V.T.I.C. Art. 21.49A, Sec. 9.)

Source Law

Sec. 9. There is no liability on the part of, and no cause of action against insurers, the inspection bureau, the association, the governing committee, their agents or employees, or the commissioner or the commissioner's authorized

representatives, with respect to any inspections required to be undertaken by this Act or for any acts or omissions in connection therewith, or for any statements made in any report and communication concerning the insurability of the property, or in the findings required by the provisions of this Act, or at the hearings conducted in connection with such inspections.

Revised Law

Sec. 2211.003. APPEALS; JUDICIAL REVIEW. (a) An applicant or affected insurer is entitled to appeal to the association. The association's decision may be appealed to the commissioner not later than the 30th day after the date of the decision.

(b) An order or decision made by the commissioner under this chapter is subject to judicial review in accordance with Subchapter D, Chapter 36. (V.T.I.C. Art. 21.49A, Sec. 8.)

Source Law

Sec. 8. (a) Any applicant or affected insurer has the right of appeal to the association. A decision of the association may be appealed to the commissioner within 30 days after such decision.

(b) All orders or decisions of the commissioner made pursuant to this Act are subject to judicial review in accordance with Subchapter D, Chapter 36, of this code.

Revisor's Note

Section 8(b), V.T.I.C. Article 21.49A, provides that an order or decision of the commissioner of insurance under the "Act," meaning Article 21.49A, is subject to judicial review in accordance with Subchapter D, Chapter 36, of this code. Article 21.49A is revised as Subchapters A-D and F of this chapter. The revised law refers to "this chapter," which includes V.T.I.C. Article 21.49A-1, revised as Subchapter E of this chapter, rather than "Subchapter A, B, C, D, or F of this chapter" because Subchapter D, Chapter 36, of this code applies by its terms to any order or decision of the commissioner, including an order or decision under Subchapter E of this chapter.

[Sections 2211.004-2211.050 reserved for expansion]

SUBCHAPTER B. ESTABLISHMENT AND ADMINISTRATION OF FAIR PLAN

Revised Law

Sec. 2211.051. ESTABLISHMENT OF FAIR PLAN. The commissioner may establish a Fair Access to Insurance Requirements Plan to deliver residential property insurance to residents of this state in underserved areas if the commissioner determines, after a public hearing, that:

(1) in all or any part of the state, residential property insurance is not reasonably available in the voluntary market to a substantial number of insurable risks; and

(2) at least 25 percent of the applicants to the residential property market assistance program who are qualified under that program's plan of operation have not been placed with an insurer in the preceding six months. (V.T.I.C. Art. 21.49A, Secs. 1(a) (part), 2(1) (part).)

Source Law

Art. 21.49A

Sec. 1. (a) If the commissioner determines, after a public hearing, that in all or any part of the state residential property insurance is not reasonably available in the voluntary market to a substantial number of insurable risks and that at least 25 percent of the applicants to the residential property market assistance program who are qualified under the plan of operation have not been placed with an insurer in the previous six-month period, the commissioner may establish a FAIR (Fair Access to Insurance Requirements) Plan to deliver residential property insurance to citizens of this state in underserved areas, . . . .

Sec. 2. (1) ["FAIR Plan Association" or "association" means a . . . association established pursuant to this Act] to develop and administer a program to provide residential property insurance in designated underserved areas in this state.

Revisor's Note

Section 1(a), V.T.I.C. Article 21.49A, refers to "citizens of this state." The revised law substitutes "residents" for "citizens" because, in the context of this section, "citizens" and "residents" are synonymous and "residents" is more commonly used.

Revised Law

Sec. 2211.052. ADMINISTRATION OF FAIR PLAN; COMPOSITION OF

GOVERNING COMMITTEE. (a) The governing committee shall administer the FAIR Plan under a plan of operation.

(b) The governing committee is composed of 11 members appointed by the commissioner as follows:

(1) five members who represent the interests of insurers;

(2) four public members; and

(3) two members who are general property and casualty agents.

(c) The commissioner or an employee of the department designated by the commissioner serves as an ex officio member.

(d) Each member of the governing committee who represents the interests of insurers must be a full-time employee of an insurer. (V.T.I.C. Art. 21.49A, Secs. 3(a) (part), (b), (c), (d).)

Source Law

> Sec. 3. (a) The FAIR Plan shall be administered by the governing committee of the association pursuant to a plan of operation. . . .
>
> (b) The governing committee shall be composed of 11 members appointed by the commissioner as follows:
>
> (1) five members who represent the interests of insurers;
>
> (2) four public members; and
>
> (3) two members who are licensed local recording agents.
>
> (c) The commissioner or the commissioner's designated representative from within the Texas Department of Insurance shall serve as an ex officio member.
>
> (d) To be eligible to serve on the governing committee as a representative of insurers, a person must be a full-time employee of an authorized insurer.

Revisor's Note

(1) Section 3(b)(3), V.T.I.C. Article 21.49A, refers to "licensed" agents. Throughout this chapter, the revised law omits "licensed" as unnecessary in this context because under Section 4001.101 of this code a person may not act as an agent unless the person holds a license.

(2) Section 3(b)(3), V.T.I.C. Article 21.49A, refers to "local recording agents." 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.

(3) Section 3(c), V.T.I.C. Article 21.49A, refers to "the commissioner's designated representative from within the Texas Department of Insurance." The revised law substitutes a reference to "an employee of the department designated by the commissioner" because the only individual within the Texas Department of Insurance who is not a department employee is the commissioner of insurance.

(4) Section 3(d), V.T.I.C. Article 21.49A, refers to an "authorized" insurer. The revised law omits the reference to "authorized" because Section 2(2), V.T.I.C. Article 21.49A, revised in this chapter as Section 2211.001(5), defines "insurer" to mean an authorized insurer.

Revised Law

Sec. 2211.053. AMENDMENTS TO PLAN OF OPERATION. (a) The governing committee may, on the committee's own initiative or at the commissioner's request, propose amendments to the plan of operation.

(b) Amendments to the plan must be adopted by the commissioner by rule. (V.T.I.C. Art. 21.49A, Sec. 3(a) (part).)

Source Law

(a) . . . Subject to the approval of the commissioner, the governing committee shall develop the plan of operation and propose amendments thereto. The plan of operation and any amendments thereto shall be adopted by the commissioner by rule. The governing committee may on its own initiative or at the request of the commissioner amend the plan of operation.

Revisor's Note

Section 3(a), V.T.I.C. Article 21.49A, requires the governing committee of the FAIR Plan Association to develop the association's plan of operation and provides that the plan of operation must be adopted by the commissioner of insurance by rule. The revised law omits those provisions as executed.

Revised Law

Sec. 2211.054. CONTENTS OF PLAN OF OPERATION. The plan of operation must:

(1) provide for a nonprofit association to issue residential property insurance under this chapter and distribute the losses and expenses in writing that insurance in this state;

(2) provide that all insurers that write residential property insurance shall participate in the association in accordance with Sections 2211.101(b) and (c);

(3) provide that a participating insurer is entitled to receive credit in accordance with Section 2211.101(d);

(4) provide for the immediate binding of eligible risks;

(5) provide for the use of premium installment payment plans, adequate marketing, and service facilities;

(6) provide for the establishment of reasonable service standards;

(7) provide procedures for efficient, economical, fair, and nondiscriminatory administration of the association;

(8) provide procedures for determining the net level of participation required for each insurer in the association;

(9) provide for the use of deductibles and other underwriting devices;

(10) provide for assessment of all members in amounts sufficient to operate the association;

(11) establish maximum limits of liability to be placed through the program;

(12) establish commissions to be paid to the insurance agents submitting applications;

(13) provide that the association issue policies in the association's own name;

(14) provide reasonable underwriting standards for determining insurability of a risk;

(15) provide procedures for the association to assume and cede reinsurance; and

(16) provide any other procedure or operational matter the governing committee or the commissioner considers necessary. (V.T.I.C. Art. 21.49A, Secs. 2(1) (part), 3(e) (part).)

Source Law

[Sec. 2. (1) "FAIR Plan Association" . . . means a] nonprofit [association] . . . .

[Sec. 3]

(e) The plan of operation shall provide:

(1) for establishment of a FAIR Plan Association for the issuing of residential property insurance pursuant to this Act and the distribution of the losses and the expenses in the writing of such insurance in this state;

(2) that all insurers licensed to write property insurance and writing residential property insurance shall participate in the [writings, expenses, and losses of the] association[, in the proportion that the net direct premiums, of each participating insurer, written in this state during the preceding calendar year, bear to the aggregate net direct premium written in this state by all participating insurers;] . . . ;

(3) that a participating insurer is entitled to receive credit [for similar insurance voluntarily written in a designated underserved area] . . . ;

(4) for the immediate binding of eligible risks; for the use of premium installment payment plans, adequate marketing, and service facilities; and for the establishment of reasonable service standards;

(5) procedures for efficient, economical, fair, and nondiscriminatory administration of the FAIR Plan Association;

(6) procedures for determining the net level of participation required for each insurer in the FAIR Plan Association;

(7) for the use of deductibles and other underwriting devices and for assessment of all members in amounts sufficient to operate the association; and establish maximum limits of liability to be placed through the program; and commissions to be paid to the licensed agents submitting applications;

(8) that the association issue policies in its own name;

(9) reasonable underwriting standards for determining insurability of the risk;

(10) procedures for the assumption and

ceding of reinsurance by the association; and

(11) any other procedures or operational matters deemed necessary by the governing committee or the commissioner.

Revisor's Note

Section 3(e)(1), V.T.I.C. Article 21.49A, requires the plan of operation to provide for the establishment of a FAIR Plan Association. The revised law omits this requirement as executed.

Revised Law

Sec. 2211.055. ASSOCIATION DUTIES WITH RESPECT TO POLICIES. (a) The association may, for FAIR Plan purposes only:

(1) issue insurance policies and endorsements to those policies in the association's own name or a trade name adopted for that purpose; and

(2) act on behalf of all participating insurers in connection with those policies and act in any other manner necessary to accomplish the purposes of this chapter, including:

(A) issuing insurance policies;

(B) collecting premiums;

(C) issuing cancellations; and

(D) paying commissions, losses, judgments, and expenses.

(b) In connection with an insurance policy issued by the association:

(1) service of a notice, proof of loss, legal process, or other communication with regard to the policy must be made on the association; and

(2) an action by the insured constituting a claim under the policy may be brought only against the association, and the association is the proper party for all purposes in an action brought under or in connection with the policy.

(c) The requirements of Subsection (b) must be stated in an insurance policy issued by the association.

(d) The form and content of an insurance policy issued by the association are subject to the commissioner's approval.

(e) The association may assume and cede reinsurance as provided by the plan of operation. (V.T.I.C. Art. 21.49A, Secs. 5(a), (b) (part), (c).)

Source Law

Sec. 5. (a) The association is authorized, for FAIR Plan purposes only, to issue policies of insurance and endorsements thereto in its own name or a trade name duly adopted for that purpose, and to act on behalf of all participating insurers in connection with said policies and otherwise in any manner necessary to accomplish the purposes of this Act, including but not limited to issuance of policies, collection of premiums, issuance of cancellations, and payment of commissions, losses, judgments, and expenses.

(b) . . . In connection with any policy issued by the association:

(1) service of any notice, proof of loss, legal process, or other communication with respect to the policy shall be made upon the association; and

(2) any action by the insured constituting a claim under the policy shall be brought only against the association, and the association shall be the proper party for all purposes in any action brought under or in connection with any such policy. The foregoing requirements shall be set forth in any policy issued by the association and the form and content of any such policy shall be subject to the approval of the commissioner.

(c) The association is authorized to assume and cede reinsurance in conformity with the plan of operation.

Revisor's Note

(1) Section 5(a), V.T.I.C. Article 21.49A, refers to a trade name "duly" adopted by the FAIR Plan Association. The revised law omits "duly" as unnecessary because the word does not add to the clear meaning of the law. A trade name that is not properly adopted by the association is not a trade name of the association.

(2) Section 5(a), V.T.I.C. Article 21.49A, 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, applicable to the revised law, 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. 2211.056. FILING AND APPROVAL OF RATES. (a) The association shall file with the commissioner for approval the proposed rates and supplemental rate information to be used in connection with the issuance of insurance policies or endorsements.

(b) The association shall set rates in an amount sufficient to:

(1) carry all claims to maturity; and

(2) meet the expenses incurred in the writing and servicing of the business.

(c) Not later than the 60th day after the date the association files the proposed rates, the commissioner shall enter an order approving or disapproving, wholly or partly, the proposed rates. The commissioner may, on notice to the association, extend the period for entering an order under this section an additional 30 days.

(d) An order disapproving a rate must state:

(1) the grounds for the disapproval; and

(2) the findings in support of the disapproval.

(e) The association may not issue an insurance policy or endorsement until the commissioner approves the rates to be applied to the policy or endorsement. (V.T.I.C. Art. 21.49A, Sec. 7.)

Source Law

Sec. 7. The association shall file with the commissioner for approval the proposed rates and supplemental rate information to be used in connection with the issuance of policies or endorsements. Rates shall be set in an amount sufficient to carry all claims to maturity and to meet the expenses incurred in the writing and servicing of the business. Within 60 days of the filing of the proposed rates, the commissioner shall enter an order either approving or disapproving, in whole or in part, the proposed rates. The commissioner may, upon notice to the association, extend the period for entering an order under this section an additional 30 days. No such policies or endorsements shall be issued until such time as the commissioner approves the rates to be applied to the

policy or endorsement. An order disapproving a rate shall state the grounds for the disapproval and the findings in support thereof.

Revised Law

Sec. 2211.057. POWERS OF COMMISSIONER. The commissioner is charged with the authority to supervise the association and the inspection bureau. The commissioner also has the power to:

(1) examine the operation of the association and the inspection bureau through free access to all the books, records, files, papers, and documents relating to the operation of the association and the inspection bureau;

(2) summon, qualify, and examine as a witness any person who has knowledge of the operation of the association or the inspection bureau, including a member of the governing committee or an officer or employee of the association or the inspection bureau;

(3) take any action necessary to enable this state and the association to fully participate in any federal reinsurance program that is enacted for purposes similar to the purposes of this chapter;

(4) require reports from the association concerning risks the association insures under this chapter as the commissioner considers necessary; and

(5) adopt policy forms and endorsements, promulgate rates, and adopt rating and rule manuals for use by the association. (V.T.I.C. Art. 21.49A, Sec. 14.)

Source Law

Sec. 14. (a) In addition to any powers conferred upon the commissioner by this or any other law, the commissioner is charged with the authority to supervise the association and the inspection bureau. In addition, the commissioner has the power:

(1) to examine the operation of the association and the inspection bureau through free access to all the books, records, files, papers, and documents relating to their operation and may summon, qualify, and examine as witnesses all persons having knowledge of such operations, including the governing committee, officers, or employees thereof;

(2) to do all things necessary to enable the State of Texas and the association to fully participate in any federal program of reinsurance which may be enacted for purposes similar to the purposes of this Act;

(3) to require such reports from the

association concerning risks insured by the association pursuant to this Act as may be deemed necessary; and

(4) to adopt policy forms, endorsements, rates, and rating and rule manuals for use by the association.

Revisor's Note

(1) Section 14(a), V.T.I.C. Article 21.49A, provides that "[i]n addition to any powers conferred upon the commissioner by this or any other law," the commissioner of insurance has certain specified powers. The revised law omits the quoted language 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.

(2) Section 14(a)(4), V.T.I.C. Article 21.49A, authorizes the commissioner of insurance to "adopt policy forms, endorsements, rates, and rating and rule manuals." The revised law substitutes "promulgate rates" for the reference to "adopt . . . rates" for consistency of terminology throughout this code.

Revised Law

Sec. 2211.058. ANNUAL OPERATING REPORT. (a) Not later than March 31 of each year, the association shall compile and submit to the commissioner an operating report covering the preceding calendar year.

(b) The report is a public record. (V.T.I.C. Art. 21.49A, Sec. 13.)

Source Law

Sec. 13. The association shall compile a calendar year annual operating report and submit such annual report to the commissioner on or before March 31 of the following calendar year. This annual report shall be a matter of public record.

[Sections 2211.059-2211.100 reserved for expansion]

SUBCHAPTER C. INSURER PARTICIPATION IN FAIR PLAN

Revised Law

Sec. 2211.101. COVERAGE PROVIDED TO INSUREDS IN UNDERSERVED AREA. (a) In accordance with the plan of operation, the association shall develop and administer a program for participation by each insurer that writes residential property insurance in this state.

(b) Each insurer, as a condition of the insurer's authority to engage in the business of residential property insurance in this state, shall participate in the association in accordance with this chapter, including participating in the association's writings, expenses, and losses in the proportion that the insurer's net direct premiums written in this state during the preceding calendar year bear to the aggregate net direct premiums written in this state by all participating insurers.

(c) An insurer's participation under Subsection (b) in the association's writings, expenses, and losses must be determined in accordance with the residential property statistical plan adopted by the commissioner.

(d) A participating insurer is entitled to receive credit for similar insurance voluntarily written in an underserved area. The participation of an insurer entitled to receive credit under this subsection must be reduced in accordance with the plan of operation. (V.T.I.C. Art. 21.49A, Secs. 1(b), 3(e) (part), 4 (part), 5(d).)

Source Law

[Sec. 1]

(b) Each insurer, as defined herein, as a condition of its authority to transact residential property insurance in this state, shall participate in the FAIR Plan Association in accordance with this Act.

[Sec. 3]

(e) [The plan of operation shall provide:]

. . .

(2) that all insurers licensed to write property insurance and writing residential property insurance shall participate in the writings, expenses, and losses of the association, in the proportion that the net direct premiums, of each participating insurer, written in this state during the preceding

calendar year, bear to the aggregate net direct premium written in this state by all participating insurers; such information shall be determined in accordance with the residential property statistical plan adopted by the commissioner;

(3) that a participating insurer is entitled to receive credit for similar insurance voluntarily written in a designated underserved area and its participation in the writings in the association shall be reduced in accordance with the provisions of the plan of operation;

. . . .

Sec. 4. Pursuant to procedures and requirements set forth in the plan of operation, the FAIR Plan Association (association) shall develop and administer a program for participation by all insurers licensed to write property insurance in this state and writing residential property insurance in this state.

. . .

[Sec. 5]

(d) Each insurer must participate in the writings, expenses, and losses of the association in the proportion that its net direct premiums written bear to the aggregate net direct premiums written by all insurers.

Revisor's Note

Section 3(e)(3), V.T.I.C. Article 21.49A, refers to insurance written in a "designated" underserved area. Throughout this chapter, the revised law omits the reference to "designated" in this context as unnecessary because Section 1(a), V.T.I.C. Article 21.49A, revised in pertinent part in this chapter as Section 2211.152, requires the commissioner of insurance to designate areas as underserved, and only designated areas are considered underserved for purposes of this chapter.

Revised Law

Sec. 2211.102. LIABILITY OF INSURERS TO ASSOCIATION; ASSESSMENTS. The participating insurers are liable to the association as provided by this chapter and the plan of operation for the expenses and liabilities incurred by the association as provided by this chapter and the plan. The association shall make assessments against the participating insurers as required to meet those expenses and liabilities. (V.T.I.C. Art. 21.49A, Sec. 5(b) (part).)

Source Law

> (b) The participating insurers shall be liable to the association as provided in this Act and the plan of operation for the expenses and liabilities so incurred by the association, and the association shall make assessments against the participating insurers as required to meet such expenses and liabilities. . . .

Revised Law

Sec. 2211.103. RECOMPUTATION OF REIMBURSEMENT RATIOS. If a participating insurer fails to pay an assessment because of the insurer's insolvency, the association shall immediately recompute the reimbursement ratios to exclude from the ratios the amount of that assessment the commissioner determines is uncollectible, so that the uncollectible amount is assumed by and redistributed among the remaining participating insurers. (V.T.I.C. Art. 21.49A, Sec. 10.)

Source Law

> Sec. 10. In the event any participating insurer fails, by reason of insolvency, to pay any assessment, the association shall cause the reimbursement ratios to be immediately recalculated, excluding therefrom the amount of the insolvent insurer's assessment determined by the commissioner to be uncollectible, so that such uncollectible amount is, in effect, assumed and redistributed among the remaining participating insurers.

Revised Law

Sec. 2211.104. ADDITIONAL ASSESSMENT IN EVENT OF DEFICIT; PREMIUM SURCHARGE AUTHORIZED. (a) If the association incurs a deficit, the association, at the commissioner's direction, shall:

(1) request the issuance of public securities as authorized by Subchapter E; or

(2) assess participating insurers in accordance with this section.

(b) If the association assesses participating insurers under this section, each insurer may charge a premium surcharge on every property insurance policy insuring property in this state that the insurer issues, the effective date of which is within the three-year period beginning on the 90th day after the date of the assessment.

(c) The insurer shall compute the amount of the surcharge

under Subsection (b) as a uniform percentage of the premium on each policy described by Subsection (b). The percentage must be equal to one-third of the ratio of the amount of the participating insurer's assessment to the amount of the insurer's direct earned premiums, as reported to the department in the insurer's financial statement for the calendar year preceding the year in which the assessment is made so that, over the three-year period, the aggregate of all surcharges by the insurer under this section equals the amount of the assessment.

(d) The minimum surcharge on a policy may be $1. A surcharge may be rounded to the nearest dollar. (V.T.I.C. Art. 21.49A, Sec. 11.)

Source Law

> Sec. 11. Should a deficit occur in the association, the association, at the direction of the commissioner, shall either request the issuance of public securities as authorized by Article 21.49A-1 of this code or assess participating insurers in accordance with this section. Each insurer may charge a premium surcharge on every property insurance policy issued by it insuring property in this state, the effective date of which policy is within the three-year period commencing 90 days after the date of assessment by the association under this section. The amount of the surcharge shall be calculated on the basis of a uniform percentage of the premium on such policies equal to one-third of the ratio of the amount of an insurer's assessment to the amount of its direct earned premiums as reported in its financial statement to the department for the calendar year immediately preceding the year in which the assessment is made, such that over the period of three years the aggregate of all such surcharges by an insurer shall be equal to the amount of the assessment of such insurer. The minimum surcharges on a policy may be $1; all surcharges may be rounded to the nearest dollar.

Revisor's Note

Section 11, V.T.I.C. Article 21.49A, refers to the calendar year "immediately preceding" the year in which the assessment is made. The revised law omits "immediately" as unnecessary. "The year preceding" means "the year immediately preceding."

Revised Law

Sec. 2211.105. RETENTION AND USE OF PROFITS BY ASSOCIATION. (a) The association shall retain any profits of the

association to be used for the purposes of the association.

(b) The association:

(1) shall use the profits to mitigate losses, including purchasing reinsurance and offsetting future assessments; and

(2) may not distribute the profits to insurers. (V.T.I.C. Art. 21.49A, Sec. 15.)

Source Law

> Sec. 15. The association shall retain any profits of the association to be used for the purposes of the association. The profits of the association shall be used to mitigate losses, including the purchase of reinsurance and the offset of future assessments, and may not be distributed to insurers.

[Sections 2211.106-2211.150 reserved for expansion]

SUBCHAPTER D. COVERAGE PROVIDED TO INSUREDS

Revised Law

Sec. 2211.151. MANDATORY COVERAGE PROVIDED TO CERTAIN INSUREDS. The association shall make residential property insurance available to each applicant in an underserved area whose property is insurable in accordance with reasonable underwriting standards but who, after diligent efforts, is unable to obtain residential property insurance through the voluntary market, as evidenced by two declinations from insurers authorized to engage in the business of, and writing, residential property insurance in this state. (V.T.I.C. Art. 21.49A, Sec. 4 (part).)

Source Law

> Sec. 4. . . . The association shall make residential property insurance available to applicants in underserved areas whose property is insurable in accordance with reasonable underwriting standards but who, after diligent efforts, are unable to procure such insurance through the voluntary market, as evidenced by two declinations from insurers licensed to write and actually writing residential property insurance in the state.

Revised Law

Sec. 2211.152. DESIGNATION OF AREA AS UNDERSERVED. The commissioner by rule shall designate the areas determined to be underserved. In determining which areas to designate as

underserved, the commissioner shall consider the factors specified in Section 2004.002. (V.T.I.C. Art. 21.49A, Secs. 1(a) (part), 2(6) (part).)

Source Law

> Sec. 1. (a) . . . underserved areas, which shall be determined and designated by the commissioner by rule.
>
> [Sec. 2]
>
> (6) . . . In determining which areas will be designated as underserved, the commissioner shall consider the factors specified in Section 1, Article 5.35-3, of this code.

Revised Law

Sec. 2211.153. INSPECTION BUREAU. The association, with the approval of the commissioner, shall designate one or more organizations as the inspection bureau. The inspection bureau shall:

(1) make inspections to determine the condition of a property for which residential property insurance is sought; and

(2) perform other duties authorized by the association or the commissioner. (V.T.I.C. Art. 21.49A, Sec. 2(4) (part).)

Source Law

> (4) "Inspection bureau" means the organization or organizations designated by the FAIR Plan Association with the approval of the commissioner to make inspections to determine the condition of the properties for which residential property insurance is sought and to perform such other duties as may be authorized by the FAIR Plan Association or the commissioner. . . .

Revised Law

Sec. 2211.154. PROPERTY INSPECTION. (a) A person who has an insurable interest in real or tangible personal property at a fixed location in an underserved area and who, after diligent effort, is unable to obtain residential property insurance, as evidenced by two current declinations from insurers authorized to engage in the business of residential property insurance in this state and actually writing residential property insurance in this state, is entitled on application to the association to an inspection and evaluation of the property by representatives of the

inspection bureau.

(b) A general property and casualty agent may make an application on behalf of the applicant. The applicant or agent must submit the application on a form prescribed by the association.

(c) Promptly after the application is received, the inspection bureau shall make an inspection and file an inspection report with the association. The inspection report must be made available to the applicant on request. The association shall prescribe the manner and scope of the inspection and inspection report for residential property in accordance with the plan of operation. (V.T.I.C. Art. 21.49A, Secs. 2(4) (part), 6(a), (b), (c).)

Source Law

> [Sec. 2]
>
> (4) . . . The manner and scope of the inspection and evaluation report for residential property shall be prescribed by the association pursuant to the plan of operation.
>
> Sec. 6. (a) Any person having an insurable interest in real or tangible personal property at a fixed location in an underserved area who, after diligent effort has been unable to obtain residential property insurance, as evidenced by two current declinations from insurers licensed to write property insurance and actually writing residential property insurance in the state, is entitled upon application to the association to an inspection and evaluation of the property by representatives of the inspection bureau.
>
> (b) Applications may be made on behalf of the applicant by a licensed general lines property and casualty agent and shall be submitted on forms prescribed by the association.
>
> (c) Promptly after the request for inspection is received, an inspection must be made and an inspection report filed with the association and made available to the applicant upon request.

Revisor's Note

(1) Section 2(4), V.T.I.C. Article 21.49A, refers to an "evaluation report." Section 6(c) of that article refers to an "inspection report." For consistent use of terminology in this section, the revised law substitutes "inspection report" for "evaluation report."

(2) Section 6(a), V.T.I.C. Article 21.49A,

refers to declinations to write certain insurance by insurers that are authorized to write "property insurance" and that actually write residential property insurance in this state. Section 4, V.T.I.C. Article 21.49A, revised in pertinent part in this chapter as Section 2211.151, refers to the same declinations by insurers that are authorized to write "residential property insurance" and that actually write that insurance in this state. For consistency of terminology within this chapter, the revised law substitutes "residential property insurance" for "property insurance" in this context.

(3) Section 6(b), V.T.I.C. Article 21.49A, refers to a "general lines property and casualty agent." The revised law substitutes "general property and casualty agent" for "general lines property and casualty agent" because that is the term used in Chapter 4051 of this code for that type of agent.

Revised Law

Sec. 2211.155. INSPECTION RESULTS; REINSPECTION. (a) If, after an inspection, the inspection bureau determines that residential property meets the underwriting standards established in the plan of operation, the applicant must be informed in writing of that determination and the association shall issue a policy or binder. If the residential property does not meet the underwriting standards, the applicant must be informed in writing of the reason for the failure of the residential property to meet the standards.

(b) If, at any time, an applicant whose residential property did not meet the underwriting standards makes improvements to the property or the property's condition that the applicant believes are sufficient to make the property meet the standards, an inspection bureau representative shall reinspect the property on request. In any case, the applicant is eligible for one reinspection on or before the 60th day after the date of the initial

inspection.

(c) If, on reinspection, the residential property meets the underwriting standards, the applicant must be informed in writing of that fact and the association shall issue a policy or binder. (V.T.I.C. Art. 21.49A, Secs. 6(d), (e).)

Source Law

> (d) If the inspection bureau finds that the residential property meets the reasonable underwriting standards established in the plan of operation, the applicant shall be so informed in writing and a policy or binder shall be issued by the association. If the residential property does not meet the criteria, the applicant shall be informed, in writing, of the reasons for the failure of the residential property to meet the criteria.
>
> (e) If, at any time, the applicant makes improvements in the residential property or its condition which the applicant believes are sufficient to make the residential property meet the criteria, a representative of the inspection bureau shall reinspect the residential property upon request. In any case, the applicant for residential property insurance shall be eligible for one reinspection any time within 60 days after the initial FAIR Plan inspection. If upon reinspection the residential property meets the reasonable underwriting standards established in the plan of operation, the applicant shall be so informed in writing and a policy or binder shall be issued by the association.

Revisor's Note

(1) Sections 6(d) and (e), V.T.I.C. Article 21.49A, require the inspection bureau to inform the applicant if the residential property meets the "reasonable" underwriting standards established in the plan of operation. The revised law omits the references to "reasonable" as redundant of the requirement under Section 3(e)(9), V.T.I.C. Article 21.49A, revised in this chapter as Section 2211.054(14), that the underwriting standards provided by the plan of operation be reasonable.

(2) Section 6(e), V.T.I.C. Article 21.49A, entitles an applicant for residential property insurance to a reinspection "any time within 60 days after the initial FAIR Plan inspection." The revised law omits the reference to "any time" because a

provision entitling an applicant to a reinspection within a specified period entitles the applicant to the reinspection at any time within that period unless the provision expressly provides otherwise.

Revised Law

Sec. 2211.156. CERTAIN COVERAGE EXCLUDED. The FAIR Plan may not provide windstorm and hail insurance coverage for a risk eligible for that coverage under Chapter 2210. (V.T.I.C. Art. 21.49A, Sec. 1(c).)

Source Law

(c) The FAIR Plan may not provide windstorm and hail insurance coverage for a risk eligible for that coverage under Article 21.49 of this code.

[Sections 2211.157-2211.200 reserved for expansion]

SUBCHAPTER E. REVENUE BOND PROGRAM

Revised Law

Sec. 2211.201. PURPOSE. The legislature finds that issuing public securities to provide a method to raise funds to provide residential property insurance in this state through the association is to benefit the public and to further a public purpose. (V.T.I.C. Art. 21.49A-1, Sec. 1.)

Source Law

Art. 21.49A-1

Sec. 1. The legislature finds that the issuance of public securities to provide a method to raise funds to provide residential property insurance through the FAIR Plan Association in this state is for the benefit of the public and in furtherance of a public purpose.

Revised Law

Sec. 2211.202. DEFINITIONS. In this subchapter:

(1) "Board" means the board of directors of the Texas Public Finance Authority.

(2) "Bond" means a debt instrument or other public security issued by the Texas Public Finance Authority.

(3) "Public security resolution" means the resolution or order authorizing public securities to be issued under this subchapter. (V.T.I.C. Art. 21.49A-1, Secs. 2(2), (3), (4).)

Source Law

Sec. 2. In this article:

. . .

(2) "Public security resolution" means the resolution or order authorizing public securities to be issued under this article.

(3) "Bond" means any debt instrument or public security issued by the Texas Public Finance Authority.

(4) "Board" means the board of directors of the Texas Public Finance Authority.

Revisor's Note

(1) Section 2(3), V.T.I.C. Article 21.49A-1, defines "bond" to mean a debt instrument or public security issued by the Texas Public Finance Authority. The revised law defines the term to mean a debt instrument or "other" public security issued by the Texas Public Finance Authority because a debt instrument is a form of public security.

(2) Section 2(5), V.T.I.C. Article 21.49A-1, defines "insurer" to mean an insurer required to participate in the association under Section 5, V.T.I.C. Article 21.49A, including a Lloyd's plan or a reciprocal or interinsurance exchange. The revised law omits the definition as unnecessary because it is duplicative of the definition of "insurer" provided by Section 2(2), V.T.I.C. Article 21.49A, which is revised in this chapter as Section 2211.001(5), and of the specification of the kinds of insurers required to participate in the association provided by Section 4, V.T.I.C. Article 21.49A, which is revised in pertinent part in this chapter in Section 2211.101. For consistency with the terminology used in Subchapters A-D and F of this chapter, this subchapter substitutes "participating insurer" for references to "insurer." The omitted law reads:

> (5) "Insurer" means any insurer required to participate in the association under Section 5, Article 21.49A, of this code, including a Lloyd's plan or a reciprocal or interinsurance exchange.

Revised Law

Sec. 2211.203. APPLICABILITY OF OTHER LAWS. The following laws apply to public securities issued under this subchapter to the extent consistent with this subchapter:

(1) Chapters 1201, 1202, 1204, 1205, 1231, 1232, and 1371, Government Code; and

(2) Subchapter A, Chapter 1206, Government Code. (V.T.I.C. Art. 21.49A-1, Secs. 3(b), 4.)

Source Law

[Sec. 3]

(b) To the extent not inconsistent with this article, Chapter 1232, Government Code, applies to public securities issued under this article. In the event of a conflict, this article controls.

Sec. 4. The following laws apply to public securities issued under this article to the extent consistent with this article:

(1) Chapters 1201, 1202, 1204, 1205, 1231, and 1371, Government Code; and

(2) Subchapter A, Chapter 1206, Government Code.

Revisor's Note

Section 3(b), V.T.I.C. Article 21.49A-1, provides that, to the extent not inconsistent with that article, Chapter 1232, Government Code, applies to public securities issued under that article but that, in the event of a conflict, that article controls. The revised law omits the statement that in the event of a conflict V.T.I.C. Article 21.49A-1 controls over Chapter 1232, Government Code, because that is implied by the statement that Chapter 1232, Government Code, applies to public securities issued under V.T.I.C. Article 21.49A-1 to the extent not inconsistent with that article.

Revised Law

Sec. 2211.204. ISSUANCE OF PUBLIC SECURITIES AUTHORIZED. At the request of the association and subject to Section 2211.205, the Texas Public Finance Authority shall issue public securities to:

(1) fund the association, including to:

(A) establish and maintain reserves to pay claims;

(B) pay operating expenses; and

(C) purchase reinsurance;

(2) pay costs related to issuing the public securities; and

(3) pay other costs related to the public securities as determined by the board. (V.T.I.C. Art. 21.49A-1, Sec. 3(a).)

Source Law

Sec. 3. (a) At the request of the association, the Texas Public Finance Authority shall issue public securities to:

(1) fund the association, including:

(A) to establish and maintain reserves to pay claims;

(B) to pay operating expenses; and

(C) to purchase reinsurance;

(2) pay costs related to issuance of the public securities; and

(3) pay other costs related to the public securities as may be determined by the board.

Revisor's Note

Section 3(a), V.T.I.C. Article 21.49A-1, provides that "[a]t the request of the association," the Texas Public Finance Authority shall issue public securities for certain purposes. Section 5, V.T.I.C. Article 21.49A-1, revised in this chapter as Section 2211.205, limits the total amount of public securities the authority may issue on behalf of the FAIR Plan Association. For the convenience of the reader, the revised law adds a cross-reference to Section 2211.205.

Revised Law

Sec. 2211.205. LIMITATION ON AMOUNT OF PUBLIC SECURITIES. The Texas Public Finance Authority may issue on behalf of the association public securities in a total amount not to exceed $75 million. (V.T.I.C. Art. 21.49A-1, Sec. 5.)

Source Law

Sec. 5. The Texas Public Finance Authority may issue, on behalf of the association, public securities

in a total amount not to exceed $75 million.

Revised Law

Sec. 2211.206. TERMS OF ISSUANCE. (a) Public securities issued under this subchapter may be issued at a public or private sale.

(b) Public securities must:

(1) be issued in the name of the association; and

(2) mature not more than 10 years after the date issued. (V.T.I.C. Art. 21.49A-1, Sec. 6.)

Source Law

Sec. 6. (a) Public securities issued under this article may be issued at public or private sale.

(b) Public securities may mature not more than 10 years after the date issued.

(c) Public securities must be issued in the name of the association.

Revised Law

Sec. 2211.207. CONTENTS OF PUBLIC SECURITY RESOLUTION; ADMINISTRATION OF ACCOUNTS. (a) In a public security resolution, the board may:

(1) provide for the flow of funds and the establishment, maintenance, and investment of funds and special accounts with regard to the public securities, including an interest and sinking fund account, a reserve account, and other accounts; and

(2) make additional covenants with regard to the public securities and the designated income and receipts of the association pledged to the payment of the public securities.

(b) The association shall administer the accounts in accordance with this chapter. (V.T.I.C. Art. 21.49A-1, Secs. 7, 8.)

Source Law

Sec. 7. In a public security resolution, the board may make additional covenants with respect to the public securities and the designated income and receipts of the association pledged to their payment, and may provide for the flow of funds and the establishment, maintenance, and investment of funds and accounts with respect to the public securities.

Sec. 8. (a) A public security resolution may establish special accounts, including an interest and

sinking fund account, reserve account, and other accounts.

(b) The association shall administer the accounts in accordance with Article 21.49A of this code.

Revised Law

Sec. 2211.208. SOURCE OF PAYMENT. (a) Public securities issued under this subchapter are payable only from:

(1) the service fee established under Section 2211.209; or

(2) other amounts the association is authorized to levy, charge, and collect.

(b) The public securities are obligations solely of the association and do not create a pledge, gift, or loan of the faith, credit, or taxing authority of this state.

(c) Each public security must:

(1) include a statement that the state is not obligated to pay any amount on the security and that the faith, credit, and taxing authority of this state are not pledged, given, or loaned to those payments; and

(2) state on the security's face that the security:

(A) is payable solely from the revenue pledged for that purpose; and

(B) is not a legal or moral obligation of the state. (V.T.I.C. Art. 21.49A-1, Sec. 9.)

Source Law

Sec. 9. (a) Public securities are payable only from the service fee established under Section 10 of this article or other amounts that the association is authorized to levy, charge, and collect.

(b) Public securities are obligations solely of the association. Public securities do not create a pledging, giving, or lending of the faith, credit, or taxing authority of this state.

(c) Each public security must include a statement that the state is not obligated to pay any amount on the public security and that the faith, credit, and taxing authority of this state are not pledged, given, or lent to those payments.

(d) Each public security issued under this article must state on its face that the public security is payable solely from the revenues pledged for that purpose and that the public security does not and may not constitute a legal or moral obligation of the state.

Revised Law

Sec. 2211.209. SERVICE FEE. (a) A service fee may be assessed against:

(1) each participating insurer; and

(2) the association.

(b) The commissioner shall set the service fee in an amount sufficient to pay all debt service on the public securities issued under this subchapter. Each participating insurer and the association shall pay the service fee as required by the commissioner by rule.

(c) The comptroller shall collect the service fee and the department shall reimburse the comptroller in the manner described by Section 201.052.

(d) The commissioner, in consultation with the comptroller, may coordinate payment and collection of the service fee with other payments made by participating insurers and collected by the comptroller.

(e) As a condition of engaging in the business of insurance in this state, a participating insurer agrees that, if the insurer leaves the property insurance market in this state, the insurer remains obligated to pay the insurer's share of the service fee assessed under this section until the public securities are retired. The amount assessed against an insurer under this subsection must be:

(1) proportionate to the insurer's share of the property insurance market, including residential property insurance, in this state as of the last complete reporting period before the date the insurer ceases to engage in the property insurance business in this state; and

(2) based on the insurer's gross premiums for property insurance, including residential property insurance, for the insurer's last reporting period. (V.T.I.C. Art. 21.49A-1, Sec. 10.)

Source Law

Sec. 10. (a) A service fee may be assessed against:

(1) each insurer; and

(2) the association.

(b) The service fee shall be set by the commissioner in an amount sufficient to pay all debt service on the public securities. The service fee shall be paid by each insurer and the association as required by the commissioner by rule.

(c) The comptroller shall collect the service fee and the department shall reimburse the comptroller in the manner described by Article 4.19 of this code.

(d) The commissioner, in consultation with the comptroller, may coordinate payment and collection of the service fee with other payments made by insurers and collected by the comptroller.

(e) As a condition of engaging in the business of insurance in this state, an insurer agrees that if the company leaves the property insurance market in this state the insurer remains obligated to pay, until the public securities are retired, the insurer's share of the service fee assessed under this section in an amount proportionate to that insurer's share of the property insurance market, including residential property insurance, in this state as of the last complete reporting period before the date on which the insurer ceases to engage in that insurance business in this state. The proportion assessed against the insurer shall be based on the insurer's gross premiums for property insurance, including residential property insurance, for the insurer's last reporting period.

Revised Law

Sec. 2211.210. EXEMPTION FROM TAXATION. Public securities issued under this subchapter, any interest from the public securities, and all assets pledged to secure the payment of the public securities are exempt from taxation by the state or a political subdivision of this state. (V.T.I.C. Art. 21.49A-1, Sec. 11.)

Source Law

Sec. 11. The public securities issued under this article, any interest from those public securities, and all assets pledged to secure the payment of the public securities are free from taxation by the state or a political subdivision of this state.

Revised Law

Sec. 2211.211. AUTHORIZED INVESTMENTS. Public securities issued under this subchapter are authorized investments under Subchapter B, Chapter 424, and Subchapters C and D, Chapter 425. (V.T.I.C. Art. 21.49A-1, Sec. 12.)

Source Law

Sec. 12. The public securities issued under this article constitute authorized investments under Articles 2.10 and 3.33 and Subpart A, Part I, Article 3.39 of this code.

Revisor's Note

Section 12, V.T.I.C. Article 21.49A-1, provides that bonds issued under that article are authorized investments under V.T.I.C. Articles 2.10 and 3.33 and under Subpart A, Part I, V.T.I.C. Article 3.39. Article 2.10 and Subpart A, Part I, Article 3.39, are revised in pertinent part in Subchapter B, Chapter 424, and Subchapter D, Chapter 425, respectively. While those subchapters contain provisions derived from laws other than Article 2.10 and Subpart A, Part I, Article 3.39, it is appropriate to refer to the subchapters in their entirety because inclusion of the additional provisions in the reference does not change the substantive effect of the reference.

Revised Law

Sec. 2211.212. STATE PLEDGE REGARDING PUBLIC SECURITY OWNER RIGHTS AND REMEDIES. (a) The state pledges to and agrees with the owners of public securities issued in accordance with this subchapter that the state will not limit or alter the rights vested in the association to fulfill the terms of agreements made with the owners or impair the rights and remedies of the owners until the following obligations are fully discharged:

(1) the public securities;

(2) any bond premium;

(3) interest; and

(4) all costs and expenses related to an action or proceeding by or on behalf of the owners.

(b) The association may include the state's pledge and agreement under Subsection (a) in an agreement with the owners of the public securities. (V.T.I.C. Art. 21.49A-1, Sec. 13.)

Source Law

Sec. 13. The state pledges to and agrees with the owners of any public securities issued in accordance with this article that the state will not limit or alter the rights vested in the association to fulfill the terms of any agreements made with the owners of the public securities or in any way impair the rights and remedies of those owners until the public securities, bond premium, if any, or interest, and all costs and expenses in connection with any action or proceeding by or on behalf of those owners, are fully met and discharged. The association may include this pledge and agreement of the state in any agreement with the owners of the public securities.

Revised Law

Sec. 2211.213. PAYMENT ENFORCEABLE BY MANDAMUS. A writ of mandamus and any other legal or equitable remedy are available to a party in interest to require the association or another party to fulfill an agreement or perform a function or duty under:

(1) this subchapter;

(2) the Texas Constitution; or

(3) a public security resolution. (V.T.I.C. Art. 21.49A-1, Sec. 14.)

Source Law

Sec. 14. A writ of mandamus and all other legal and equitable remedies are available to any party at interest to require the association and any other party to carry out agreements and to perform functions and duties under this article, the Texas Constitution, or a public security resolution.

[Sections 2211.214-2211.250 reserved for expansion]

SUBCHAPTER F. PENALTIES

Revised Law

Sec. 2211.251. SANCTIONS AND ADMINISTRATIVE PENALTIES. If the association, the inspection bureau, or a participating insurer is found to be in violation of or to have failed to comply with this chapter, that entity is subject to:

(1) the sanctions authorized by Chapter 82; and

(2) administrative penalties authorized by Chapter 84. (V.T.I.C. Art. 21.49A, Sec. 12 (part).)

Source Law

Sec. 12. If the association, inspection bureau, or participating insurer is found to be in violation of or in failure to comply with this Act, each entity

shall be subject to the sanctions authorized in Chapter 82 of this code and administrative penalties authorized under Chapter 84 of this code. . . .

Revisor's Note

Section 12, V.T.I.C. Article 21.49A, provides that if the FAIR Plan Association, the inspection bureau, or a participating insurer is found to be in violation of or to have failed to comply with that "Act," meaning V.T.I.C. Article 21.49A, that entity is subject to the sanctions authorized by Chapter 82 of this code and administrative penalties authorized by Chapter 84 of this code. Although Chapters 82 and 84 of this code apply by their terms to a violation of or failure to comply with any provision of this code, including Article 21.49A, the revised law codifies Section 12 for the convenience of the reader. The revised law substitutes "this chapter," which includes V.T.I.C. Article 21.49A-1, for "this Act" because Chapters 82 and 84 of this code apply by their terms to a violation of or failure to comply with any provision of this chapter and not merely a provision of Article 21.49A.

Revised Law

Sec. 2211.252. ADDITIONAL DISCIPLINARY PROCEDURES. In addition to the remedies provided by Section 2211.251, the commissioner may use any other disciplinary procedures authorized by this code, including the cease and desist procedures authorized by Chapter 83. (V.T.I.C. Art. 21.49A, Sec. 12 (part).)

Source Law

Sec. 12. . . . The commissioner may also utilize any other disciplinary procedures authorized by this code, including the cease and desist procedures authorized by Chapter 83 of this code.

CHAPTER 2212. SELF-INSURANCE TRUSTS FOR HEALTH CARE LIABILITY CLAIMS

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CHAPTER 2212. SELF-INSURANCE TRUSTS FOR HEALTH CARE LIABILITY CLAIMS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2212.001. DEFINITIONS. In this chapter:

(1) "Dentist" means a person licensed to practice dentistry in this state.

(2) "Health care liability claim" means a cause of action against a physician or dentist for treatment, lack of treatment, or other claimed departure from accepted standards of health care or safety that proximately results in injury to or death of the patient, whether the patient's claim or cause of action sounds in tort or contract.

(3) "Physician" means a person licensed to practice medicine in this state.

(4) "Trust" means a self-insurance trust organized and operated under this chapter. (V.T.I.C. Art. 21.49-4, Sec. (a); New.)

Source Law

Art. 21.49-4. (a) In this article:

(1) "Physician" means a person licensed to practice medicine in this state.

(2) "Dentist" means a person licensed to practice dentistry in this state.

(3) "Health care liability claim" means a cause of action against a physician or dentist for treatment, lack of treatment, or other claimed departure from accepted standards of health care or safety which proximately results in injury to or death of the patient, whether the patient's claim or cause of action sounds in tort or contract.

Revisor's Note

(1) Section (a), V.T.I.C. Article 21.49-4, defines terms used in V.T.I.C. Article 21.49-4, revised as Subchapters A and B of this chapter. The revised law applies the definitions to this chapter in its entirety. Although Subchapter C of this chapter is derived from V.T.I.C. Article 21.49-4a, it is appropriate to apply the definitions contained in Article 21.49-4 to those provisions because Article 21.49-4a relates to contracts issued by a trust created under Article 21.49-4.

(2) The revised law adds a definition of "trust" for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 2212.002. TRUST NOT ENGAGED IN BUSINESS OF INSURANCE. A trust is not engaged in the business of insurance under this code and other laws of this state, and this code, other than this chapter, does not apply to the trust, except as provided by Section 2212.052. (V.T.I.C. Art. 21.49-4, Sec. (e) (part).)

Source Law

(e) The trust is not engaged in the business of insurance under this code and other laws of this state and the provisions of any chapters or sections of this code are declared inapplicable to a trust organized and operated under this article, [provided that the State Board of Insurance may require any trust created under this article to satisfy reasonable minimum requirements to insure the capability of the trust to satisfy its contractual obligations.]

[Sections 2212.003-2212.050 reserved for expansion]

SUBCHAPTER B. CREATION AND OPERATION OF TRUST

Revised Law

Sec. 2212.051. CREATION OF TRUST. (a) Subject to Subsection (b), an incorporated association, a purpose of which is to unite in one compact organization the entire profession licensed to practice medicine or dentistry in this state, or a portion of the members of the profession licensed to practice medicine who are practicing a particular specialty within the practice of medicine in the state or are practicing within a particular region of the state, may create a trust to self-insure physicians or dentists and agree, by contract or otherwise, to insure other members of the organization or association against health care liability claims and related risks.

(b) The organization or association must:

(1) have been in continuing existence for at least two years;

(2) have established a health care liability claim trust or other agreement to provide coverage against health care liability claims and related risks; and

(3) employ appropriate professional staff and consultants for program management. (V.T.I.C. Art. 21.49-4, Sec. (b).)

Source Law

(b) An incorporated association, the purpose of which, among other things, shall be to federate and bring into one compact organization the entire profession licensed to practice medicine and surgery or dentistry in the State of Texas, or a portion of the members of the profession licensed to practice medicine who are practicing a particular specialty within the practice of medicine or surgery in the state or are practicing within a particular region of the state, may create a trust to self-insure physicians or dentists and by contract or otherwise agree to insure other members of the organization or association against health care liability claims and related risks on complying with the following conditions:

(1) the organization or association must have been in continuing existence for a period of at least two years;

(2) establishment of a health care liability claim trust or other agreement to provide coverage against health care liability claims and related risks; and

(3) employment of appropriate professional staff and consultants for program management.

Revisor's Note

(1) Section (b), V.T.I.C. Article 21.49-4, refers to an incorporated association, a purpose of which is to "federate and bring into" one compact organization the members of specified professions. The revised law substitutes "unite in" for "federate and bring into" because, in context, the phrases are synonymous and the former phrase is more consistent with modern usage.

(2) Section (b), V.T.I.C. Article 21.49-4, refers to the practice of "medicine and surgery." The revised law omits the reference to "surgery" because that term is included within the meaning of "medicine." Under the general law regulating the practice of medicine, Subtitle B, Title 3, Occupations Code (Medical Practice Act), the terms "physicians" and "surgeons" are synonymous, and the Medical Practice Act does not distinguish between "medicine" and "surgery" in regulating the practice of medicine.

Revised Law

Sec. 2212.052. MINIMUM REQUIREMENTS. (a) The department may require a trust to satisfy reasonable minimum requirements that ensure the trust is able to satisfy the trust's contractual obligations.

(b) On request, a trust shall provide books, records, and documents required by the department to fulfill the requirements of this section relating to the trust's solvency. (V.T.I.C. Art. 21.49-4, Secs. (e) (part), (f).)

Source Law

(e) [The trust is not engaged in the business of insurance . . .] provided that the State Board of Insurance may require any trust created under this article to satisfy reasonable minimum requirements to insure the capability of the trust to satisfy its contractual obligations.

(f) On request, the trust shall furnish such books, records and documents as are required by the State Board of Insurance to fulfill its obligations under Subsection (e) of this article relating to the solvency of the trust.

Revisor's Note

Section (e), V.T.I.C. Article 21.49-4, 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. 2212.053. FILING REQUIREMENTS. (a) A trust shall file with the department:

(1) all rates and forms, for informational purposes only;

(2) all liability claims reports required under Subchapter D, Chapter 38; and

(3) the trust's independently audited annual financial statement.

(b) An audited annual financial statement filed under this section may not be considered an examination document. (V.T.I.C. Art. 21.49-4, Secs. (g), (h), (j).)

Source Law

(g) The trust shall file, for informational purposes only, all rates and forms with the State Board of Insurance.

(h) The trust shall file with the State Board of Insurance all liability claims reports which are required pursuant to Articles 1.24A and 1.24B, Insurance Code.

(j) The trust shall file its independently audited annual financial statement with the State Board of Insurance; this audit shall not be considered an examination document.

Revisor's Note

Section (h), V.T.I.C. Article 21.49-4, refers to reports required by V.T.I.C. Articles 1.24A and 1.24B. Chapter 685, Acts of the 73rd Legislature, Regular

Session, 1993, repealed Article 1.24A. Consequently, the revised law omits the reference to Article 1.24A.

Revised Law

Sec. 2212.054. POWERS OF TRUST. (a) A trust may:

(1) purchase, on behalf of the members of the association that created the trust, medical professional liability insurance, specific excess insurance, aggregate excess insurance, and reinsurance, as necessary in the opinion of the trustees;

(2) purchase required risk management services; and

(3) pay claims that arise under any deductible provisions.

(b) A trust's investment powers and limitations are the same as the investment powers and limitations of a state bank with trust powers. (V.T.I.C. Art. 21.49-4, Secs. (c), (d) (part).)

Source Law

> (c) The trust may purchase, on behalf of the members of the organizing association, medical professional liability insurance, specific excess insurance, aggregate excess insurance, and reinsurance, as in the opinion of the trustees are necessary. The trust fund is further authorized to purchase such risk management services as may be required and pay claims that arise under any deductible provisions.
>
> (d) The trust investment powers and limitations shall be the same as those of any state bank with trust powers. . . .

Revised Law

Sec. 2212.055. GUARANTEE OF CERTAIN LIABILITIES. The trust shall adopt rules to guarantee all contingent liabilities in the event of dissolution. (V.T.I.C. Art. 21.49-4, Sec. (d) (part).)

Source Law

> (d) . . . The trust shall adopt rules and regulations to guarantee all contingent liabilities in the event of dissolution.

Revisor's Note

Section (d), V.T.I.C. Article 21.49-4, 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. Similar changes have been made throughout this chapter.

Revised Law

Sec. 2212.056. ADMINISTRATIVE SANCTIONS. If a trust is found to have violated this code or a rule adopted by the commissioner that is declared applicable to the trust, the commissioner may order sanctions under Chapter 82 for the violation. (V.T.I.C. Art. 21.49-4, Sec. (i).)

Source Law

(i) If the trust is found to be in violation of or to have failed to comply with any provision of this code or any duly promulgated rule or regulation of the State Board of Insurance which is declared applicable to a trust organized and operated under this article, the State Board of Insurance, pursuant to Section 7, Article 1.10, Insurance Code, may order sanctions for such violation.

Revisor's Note

(1) Section (i), V.T.I.C Article 21.49-4, refers to a self-insurance trust for health care liability claims that is found to be in violation of "or to have failed to comply with" certain law. The revised law omits the quoted language as redundant because a failure to comply with a law is included within the meaning of a violation of the law.

(2) Section (i), V.T.I.C. Article 21.49-4, refers to a "duly" promulgated rule. The revised law omits the reference to "duly" as unnecessary because the word does not add to the clear meaning of the law.

[Sections 2212.057-2212.100 reserved for expansion]

SUBCHAPTER C. INSURANCE CONTRACTS ISSUED BY TRUST

Revised Law

Sec. 2212.101. COVERAGE UNDER CONTRACT. A contract of professional liability insurance issued by a trust may include coverage of:

(1) a professional association or partnership of physicians, with respect to health care liability claims and related risks if a majority of the persons having a proprietary interest in the association or partnership are members of the association that created the trust;

(2) proprietary members, associates, stockholders, and executive officers and directors of an association or partnership described by Subdivision (1), with respect to potential vicarious liability for acts or omissions of others giving rise to health care liability claims and related risks;

(3) an insured physician and, as applicable, an insured professional association or partnership, including proprietary members, associates, stockholders, and executive officers and directors of the association or partnership, with respect to liability of an insured arising out of:

(A) injury to a patient related to ownership, maintenance, or use of premises for the practice of medicine, including necessary or incidental operations;

(B) service by an insured physician as a member of a committee, board, or similar group of a hospital medical staff or of a professional association or society with respect to medical staff privileges, accreditation, or disciplinary matters relating to competency or patient safety and risk reduction programs; or

(C) a health care liability claim or related risk based in whole or part on an act or omission occurring before the date a contract of professional insurance is issued by the trust; or

(4) an applicant for membership in the association that created the trust, pending final action on the application, with respect to health care liability claims and related risks, including coverage described by Subdivision (1), (2), or (3), as applicable. (V.T.I.C. Art. 21.49-4a.)

Source Law

Art. 21.49-4a. Contracts of professional liability insurance issued by a health care liability claim trust created under Article 21.49-4, Insurance

Code, may include any of the following:

(1) Coverage of professional associations and partnerships of physicians against health care liability claims and related risks where a majority of the persons having a proprietary interest in the professional association or partnership to be insured are members of the association that created such trust.

(2) Coverage of proprietary members, associates, and stockholders of such professional associations and partnerships and executive officers and directors thereof, with respect to potential vicarious liability for acts or omissions of others giving rise to health care liability claims and related risks.

(3) Coverage of insured physicians and, as applicable, insured professional associations and partnerships (including proprietary members, associates, and stockholders thereof and executive officers and directors thereof) with respect to liability on the part of any applicable insured arising out of:

(i) injuries to patients related to ownership, maintenance, or use of premises for the practice of medicine, including operations necessary or incidental thereto; or

(ii) service by an insured physician as a member of a duly established committee, board, or similar group of a hospital medical staff or of a professional association or society with respect to medical staff privileges, accreditation, or disciplinary matters relating to competency or patient safety and risk reduction programs; or

(iii) health care liability claims or related risks based in whole or in part upon any act or omission occurring prior to the date a contract of professional insurance is issued by such trust.

(4) Coverage of an applicant for membership in the association that created such trust, pending final action upon such application, with respect to health care liability claims and related risks, including coverages described in the preceding Subparagraphs (1), (2), and (3), as applicable.

Revisor's Note

V.T.I.C. Article 21.49-4a refers to a "duly established" committee, board, or similar group. The revised law omits the quoted language as unnecessary because the phrase does not add to the clear meaning of the law. A committee, board, or similar group does not exist if it is not established.

CHAPTER 2213. SELF-INSURANCE TRUSTS FOR BANKS AND SAVINGS AND LOAN ASSOCIATIONS

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CHAPTER 2213. SELF-INSURANCE TRUSTS FOR BANKS AND SAVINGS AND LOAN ASSOCIATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2213.001. DEFINITIONS. In this chapter:

(1) "Bank" means a bank chartered under federal or state law.

(2) "Plan" means a self-insurance trust's plan of organization and operation.

(3) "Savings and loan association" means a savings and loan association chartered under federal or state law.

(4) "Self-insurance trust" means a self-insurance trust organized and operated under this chapter.

(5) "Trustees" means the trustees of a self-insurance trust. (V.T.I.C. Art. 21.49-6, Secs. 1(1), (3); Art. 21.49-7, Secs. 1(1) (part), (3); New.)

Source Law

Art. 21.49-6
Sec. 1. In this article:
(1) "Bank" means any bank chartered under the provisions of federal or state law.

(3) "Trustees" means the trustees of a self-insurance trust created under this article.

Art. 21.49-7
Sec. 1. In this article:
(1) "Savings and loan association" means a savings and loan association chartered under federal or state law . . . .

(3) "Trustees" means the trustees of a self-insurance trust created under this article.

Revisor's Note

(1) Section 1(2), V.T.I.C. Article 21.49-6, and Section 1(2), V.T.I.C. Article 21.49-7, define "board" as 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 board have been changed appropriately. For this reason, the revised law omits the definitions of "board." The omitted law reads:

[Art. 21.49-6]
[Sec. 1. In this article:]

(2) "Board" means the State Board of Insurance.

[Art. 21.49-7]
[Sec. 1. In this article:]

(2) "Board" means the State Board of Insurance.

(2) The revised law adds a definition of "plan" and a definition of "self-insurance trust" for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definitions.

Revised Law

Sec. 2213.002. SELF-INSURANCE TRUST NOT ENGAGED IN BUSINESS

OF INSURANCE. (a) A self-insurance trust is not engaged in the business of insurance under this code or other laws of this state.

(b) Other than this chapter, the provisions of this code, including the Texas Property and Casualty Insurance Guaranty Act, Chapter 462, do not apply to a self-insurance trust. (V.T.I.C. Art. 21.49-6, Sec. 11; Art. 21.49-7, Sec. 11.)

Source Law

[Art. 21.49-6]

Sec. 11. A self-insurance trust created under this article is not engaged in the business of insurance under this code and under other laws of this state, and the provisions of any chapters or articles of this code, including Article 21.28-C, are declared inapplicable to a trust organized and operated under this article.

[Art. 21.49-7]

Sec. 11. A trust created under this article is not engaged in the business of insurance under this code and under other laws of this state, and this code, including the Texas Property and Casualty Insurance Guaranty Act (Article 21.28-C, Vernon's Texas Insurance Code), is inapplicable to a trust organized and operated under this article.

Revised Law

Sec. 2213.003. RULES. The commissioner may adopt:

(1) necessary rules to carry out the provisions of this chapter relating to bank self-insurance trusts; and

(2) reasonable rules necessary to carry out the provisions of this chapter relating to savings and loan self-insurance trusts. (V.T.I.C. Art. 21.49-6, Sec. 10; Art. 21.49-7, Sec. 10.)

Source Law

[Art. 21.49-6]

Sec. 10. The board may adopt necessary rules to carry out the provisions of this article.

[Art. 21.49-7]

Sec. 10. The board may adopt reasonable rules that are necessary to carry out this article.

[Sections 2213.004-2213.050 reserved for expansion]

SUBCHAPTER B. CREATION AND OPERATION OF SELF-INSURANCE TRUST

Revised Law

Sec. 2213.051. CREATION OF BANK SELF-INSURANCE TRUST; COVERAGE. (a) A group or association of banks or bankers, composed

of any number of members, may create a bank self-insurance trust to self-insure banks that are members of the group or association, or that have any officers who are members of the group or association, against losses described by this section.

(b) The bank self-insurance trust may self-insure a bank described by Subsection (a) against losses resulting from:

(1) dishonest acts and criminal acts of employees;

(2) a robbery or other act commonly included within a bank's bond coverage; and

(3) indemnification for a wrongful act committed by a director, officer, or employee of a member of the group or association, subject to the limitations under Chapter 8, Business Organizations Code.

(c) The trustees shall determine, according to the plan, the amount of coverage to be provided to a bank participating in the bank self-insurance trust.

(d) Notwithstanding Subsection (b), on or before December 31, 2009, the bank self-insurance trust may self-insure a bank described by Subsection (a) against losses resulting from:

(1) dishonest acts and criminal acts of employees;

(2) a robbery or other act commonly included within a bank's bond coverage; and

(3) indemnification for a wrongful act committed by a director, officer, or employee of a member of the group or association, subject to the limitations under Article 2.02-1, Texas Business Corporation Act, or Chapter 8, Business Organizations Code, as applicable.

(e) This subsection and Subsection (d) expire January 1, 2010. (V.T.I.C. Art. 21.49-6, Secs. 2, 7 (part).)

Source Law

Sec. 2. On approval of its plan of organization and operation as provided in Section 3 of this article, a group or association of banks or bankers, composed of any number of members, may create a trust to self-insure banks that are members of the group or association or any of whose officers are members of the group or association against losses resulting from (a)

dishonest acts and criminal acts of employees or losses resulting from robbery or other acts commonly included within a bank's bond coverage, and (b) indemnification for wrongful acts committed by directors, officers, and employees of a member of the group or association subject to the limitations contained in Article 2.02-1, Texas Business Corporation Act.

Sec. 7. The amount of coverage to be provided banks participating in the trust and . . . shall be determined by the trustees as provided in the plan.

Revisor's Note

(1) Section 2, V.T.I.C. Article 21.49-6, states that a bank self-insurance trust may be created "[o]n approval of its plan of organization and operation as provided in Section 3 of this article." The revised law omits the quoted language as unnecessary because it duplicates the requirements established by Section 3, Article 21.49-6, revised in this chapter as Section 2213.053.

(2) Section 2, V.T.I.C. Article 21.49-6, refers to Article 2.02-1, Texas Business Corporation Act. Article 2.02-1 was codified as Chapter 8, Business Organizations Code, by Chapter 182, Acts of the 78th Legislature, Regular Session, 2003. The Business Organizations Code takes effect January 1, 2006, and applies only to domestic business entities formed on or after that date, to domestic business entities formed before that date that elect to have that code govern their operations, and to certain foreign business entities. On January 1, 2010, the Texas Business Corporation Act expires, and the Business Organizations Code will apply to all business entities without regard to date of formation or whether an entity is a foreign or domestic business entity. The revised law is drafted to reflect the applicability of these statutes in accordance with their effective dates or on election by a business entity.

Revised Law

Sec. 2213.052. CREATION OF SAVINGS AND LOAN SELF-INSURANCE TRUST; COVERAGE. (a) Two or more savings and loan associations that have their principal offices located in this state may create a savings and loan self-insurance trust to provide insurance and indemnity coverage for the savings and loan self-insurance trust's members and the officers and directors of the savings and loan self-insurance trust's members.

(b) Insurance and indemnity coverage provided by the savings and loan self-insurance trust is limited to savings and loan blanket bonds covering losses resulting from:

(1) dishonest acts and criminal acts of employees; or

(2) robbery.

(c) The trustees shall determine, according to the plan, the amount of coverage to be provided to a savings and loan association participating in the savings and loan self-insurance trust. (V.T.I.C. Art. 21.49-7, Secs. 1(1) (part), 2, 7 (part).)

Source Law

Sec. 1. [In this article:]

(1) ["Savings and loan association" means a savings and loan association] . . . whose principal office is located in this state.

Sec. 2. (a) Two or more savings and loan associations may create a trust under this article to provide insurance and indemnity coverage for its members and their officers and directors.

(b) Insurance and indemnity coverage provided by the trust shall be limited to savings and loan blanket bonds covering losses resulting from dishonest acts and criminal acts of employees or losses resulting from robbery or both.

Sec. 7. The trustees shall determine in accordance with the plan the amount of coverage to be provided savings and loan associations participating in the trust and . . . .

Revised Law

Sec. 2213.053. PLAN OF ORGANIZATION AND OPERATION; TRUSTEES. (a) Before organizing and operating a self-insurance trust, the group or association of banks or bankers or the savings and loan associations, as applicable, proposing to organize the self-insurance trust shall:

(1) select trustees to administer the self-insurance trust; and

(2) prepare a detailed plan of organization and operation in the form and manner prescribed by the commissioner.

(b) The group or association of banks or bankers or the savings and loan associations shall submit the proposed plan to the commissioner for examination, suggested changes, and final approval.

(c) The commissioner shall approve the proposed plan only if the commissioner is satisfied that the self-insurance trust is able and will continue to be able to pay valid claims made to the self-insurance trust.

(d) After final approval, the plan may be amended with the commissioner's approval. (V.T.I.C. Art. 21.49-6, Secs. 3, 4; Art. 21.49-7, Secs. 3, 4.)

Source Law

[Art. 21.49-6]

Sec. 3. Before organizing and operating a trust as provided in this article, the group or association proposing to organize the trust shall select trustees to administer the trust and shall prepare a detailed plan of organization and operation in the form and manner prescribed by the board. The plan shall be submitted to the board for examination, suggested changes, and final approval, and may be amended from time to time with the approval of the board.

Sec. 4. The board shall approve a self-insurance plan under this article only if it is satisfied that the trust has and will continue to possess the ability to pay valid claims made against it.

[Art. 21.49-7]

Sec. 3. Before organizing and operating a trust under this article, the savings and loan associations proposing to organize the trust shall select trustees to administer the trust and shall prepare a detailed plan of organization and operation in the form and manner prescribed by the board. The proposed plan shall be submitted to the board for examination, suggested changes, and final approval. After final approval the plan may be amended with the approval of the board.

Sec. 4. The board shall approve a proposed plan under this article only if it is satisfied that the trust has and will continue to possess the ability to pay valid claims made to it.

Revisor's Note

Section 3, V.T.I.C. Article 21.49-6, provides

that a plan of organization and operation for a self-insurance trust may be amended "from time to time." The revised law omits "from time to time" as unnecessary because, without an express limitation, the authority to amend the plan includes the authority to amend the plan "from time to time."

Revised Law

Sec. 2213.054. MINIMUM REQUIREMENTS; COMMISSIONER SUPERVISION. (a) After approval of a self-insurance trust's plan, the self-insurance trust is subject to continuing supervision by the commissioner relating to:

(1) the solvency of the self-insurance trust; and

(2) the approval of the self-insurance trust's policy forms.

(b) The commissioner may set minimum requirements to ensure that a self-insurance trust is able to satisfy the self-insurance trust's contractual obligations. (V.T.I.C. Art. 21.49-6, Sec. 9; Art. 21.49-7, Sec. 9.)

Source Law

[Art. 21.49-6]

Sec. 9. A self-insurance trust approved by the board under the provisions of this article is subject to the continuing supervision of the board relating to its solvency and to approval of its policy forms, and the board may set certain minimum requirements to ensure the capability of the trust to satisfy its contractual obligations.

[Art. 21.49-7]

Sec. 9. A trust whose plan is approved by the board under this article is subject to the continuing supervision of the board relating to its solvency and to approval of its policy forms. The board may set certain minimum requirements to ensure the capability of the trust to satisfy its contractual obligations.

Revised Law

Sec. 2213.055. CREATION OF TRUST FUND. (a) The trustees shall create a trust fund to pay claims made under the coverage provided by the self-insurance trust under Section 2213.051 or 2213.052, as applicable.

(b) The trustees shall administer and control the trust fund

and shall pay claims from and invest the money of the trust fund as provided by the plan. (V.T.I.C. Art. 21.49-6, Sec. 5; Art. 21.49-7, Sec. 5.)

Source Law

[Art. 21.49-6]

Sec. 5. (a) The trustees of the self-insurance trust shall create a trust fund to pay claims made under the coverage provided in Section 2 of this article.

(b) The fund shall be under the administration and control of the trustees and shall be paid out on claims and shall be invested as provided in the plan.

[Art. 21.49-7]

Sec. 5. (a) The trustees of the trust shall create a trust fund to pay claims made under the coverage provided by the trust.

(b) The trustees shall administer and control the trust fund and shall pay claims and invest money of the trust fund as provided by the plan.

Revised Law

Sec. 2213.056. PERSONNEL; PAYMENT OF EXPENSES. (a) The trustees shall employ appropriate professional employees and consultants for management of the self-insurance trust program.

(b) The trustees shall pay the salaries of professional employees and consultants and other costs of administering the self-insurance trust program from the trust fund.

(c) The total amount paid for salaries and administration may not exceed an amount set by the commissioner. The amount set by the commissioner may not exceed 35 percent of the total amount of money in the trust fund in any year. (V.T.I.C. Art. 21.49-6, Sec. 8; Art. 21.49-7, Sec. 8.)

Source Law

[Art. 21.49-6]

Sec. 8. (a) The trustees shall employ appropriate professional staff and consultants for program management.

(b) Salaries for professional staff and consultants and for paying the costs of administering the trust program shall be paid from the trust fund; provided that, the total amount for payment of salaries and administration shall not exceed an amount fixed by the board but in no event to exceed 35 percent of the total amount of money in the trust fund in any one year.

[Art. 21.49-7]

Sec. 8. (a) The trustees shall employ appropriate professional staff and consultants for

management of the trust program.

(b) The trustees shall pay the salaries of professional staff and consultants and other costs of administering the trust program from the trust fund. The total amount paid for payment of salaries and administration may not exceed an amount fixed by the board, which amount may not exceed 35 percent of the total amount of money in the trust fund in any one year.

[Sections 2213.057-2213.100 reserved for expansion]

SUBCHAPTER C. PARTICIPATION IN SELF-INSURANCE TRUST

Revised Law

Sec. 2213.101. PARTICIPATION. A bank that is a member, or that has an officer who is a member, of a group or association of banks or bankers organizing a bank self-insurance trust or of savings and loan associations organizing a savings and loan self-insurance trust may participate in the applicable self-insurance trust by:

(1) entering into a contract or agreement with the trustees for coverage that the self-insurance trust may provide under Section 2213.051 or 2213.052, as applicable; and

(2) paying the required contribution to the trust fund in the amount determined by the trustees in accordance with the plan. (V.T.I.C. Art. 21.49-6, Secs. 6, 7 (part); Art. 21.49-7, Secs. 6, 7 (part).)

Source Law

[Art. 21.49-6]

Sec. 6. Any bank that is a member or any of whose officers are members of the group or association organizing the trust may participate in the self-insurance trust by entering into contract or agreement with the trustees for insurance under the trust against losses resulting from (a) dishonest acts or criminal acts of its employees or losses resulting from robbery or other acts commonly included within a bank's bond coverage, and (b) indemnification for wrongful acts committed by directors, officers, and employees of a member of the group or association subject to the limitations contained in Article 2.02-1, Texas Business Corporation Act. The bank or officers shall pay the required contribution to the trust fund.

Sec. 7. . . . the amount of contributions to be paid by those banks shall be determined by the trustees as provided in the plan.

[Art. 21.49-7]

Sec. 6. A savings and loan association that is one of the associations organizing the trust may participate in the trust by entering into contracts or

agreements with the trustees for insurance and indemnity coverage that the trust may provide and paying the required contribution to the trust fund.

Sec. 7. The trustees shall determine in accordance with the plan . . . the amount of contributions to be paid by those associations.

[Chapters 2214-2250 reserved for expansion]

SUBTITLE H. RATEMAKING IN GENERAL

CHAPTER 2251. RATES

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CHAPTER 2251. RATES

SUBCHAPTER A. GENERAL PROVISIONS FOR RATES

Revised Law

Sec. 2251.001. PURPOSE. The purposes of this subchapter and Subchapters B, C, D, and E are to:

(1) promote the public welfare by regulating insurance rates to prohibit excessive, inadequate, or unfairly discriminatory rates;

(2) promote the availability of insurance;

(3) promote price competition among insurers to provide rates and premiums that are responsive to competitive market conditions;

(4) prohibit price-fixing agreements and other anticompetitive behavior by insurers; and

(5) provide regulatory procedures for the maintenance of appropriate information reporting systems. (V.T.I.C. Art. 5.13-2, Sec. 1 (part).)

Source Law

> Sec. 1. . . . The purposes of this article are to:
>
> (1) promote the public welfare by regulating insurance rates to prohibit excessive, inadequate, or unfairly discriminatory rates;
>
> (2) promote availability of insurance;
>
> (3) promote price competition among insurers to provide rates and premiums that are responsive to competitive market conditions;
>
> (4) prohibit price-fixing agreements and other anticompetitive behavior by insurers;
>
> . . .
>
> (6) provide regulatory procedures for the maintenance of appropriate information reporting systems.

Revised Law

Sec. 2251.002. DEFINITIONS. In this chapter:

(1) "Disallowed expenses" includes:

(A) administrative expenses, other than acquisition, loss control, and safety engineering expenses, that exceed 110 percent of the industry median for those expenses;

(B) lobbying expenses;

(C) advertising expenses, other than for advertising:

(i) directly related to the services or products provided by the insurer; or

(ii) designed and directed at loss prevention;

(D) amounts paid by an insurer:

(i) as damages in an action brought against the insurer for bad faith, fraud, or any matters other than payment

under the insurance contract; or

(ii) as fees, fines, penalties, or exemplary damages for a civil or criminal violation of law;

(E) contributions to:

(i) social, religious, political, or fraternal organizations; or

(ii) organizations engaged in legislative advocacy;

(F) except as authorized by commissioner rule, fees and assessments paid to advisory organizations;

(G) any amount determined by the commissioner to be excess premiums charged by the insurer; and

(H) any unreasonably incurred expenses, as determined by the commissioner after notice and hearing.

(2) "Filer" means an insurer that files rates, prospective loss costs, or supplementary rating information under this chapter.

(3) "Prospective loss cost" means that portion of a rate that:

(A) does not include a provision for expenses or profit, other than loss adjustment expenses; and

(B) is based on historical aggregate losses and loss adjustment expenses projected by development to the ultimate value of those losses and expenses and projected through trending to a future point in time.

(4) "Rate" means the cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost, adjusted to account for the treatment of expenses, profit, and individual insurer variation in loss experience, before applying individual risk variations based on loss or expense considerations.

(5) "Rating manual" means a publication or schedule that lists rules, classifications, territory codes and descriptions, rates, premiums, and other similar information used

by an insurer to determine the applicable premium charged an insured.

(6) "Residential property insurance" means insurance coverage against loss to real or tangible personal property at a fixed location that is provided through a homeowners insurance policy, including a tenants insurance policy, a condominium owners insurance policy, or a residential fire and allied lines insurance policy.

(7) "Supplementary rating information" means any manual, rating schedule, plan of rules, rating rules, classification systems, territory codes and descriptions, rating plans, and other similar information used by the insurer to determine the applicable premium for an insured. The term includes factors and relativities, including increased limits factors, classification relativities, deductible relativities, premium discount, and other similar factors and rating plans such as experience, schedule, and retrospective rating.

(8) "Supporting information" means:

(A) the experience and judgment of the filer and the experience or information of other insurers or advisory organizations on which the filer relied;

(B) the interpretation of any other information on which the filer relied;

(C) a description of methods used in making a rate; and

(D) any other information the department requires to be filed. (V.T.I.C. Art. 5.13-2, Secs. 3(a)(1), (2), (4), (5), (6), (7), (8), (9); Art. 5.13-2C, Sec. 1(2).)

Source Law

[Art. 5.13-2]

Sec. 3. (a) In this article:

(1) "Disallowed expenses" includes:

(A) administrative expenses, not including acquisition, loss control, and safety engineering expenses, that exceed 110 percent of the industry median for those expenses;

(B) lobbying expenses;

(C) advertising expenses, other than

for advertising:

(i) directly related to the services or products provided by the insurer; or

(ii) designed and directed at loss prevention;

(D) amounts paid by an insurer:

(i) as damages in an action brought against the insurer for bad faith, fraud, or any matters other than payment under the insurance contract; or

(ii) as fees, fines, penalties, or exemplary damages for a civil or criminal violation of law;

(E) contributions to:

(i) social, religious, political, or fraternal organizations; or

(ii) organizations engaged in legislative advocacy;

(F) except as authorized by rule by the commissioner, fees and assessments paid to advisory organizations;

(G) any amount determined by the commissioner to be excess premiums charged by the insurer; and

(H) any unreasonably incurred expenses, as determined by the commissioner after notice and hearing.

(2) "Filer" means an insurer that files rates, prospective loss costs, or supplementary rating information under this article.

(4) "Prospective loss costs" means that portion of a rate that does not include provisions for profit or expenses, other than loss adjustment expenses, that is based on historical aggregate losses and loss adjustment expenses projected by development to their ultimate value and through trending to a future point in time.

(5) "Rate" means the cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost, with an adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, before any application of individual risk variations based on loss or expense considerations.

(6) "Rating manual" means a publication or schedule that lists rules, classifications, territory codes and descriptions, rates, premiums, and other similar information used by an insurer to determine the applicable premium charged an insured.

(7) "Residential property insurance" means insurance coverage against loss to real or tangible personal property at a fixed location that is provided through a homeowners policy, including a tenants policy, a condominium owners policy, or a residential fire and allied lines policy.

(8) "Supplementary rating information" means any manual, rating schedule, plan of rules, rating rules, classification systems, territory codes and descriptions, rating plans, and other similar information used by the insurer to determine the applicable premium for an insured. The term includes factors and relativities, including increased limits factors, classification relativities, deductible relativities, premium discount, and other similar factors and rating plans such as experience, schedule, and retrospective rating.

(9) "Supporting information" means:

(A) the experience and judgment of the filer and the experience or information of other insurers or advisory organizations relied on by the filer;

(B) the interpretation of any other information relied on by the filer;

(C) descriptions of methods used in making the rates; and

(D) any other information required by the department to be filed.

Art. 5.13-2C

Sec. 1. In this article:

(2) "Residential property insurance" means insurance coverage against loss to real or tangible personal property at a fixed location that is provided through a homeowners policy, including a tenants policy, a condominium owners policy, or a residential fire and allied lines policy.

Revisor's Note

(1) Section 3(a), V.T.I.C. Article 5.13-2, defines terms used in Article 5.13-2. Although some provisions revised in this chapter are derived from V.T.I.C. Article 5.13-2C, the revised law applies the definitions contained in Section 3(a) throughout this chapter. It is appropriate to apply those definitions throughout this chapter because the terms defined by Section 3(a) are not used in Article 5.13-2C, with the exception of the term "residential property insurance." However, that term is defined by both Section 3(a), Article 5.13-2, and Section 1(2), Article 5.13-2C, to have the same meaning.

(2) Section 3(a)(2), V.T.I.C. Article 5.13-2, defines "[f]iler" as an insurer that files certain specified information under "this article," meaning Article 5.13-2. Although this chapter also contains provisions derived from Article 5.13-2C, the revised law substitutes "this chapter" for "this article" because the only provisions revised in this chapter that relate to filing the specified information are derived from Article 5.13-2. Similar changes are made throughout this chapter in this context.

Revised Law

Sec. 2251.003. APPLICABILITY OF CERTAIN SUBCHAPTERS. (a) This subchapter and Subchapters B, C, D, and E apply to:

(1) an insurer to which Article 5.13 applies, other than the Texas Windstorm Insurance Association, the FAIR Plan Association, and the Texas Automobile Insurance Plan Association; and

(2) except as provided by Subsection (c), a Lloyd's plan, reciprocal or interinsurance exchange, and county mutual insurance company with respect to the lines of insurance described by Subsection (b).

(b) This subchapter and Subchapters B, C, D, and E apply to all lines of the following kinds of insurance written under an insurance policy or contract issued by an insurer authorized to engage in the business of insurance in this state:

(1) general liability insurance;

(2) residential and commercial property insurance, including farm and ranch insurance and farm and ranch owners insurance;

(3) personal and commercial casualty insurance, except as provided by Section 2251.004;

(4) medical professional liability insurance;

(5) fidelity and surety bonds other than criminal court appearance bonds;

(6) personal umbrella insurance;

(7) personal liability insurance;

(8) guaranteed auto protection (GAP) insurance;

(9) involuntary unemployment insurance;

(10) financial guaranty insurance;

(11) inland marine insurance;

(12) rain insurance;

(13) hail insurance on farm crops; and

(14) personal and commercial automobile insurance.

(c) Sections 2251.008, 2251.052, 2251.101, 2251.102,

2251.103, 2251.104, 2251.105, and 2251.107 do not apply to a Lloyd's plan or a reciprocal or interinsurance exchange with respect to commercial property insurance, inland marine insurance, rain insurance, or hail insurance on farm crops. (V.T.I.C. Art. 5.13-2, Secs. 1 (part), 2(a), 3(a)(3).)

Source Law

Art. 5.13-2

Sec. 1. This article governs the regulation of insurance described by Section 2 of this article. . . .

Sec. 2. (a) This article applies to all lines of the following insurance written under policies or contracts of insurance issued by an insurer authorized to engage in the business of insurance in this state:

(1) general liability insurance;

(2) residential and commercial property insurance, including farm and ranch insurance and farm and ranch owners insurance;

(3) personal and commercial casualty insurance, except as provided by Subsection (b) of this section;

(4) medical professional liability insurance;

(5) fidelity and surety bonds other than criminal court appearance bonds;

(6) personal umbrella insurance;

(7) personal liability insurance;

(8) guaranteed auto protection (GAP) insurance;

(9) involuntary unemployment insurance;

(10) financial guaranty insurance;

(11) inland marine insurance;

(12) rain insurance;

(13) hail insurance on farm crops; and

(14) personal and commercial automobile insurance.

Sec. 3. (a) In this article:

(3) "Insurer" means an insurer to which Article 5.13 of this code applies, but does not include the Texas Windstorm Insurance Association or the Texas FAIR Plan Association, or the Texas Automobile Insurance Plan Association. All provisions of this article shall apply to Lloyd's plans, reciprocals and interinsurance exchanges, and county mutual insurance companies with respect to the lines of insurance described in Section 2 of this article, except that the provisions of Sections 4, 5, 6, and 7 of this article shall not apply to Lloyd's or reciprocals with respect to commercial property insurance, and the provisions of Sections 4, 5, 6, 7, and 8 of this article shall not apply to Lloyd's or reciprocals with respect to inland marine insurance, rain insurance, or hail insurance on farm crops.

Revisor's Note

(1) Sections 1, 2(a), and 3(a)(3), V.T.I.C. Article 5.13-2, prescribe the applicability of Article

5.13-2, revised in this chapter as this subchapter and Subchapters B-E. Although it is clear that the applicability of Article 5.13-2 and V.T.I.C. Article 5.13-2C, revised in relevant part in this chapter as Section 2251.251, overlaps to some extent, to preserve the intent of the articles, their substance has been revised separately. Furthermore, the revised law substitutes a reference to "[t]his subchapter and Subchapters B, C, D, and E" for the references in Sections 1, 2(a), and 3(a)(3) to "[t]his article" to limit the applicability provisions of Article 5.13-2 to the revised law derived from that article.

(2) Section 3(a)(3), V.T.I.C. Article 5.13-2, refers to "Lloyd's" or "reciprocals." The revised law substitutes "Lloyd's plan" for "Lloyd's" because that is the term used in Chapter 941 of this code, which regulates Lloyd's plans. The revised law substitutes "reciprocal or interinsurance exchange" for "reciprocals" because that is the term used in Chapter 942 of this code, which regulates reciprocal and interinsurance exchanges.

(3) Section 3(a)(3), V.T.I.C. Article 5.13-2, refers to Section 8, Article 5.13-2. The revised law omits the reference to Section 8 as unnecessary in this context because that section relates only to policy forms and is revised in Chapter 2301 of this code, and that chapter contains a provision derived from Section 3(a)(3) that corresponds to this section.

Revised Law

Sec. 2251.004. REGULATION OF INLAND MARINE RATES. The commissioner shall adopt rules governing the manner in which rates for the various classifications of risks insured under inland marine insurance, as determined by the commissioner, are regulated. (V.T.I.C. Art. 5.13-2, Sec. 2(b) (part).)

Source Law

> (b) The commissioner shall adopt rules governing the manner in which . . . rates for the various classifications of risks insured under inland marine insurance, as determined by the commissioner, are regulated.

Revised Law

Sec. 2251.005. NOTICE OF RATE INCREASE FOR RESIDENTIAL PROPERTY INSURANCE POLICIES. (a) An insurer shall notify a policyholder of a residential property insurance policy issued by the insurer of a rate increase scheduled to take effect on the policy's renewal that will result in a premium amount to be paid by the policyholder that is at least 10 percent greater than the lesser of:

(1) the premium amount paid by the policyholder for coverage under the policy during the 12-month period preceding the policy's renewal date; or

(2) the premium amount paid by the policyholder for coverage under the policy during the policy period preceding the policy's renewal date.

(b) An insurer shall send the notice required by Subsection (a) before the renewal date and not later than the 30th day before the date the rate increase is scheduled to take effect.

(c) An insurer may send the notice described by Subsection (a) to any policyholder of a residential property insurance policy issued by the insurer, regardless of whether the policyholder's premium amount will increase as a result of the scheduled rate change.

(d) The commissioner by rule may exempt an insurer from the notice requirements of this section for a short-term policy, as defined by the commissioner, that is written by the insurer. (V.T.I.C. Art. 5.13-2, Sec. 15.)

Source Law

> Sec. 15. (a) An insurer shall send a policyholder of a policy of residential property insurance issued by the insurer notice of any rate increase scheduled to take effect on the renewal of the policy that will result in an increase in the premium

amount to be paid by the policyholder that is at least 10 percent greater than the lesser of the premium amount paid by the policyholder for coverage under the policy during:

(1) the 12-month period preceding the renewal date of the policy; or

(2) the policy period preceding the renewal date of the policy.

(b) An insurer shall send the notice required by Subsection (a) of this section before the renewal date but not later than the 30th day before the date the rate increase is scheduled to take effect.

(c) In addition to the mandatory notice under Subsection (a) of this section, the insurer may send the notice required by Subsection (a) of this section to any policyholder of residential property insurance issued by the insurer, regardless of whether that policyholder's premium amount to be paid will increase as a result of the scheduled rate change.

(d) The commissioner by rule may exempt an insurer from the notice requirements under this section for a short-term policy, as defined by the commissioner, that is written by the insurer.

Revised Law

Sec. 2251.006. CONSIDERATION OF CERTAIN OTHER LAW. In reviewing rates under this chapter, the commissioner shall consider any state or federal law that may affect rates for liability coverage included in an insurance policy subject to this chapter. (V.T.I.C. Art. 5.13-2, Sec. 14.)

Source Law

Sec. 14. In reviewing rates under this article, the commissioner shall consider any state or federal legislation that has been enacted and that may impact rates for liability coverage included in a policy subject to this article.

Revisor's Note

Section 14, V.T.I.C. Article 5.13-2, refers to the commissioner of insurance reviewing rates under "this article" and to an insurance policy subject to "this article," meaning Article 5.13-2. Although this chapter also contains provisions derived from Article 5.13-2C, the revised law substitutes "this chapter" for "this article" because the only provisions revised in this chapter under which the commissioner would review rates are derived from Article 5.13-2, and the commissioner would only be reviewing the rates under those provisions if the relevant insurance policies

were subject to those provisions.

Revised Law

Sec. 2251.007. ADMINISTRATIVE PROCEDURE ACT APPLICABLE. Chapter 2001, Government Code, applies to all rate hearings conducted under this chapter. (V.T.I.C. Art. 5.13-2, Sec. 10.)

Source Law

> Sec. 10. Chapter 2001, Government Code (the Administrative Procedure Act), applies to all rate hearings conducted under this article.

Revisor's Note

Section 10, V.T.I.C. Article 5.13-2, refers to rate hearings conducted under "this article," meaning Article 5.13-2. Although this chapter also contains provisions derived from Article 5.13-2C, the revised law substitutes "this chapter" for "this article" because the only provisions revised in this chapter under which a rate hearing would be conducted are derived from Article 5.13-2.

Revised Law

Sec. 2251.008. QUARTERLY REPORT OF INSURER; LEGISLATIVE REPORT. (a) The commissioner shall require each insurer subject to this subchapter to quarterly file with the commissioner information relating to changes in losses, premiums, and market share since January 1, 1993.

(b) Quarterly, the commissioner shall report to the governor, the lieutenant governor, and the speaker of the house of representatives regarding:

(1) the information provided to the commissioner in the insurers' reports under Subsection (a); and

(2) market conduct, especially consumer complaints. (V.T.I.C. Art. 5.13-2, Sec. 5(e).)

Source Law

> (e) The commissioner shall require each insurer subject to this article to file information with the commissioner on a quarterly basis. Each insurer shall provide the commissioner with information relating to changes in losses, premiums, and market share since

January 1, 1993. The commissioner shall report to the governor, lieutenant governor, and speaker of the house of representatives on a quarterly basis, relating to the information provided by the insurers' reports and to market conduct, especially consumer complaints.

[Sections 2251.009-2251.050 reserved for expansion]

SUBCHAPTER B. RATE STANDARDS

Revised Law

Sec. 2251.051. EXCESSIVE, INADEQUATE, AND UNFAIRLY DISCRIMINATORY RATES. (a) A rate is excessive, inadequate, or unfairly discriminatory for purposes of this chapter as provided by this section.

(b) A rate is excessive if the rate is likely to produce a long-term profit that is unreasonably high in relation to the insurance coverage provided.

(c) A rate is inadequate if:

(1) the rate is insufficient to sustain projected losses and expenses to which the rate applies; and

(2) continued use of the rate:

(A) endangers the solvency of an insurer using the rate; or

(B) has the effect of substantially lessening competition or creating a monopoly in a market.

(d) A rate is unfairly discriminatory if the rate:

(1) is not based on sound actuarial principles;

(2) does not bear a reasonable relationship to the expected loss and expense experience among risks; or

(3) is based wholly or partly on the race, creed, color, ethnicity, or national origin of the policyholder or an insured. (V.T.I.C. Art. 5.13-2, Sec. 3(b).)

Source Law

(b) For purposes of this article, a rate is:

(1) excessive if the rate is likely to produce a long-term profit that is unreasonably high in relation to the insurance coverage provided;

(2) inadequate if the rate is insufficient to sustain projected losses and expenses to which the rate applies, and continued use of the rate:

(A) endangers the solvency of an insurer using the rate; or

(B) has the effect of substantially lessening competition or creating a monopoly within any market; or

(3) unfairly discriminatory if the rate:

(A) is not based on sound actuarial principles;

(B) does not bear a reasonable relationship to the expected loss and expense experience among risks; or

(C) is based wholly or partly on the race, creed, color, ethnicity, or national origin of the policyholder or an insured.

Revisor's Note

Section 3(b), V.T.I.C. Article 5.13-2, specifies the criteria under which a rate is excessive, inadequate, or unfairly discriminatory for purposes of "this article," meaning Article 5.13-2. The provisions of Article 5.13-2 relating to rates are revised as Subchapters A-E of this chapter. Although Subchapter F is derived from V.T.I.C. Article 5.13-2C, the revised law substitutes "this chapter" for "this article" because the provisions revised in Subchapter F do not relate to whether a rate is excessive, inadequate, or unfairly discriminatory.

Revised Law

Sec. 2251.052. RATE STANDARDS. (a) In setting rates, an insurer shall consider:

(1) past and prospective loss experience:

(A) inside this state; and

(B) outside this state if the data from this state are not credible;

(2) the peculiar hazards and experiences of individual risks, past and prospective, inside and outside this state;

(3) the insurer's actuarially credible historical premium, exposure, loss, and expense experience;

(4) catastrophe hazards in this state;

(5) operating expenses, excluding disallowed expenses;

(6) investment income;

(7) a reasonable margin for profit; and

(8) any other factors inside and outside this state:

(A) determined to be relevant by the insurer; and

(B) not disallowed by the commissioner.

(b) A rate may not be excessive, inadequate, unreasonable, or unfairly discriminatory for the risks to which the rate applies.

(c) The insurer may:

(1) group risks by classification to establish rates and minimum premiums; and

(2) modify classification rates to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in those risks on the basis of any factor listed in Subsection (a).

(d) In setting rates that apply only to policyholders in this state, an insurer shall use available premium, loss, claim, and exposure information from this state to the full extent of the actuarial credibility of that information. The insurer may use experience from outside this state as necessary to supplement information from this state that is not actuarially credible.

(e) In determining rating territories and territorial rates, an insurer shall use methods based on sound actuarial principles. (V.T.I.C. Art. 5.13-2, Secs. 4(b), (c), (d), (e), (f).)

Source Law

(b) In setting rates, an insurer shall consider:

(1) past and prospective loss experience inside this state, and outside this state if the state data are not credible;

(2) the peculiar hazards and experiences of individual risks, past and prospective, inside and outside this state;

(3) the insurer's actuarially credible historical premium, exposure, loss, and expense experience;

(4) catastrophe hazards within this state;

(5) operating expenses, excluding disallowed expenses;

(6) investment income;

(7) a reasonable margin for profit; and

(8) any other factors inside and outside this state determined to be relevant by the insurer and not disallowed by the commissioner.

(c) The insurer may group risks by classifications for the establishment of rates and minimum premiums and may modify classification rates

to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in those risks on the basis of any factor listed in Subsection (b) of this section.

(d) Rates established under this article may not be excessive, inadequate, unreasonable, or unfairly discriminatory for the risks to which they apply.

(e) In setting rates applicable solely to policyholders in this state, an insurer shall use available premium, loss, claim, and exposure information from this state to the full extent of the actuarial credibility of that information. The insurer may use experience from outside this state as necessary to supplement information from this state that is not actuarially credible.

(f) In determining rating territories and territorial rates, an insurer shall use methods based on sound actuarial principles.

Revisor's Note

Section 4(a), V.T.I.C. Article 5.13-2, states that rates established under Article 5.13-2 must be made in accordance with the provisions of Section 4 of that article, which are revised as this section. The revised law omits Section 4(a) as unnecessary because the other provisions of Section 4 apply by their own terms to a rate established under Article 5.13-2. The omitted law reads:

> Sec. 4. (a) Rates under this article shall be made in accordance with the provisions of this section.

[Sections 2251.053-2251.100 reserved for expansion]

SUBCHAPTER C. RATE FILINGS

Revised Law

Sec. 2251.101. RATE FILINGS AND SUPPORTING INFORMATION. (a) Except as provided by Subchapter D, for risks written in this state, each insurer shall file with the commissioner all rates, applicable rating manuals, supplementary rating information, and additional information as required by the commissioner.

(b) The commissioner by rule shall determine the information required to be included in the filing, including:

(1) categories of supporting information and supplementary rating information;

(2) statistics or other information to support the rates to be used by the insurer, including information necessary to

evidence that the computation of the rate does not include disallowed expenses; and

(3) information concerning policy fees, service fees, and other fees that are charged or collected by the insurer under Section 550.001 or 4005.003. (V.T.I.C. Art. 5.13-2, Secs. 5(a), (a-1).)

Source Law

Sec. 5. (a) Except as provided by Section 5A of this article, each insurer shall file with the commissioner all rates, applicable rating manuals, supplementary rating information, and additional information as required by the commissioner for risks written in this state.

(a-1) The commissioner by rule shall determine the information required to be provided in the filing, including:

(1) the categories of supporting information;

(2) the categories of supplementary rating information;

(3) any statistics or other information to support the rates to be used by the insurer, including information necessary to evidence that the computation of the rate does not include disallowed expenses; and

(4) information concerning policy fees, service fees, and other fees that are charged or collected by the insurer under Article 21.35A or 21.35B of this code.

Revisor's Note

Section 5(a-1)(4), V.T.I.C. Article 5.13-2, refers to fees charged or collected under "[V.T.I.C.] Article 21.35A." That article was revised in 2003 as Subchapter A, Chapter 4005, of this code. Only Section 4005.003 of that subchapter deals with the charging of fees. The revised law is drafted accordingly.

Revised Law

Sec. 2251.102. FILING REQUIREMENTS FOR INSURERS WITH LESS THAN FIVE PERCENT OF MARKET. In determining filing requirements under Section 2251.101 for an insurer with less than five percent of the market, the commissioner shall consider insurer and market-specific attributes, as applicable. The commissioner shall determine filing requirements for those insurers accordingly to accommodate premium volume and loss experience, targeted markets, limitations on coverage, and any potential barriers to market entry

or growth. (V.T.I.C. Art. 5.13-2, Sec. 5(a-2).)

Source Law

> (a-2) For an insurer with less than five percent of the market, the commissioner shall consider insurer and market-specific attributes, as applicable, and shall promulgate filing requirements accordingly to accommodate premium volume and loss experience, targeted markets, limitations on coverage, and any potential barriers to market entry or growth.

Revised Law

Sec. 2251.103. DISAPPROVAL OF RATE IN RATE FILING; HEARING. (a) The commissioner shall disapprove a rate if the commissioner determines that the rate filing made under this chapter does not meet the standards established under Subchapter B.

(b) If the commissioner disapproves a filing, the commissioner shall issue an order specifying in what respects the filing fails to meet the requirements of this chapter.

(c) The filer is entitled to a hearing on written request made to the commissioner not later than the 30th day after the date the order disapproving the rate filing takes effect. (V.T.I.C. Art. 5.13-2, Secs. 7(a), (b).)

Source Law

> Sec. 7. (a) The commissioner shall disapprove a rate if the commissioner determines that the rate filing made under this article does not meet the standards established under that section.
>
> (b) If the commissioner disapproves a filing, the commissioner shall issue an order specifying in what respects the filing fails to meet the requirements of this article. The filer is entitled to a hearing on written request made to the commissioner not later than the 30th day after the effective date of the disapproval order.

Revisor's Note

Section 7(a), V.T.I.C. Article 5.13-2, states that the commissioner of insurance shall disapprove a rate if the commissioner determines that the rate filing made under "this article" does not meet the standards established under "that section." Section 7(b), Article 5.13-2, requires the commissioner to issue an order specifying in what respects the filing fails to meet the requirements of "this article." The

revised law substitutes a reference to "this chapter" for the references to "this article" because the provisions relating to making a rate filing are revised throughout this chapter and are all derived from Article 5.13-2. Similar changes are made throughout this chapter in this context. In addition, it is clear from the context that the reference in Section 7(a) to "that section" refers to rate filing standards established elsewhere in Article 5.13-2. Because the relevant portions of that article are revised in Subchapter B, the revised law substitutes a reference to Subchapter B for the reference to "that section."

Revised Law

Sec. 2251.104. DISAPPROVAL OF RATE IN EFFECT; HEARING. (a) The commissioner may disapprove a rate that is in effect only after a hearing. The commissioner shall provide the filer at least 20 days' written notice.

(b) The commissioner must issue an order disapproving a rate under Subsection (a) not later than the 15th day after the close of the hearing. The order must:

(1) specify in what respects the rate fails to meet the requirements of this chapter; and

(2) state the date on which further use of the rate is prohibited, which may not be earlier than the 45th day after the close of the hearing under this section. (V.T.I.C. Art. 5.13-2, Sec. 7(c).)

Source Law

(c) If the commissioner disapproves a rate that is in effect, the commissioner may issue a disapproval order only after a hearing held after at least 20 days' written notice to the insurer that made the filing. The disapproval order must be issued not later than the 15th day after the close of the hearing and must specify how the rate fails to meet the requirements of this article. The disapproval order must state the date on which the further use of that rate is prohibited. The commissioner shall set the date not earlier than the 45th day after the date on which the

hearing closes.

Revisor's Note

Section 7(c), V.T.I.C. Article 5.13-2, refers to an order that specifies in what respects a rate fails to meet the requirements of "this article," meaning Article 5.13-2. Although provisions of this chapter are also derived from Article 5.13-2C, the revised law substitutes "this chapter" for "this article" because the only provisions that relate to the requirements for rates and that are revised in this chapter are derived from Article 5.13-2.

Revised Law

Sec. 2251.105. GRIEVANCE. (a) An insured who is aggrieved with respect to any filing under this chapter that is in effect, or the public insurance counsel, may apply to the commissioner in writing for a hearing on the filing. The application must specify the grounds for the applicant's grievance.

(b) The commissioner shall hold a hearing on an application filed under Subsection (a) not later than the 30th day after the date the commissioner receives the application if the commissioner determines that:

(1) the application is made in good faith;

(2) the applicant would be aggrieved as alleged if the grounds specified in the application were established; and

(3) the grounds specified in the application otherwise justify holding the hearing.

(c) The commissioner shall provide written notice of a hearing under Subsection (b) to the applicant and each insurer that made the filing not later than the 10th day before the date of the hearing.

(d) If, after the hearing, the commissioner determines that the filing does not meet the requirements of this chapter, the commissioner shall issue an order:

(1) specifying in what respects the filing fails to

meet those requirements; and

(2) stating the date on which the filing is no longer in effect, which must be within a reasonable period after the order date.

(e) The commissioner shall send copies of the order issued under Subsection (d) to the applicant and each affected insurer. (V.T.I.C. Art. 5.13-2, Secs. 5(c), (d).)

Source Law

> (c) An insured that is aggrieved with respect to any filing in effect, or the public insurance counsel, may make a written application to the commissioner for a hearing on the filing. The application must specify the grounds on which the applicant bases the grievance. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if the grounds in the application are established, and that those grounds otherwise justify holding the hearing, the commissioner shall hold a hearing not later than the 30th day after the date of receipt of the application. The commissioner must give at least 10 days' written notice to the applicant and to each insurer that made the filing in question.
>
> (d) If, after the hearing, the commissioner finds that the filing does not meet the requirements of this article, the commissioner shall issue an order specifying how the filing fails to meet the requirements of this article and stating the date on which, within a reasonable period after the order date, the filing is no longer in effect. The commissioner shall send copies of the order to the applicant and to each affected insurer.

Revisor's Note

Section 7(d), V.T.I.C. Article 5.13-2, refers to an order specifying in what respects a filing fails to meet the requirements of "this article," meaning Article 5.13-2. The revised law substitutes "this chapter" for "this article" for the reason stated in the revisor's note to Section 2251.104.

Revised Law

Sec. 2251.106. ROLE OF PUBLIC INSURANCE COUNSEL. (a) On request to the commissioner, the public insurance counsel may review all rate filings and additional information provided by an insurer under this chapter. Confidential information reviewed under this subsection remains confidential.

(b) The public insurance counsel, not later than the 30th day after the date of a rate filing under this chapter, may file with the commissioner a written objection to:

(1) an insurer's rate filing; or

(2) the criteria on which the insurer relied to determine the rate.

(c) A written objection filed under Subsection (b) must contain the reasons for the objection. (V.T.I.C. Art. 5.13-2, Sec. 16.)

Source Law

> Sec. 16. (a) On request to the commissioner, the public insurance counsel may review all rate filings and additional information provided by an insurer under this article. Confidential information reviewed under this subsection remains confidential.
>
> (b) The public insurance counsel, not later than the 30th day after the date of a rate filing under this article, may object to an insurer's rate filing or the criteria relied on by the insurer to determine the rate by filing a written objection with the commissioner. The written objection must contain the reasons for the objection.

Revised Law

Sec. 2251.107. PUBLIC INSPECTION OF INFORMATION. Each filing made, and any supporting information filed, under this chapter is open to public inspection as of the date of the filing. (V.T.I.C. Art. 5.13-2, Sec. 6.)

Source Law

> Sec. 6. Each filing and any supporting information filed under this article is open to public inspection as of the date of the filing.

[Sections 2251.108-2251.150 reserved for expansion]

SUBCHAPTER D. PRIOR APPROVAL OF RATES UNDER CERTAIN CIRCUMSTANCES

Revised Law

Sec. 2251.151. REQUIREMENT TO FILE RATES FOR PRIOR APPROVAL UNDER CERTAIN CIRCUMSTANCES. (a) The commissioner by order may require an insurer to file with the department for the commissioner's approval all rates, supplementary rating information, and any supporting information in accordance with this

subchapter if the commissioner determines that:

(1) the insurer's rates require supervision because of the insurer's financial condition or rating practices; or

(2) a statewide insurance emergency exists.

(b) From the date of the filing of the rate with the department to the effective date of the new rate, the insurer's previously filed rate that is in effect on the date of the filing remains in effect.

(c) The commissioner may require an insurer to file the insurer's rates under this section until the commissioner determines that the conditions described by Subsection (a) no longer exist.

(d) For purposes of this section, a rate is filed with the department on the date the department receives the rate filing. (V.T.I.C. Art. 5.13-2, Secs. 5A(a), (b) (part), (j), (m).)

Source Law

> Sec. 5A. (a) The commissioner by order may require an insurer to file with the commissioner all rates, supplementary rate information, and any supporting information as prescribed by this section if the commissioner determines that:
>
> (1) an insurer's rates require supervision because of the insurer's financial condition;
>
> (2) an insurer's rates require supervision because of the insurer's rating practices; or
>
> (3) a statewide insurance emergency exists.
>
> (b) . . . [an insurer may not use a rate until the rate has been filed with the department and] approved by the commissioner . . . . For purposes of this section, a rate is filed with the department on the date the rate filing is received by the department.
>
> (j) From the date of the filing of the rate with the department to the effective date of the new rate, the insurer's previously filed rate that is in effect on the date of the filing remains in effect.
>
> (m) The commissioner may require an insurer to file the insurer's rates under this section until the commissioner determines that the conditions described by Subsection (a) of this section no longer exist.

Revised Law

Sec. 2251.152. RATE APPROVAL REQUIRED; EXCEPTION. (a) An insurer subject to this subchapter may not use a rate until the rate has been filed with the department and approved by the commissioner

in accordance with this subchapter.

(b) Notwithstanding Subsection (a), after a rate filing is approved under this subchapter, an insurer, without prior approval of the commissioner, may use any rate subsequently filed by the insurer if the subsequently filed rate does not exceed the lesser of:

(1) 107.5 percent of the rate approved by the commissioner; or

(2) 110 percent of any rate used by the insurer in the previous 12-month period.

(c) Filed rates under Subsection (b) take effect on the date specified by the insurer. (V.T.I.C. Art. 5.13-2, Secs. 5A(b) (part), (k).)

Source Law

> (b) Except as provided by Subsection (k) of this section, an insurer may not use a rate until the rate has been filed with the department and approved by the commissioner as provided by this section. . . .
>
> (k) After approval of a rate filing under this section, an insurer may use any rate subsequently filed by the insurer, without prior approval of the commissioner, if the subsequently filed rate does not exceed the lesser of 107.5 percent of the rate approved by the commissioner or 110 percent of any rate used by the insurer within the previous 12-month period. Filed rates under this subsection take effect on the date specified by the insurer.

Revised Law

Sec. 2251.153. COMMISSIONER ACTION. (a) Not later than the 30th day after the date a rate is filed with the department under this subchapter, the commissioner shall:

(1) approve the rate if the commissioner determines that the rate complies with the requirements of this chapter; or

(2) disapprove the rate if the commissioner determines that the rate does not comply with the requirements of this chapter.

(b) Except as provided by Subsection (c), if a rate has not been approved or disapproved by the commissioner before the expiration of the 30-day period described by Subsection (a), the rate is considered approved and the insurer may use the rate unless

the rate proposed in the filing represents an increase of 12.5 percent or more from the insurer's previously filed rate.

(c) For good cause, the commissioner may, on the expiration of the 30-day period described by Subsection (a), extend the period for approval or disapproval of a rate for one additional 30-day period. The commissioner and the insurer may not by agreement extend the 30-day period described by Subsection (a). (V.T.I.C. Art. 5.13-2, Secs. 5A(c), (d), (e), (f).)

Source Law

> (c) Not later than the 30th day after the date the rate is filed with the department, the commissioner shall:
>
> (1) approve the rate if the commissioner determines that the rate complies with the requirements of this article; or
>
> (2) disapprove the rate if the commissioner determines that the rate does not comply with the requirements of this article.
>
> (d) Except as provided by Subsection (f) of this section, if the rate has not been approved or disapproved by the commissioner before the expiration of the 30-day period described by Subsection (c) of this section, the rate is considered approved and the insurer may use the rate unless the rate proposed in the filing represents an increase of 12.5 percent or more from the insurer's prior filed rate.
>
> (e) The commissioner and the insurer may not by agreement extend the 30-day period described by Subsection (c) of this section.
>
> (f) For good cause, the commissioner may extend the period for approval or disapproval of a rate for one additional 30-day period on the expiration of the 30-day period described by Subsection (c) of this section.

Revisor's Note

Section 5A(c), V.T.I.C. Article 5.13-2, refers to compliance of a rate with the requirements of "this article," meaning Article 5.13-2. The revised law substitutes "this chapter" for "this article" for the reason stated in the revisor's note to Section 2251.104.

Revised Law

Sec. 2251.154. ADDITIONAL INFORMATION. (a) If the department determines that the information filed by an insurer under this chapter is incomplete or otherwise deficient, the department may request additional information from the insurer. If

the department requests additional information from the insurer during the 30-day period provided by Section 2251.153(a) or under a second 30-day period provided under Section 2251.153(c), the time between the date the department submits the request to the insurer and the date the department receives the information requested is not included in the computation of the first 30-day period or the second 30-day period, as applicable.

(b) For purposes of this section, the date of the department's submission of a request for additional information is:

(1) the date of the department's electronic mailing or telephone call relating to the request for additional information; or

(2) the postmarked date on the department's letter relating to the request for additional information. (V.T.I.C. Art. 5.13-2, Sec. 5A(g).)

Source Law

> (g) If the department determines that the information filed by the insurer under this article is incomplete or otherwise deficient, the department may request additional information from the insurer. If the department requests additional information from the insurer during the first 30-day review period provided under Subsection (c) of this section or under the second 30-day review period provided under Subsection (f) of this section, the period of time between the date of the department's submission of the request for additional information to the insurer and the date of the receipt of the additional information by the department from the insurer is not counted to determine what constitutes the first 30-day review period or the second 30-day review period. For purposes of this subsection, the date of the department's submission of the request for additional information is the date of the electronic mailing or telephone call or the postmarked date on the department's letter relating to the request for additional information.

Revised Law

Sec. 2251.155. RATE FILING APPROVAL BY COMMISSIONER; USE OF RATE. (a) The commissioner shall approve a rate filing under this subchapter if the proposed rate is adequate, not excessive, and not unfairly discriminatory.

(b) If the commissioner approves a rate filing under this section, the commissioner shall provide the insurer with a written

or electronic notification of the approval. The insurer may use the rate on receipt of the approval notice. (V.T.I.C. Art. 5.13-2, Secs. 5A(h), (i).)

Source Law

> (h) The commissioner shall approve the rate filing if the proposed rate is adequate, not excessive, and not unfairly discriminatory.
>
> (i) If the commissioner approves a rate filing, the commissioner shall provide written or electronic notification of the approval to the insurer. On receipt of the notice of the commissioner's approval of a rate, the insurer may use the rate.

Revised Law

Sec. 2251.156. RATE FILING DISAPPROVAL BY COMMISSIONER; HEARING. (a) If the commissioner disapproves a rate filing under Section 2251.153(a)(2), the commissioner shall issue an order disapproving the filing in accordance with Section 2251.103(b).

(b) An insurer whose rate filing is disapproved is entitled to a hearing in accordance with Section 2251.103(c). (V.T.I.C. Art. 5.13-2, Sec. 5A(l).)

Source Law

> (l) If the commissioner disapproves a rate filing under Subsection (c)(2) of this section, the commissioner shall issue an order in the manner prescribed by Section 7(b) of this article. The insurer is entitled to a hearing in accordance with Section 7(b) of this article.

[Sections 2251.157-2251.200 reserved for expansion]

SUBCHAPTER E. STANDARD RATE INDEX FOR PERSONAL AUTOMOBILE INSURANCE

Revised Law

Sec. 2251.201. APPLICABILITY OF SUBCHAPTER. (a) This subchapter governs rate regulation of personal automobile insurance issued by a county mutual insurance company as prescribed by this subchapter.

(b) The commissioner by rule may designate other types of insurers that, historically and as of June 11, 2003, have served exclusively or are serving exclusively the high-risk, nonstandard market and meet capitalization and solvency requirements set by the commissioner. An insurer designated by the commissioner under this

subsection is governed by this subchapter. (V.T.I.C. Art. 5.13-2, Secs. 13(a), (g).)

Source Law

> Sec. 13. (a) This section governs rate regulation of personal automobile insurance issued by a county mutual insurance company as prescribed by this section.
>
> (g) The commissioner by rule may designate other types of insurers that historically and as of the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003, have served exclusively or are serving exclusively the high-risk, nonstandard market and meet capitalization and solvency requirements set by the commissioner. An insurer designated by the commissioner under this subsection is governed by this section.

Revisor's Note

Section 13(g), V.T.I.C. Article 5.13-2, refers to "the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003." Although portions of that bill took effect on various dates, the bill had a general effective date of June 11, 2003. For that reason, the revised law substitutes "June 11, 2003," for the quoted language.

Revised Law

Sec. 2251.202. STATEWIDE STANDARD RATE INDEX FOR PERSONAL AUTOMOBILE INSURANCE. (a) Using standard and generally accepted actuarial techniques, the commissioner shall annually compute and publish a statewide standard rate index that accurately reflects the average statewide rates for classifications for each of the following coverages under a personal automobile insurance policy:

(1) bodily injury liability;

(2) property damage liability;

(3) personal injury protection;

(4) medical payments;

(5) uninsured and underinsured motorist;

(6) physical damage--collision; and

(7) physical damage--other than collision.

(b) The commissioner shall compute the rate index using the

benchmark rate in effect for personal automobile insurance under former Article 5.101 on June 11, 2003. The commissioner shall adjust the rate index annually to reflect average changes in claims costs in the personal automobile insurance market in this state. (V.T.I.C. Art. 5.13-2, Secs. 13(b), (c) (part).)

Source Law

> (b) Using standard and generally accepted actuarial techniques, the commissioner shall annually compute and publish a statewide standard rate index that accurately reflects the average statewide rates for classifications for each of the following coverages for personal automobile insurance policies:
>
> (1) bodily injury liability;
> (2) property damage liability;
> (3) personal injury protection;
> (4) medical payments;
> (5) uninsured and underinsured motorists;
> (6) physical damage--collision; and
> (7) physical damage--other than collision.
>
> (c) The commissioner shall compute the rate index using the benchmark rate in effect for personal automobile insurance under Article 5.101 of this code on the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003, and adjusted annually thereafter by the commissioner to reflect average changes in claims costs in the personal automobile insurance market in this state. . . .

Revisor's Note

(1) Section 13(c), V.T.I.C. Article 5.13-2, refers to "the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003." The revised law substitutes "June 11, 2003," for the quoted language for the reason stated in the revisor's note to Section 2251.201.

(2) Section 13(c), V.T.I.C. Article 5.13-2, in part allows the commissioner of insurance to adjust the computation of the rate index required by Section 13, Article 5.13-2, "[a]fter the effective date of [Chapter 206,] S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003, and before the first annual adjustment by the commissioner" under other parts of Section 13(c), revised in this section. The revised law omits the referenced language as

executed because the effective date of Chapter 206 was June 11, 2003, and the first annual adjustment occurred approximately one year after that date. The omitted law reads:

> (c) . . . After the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003, and before the first annual adjustment by the commissioner, the commissioner may adjust the computation of the rate index under this section as the commissioner determines necessary.

Revised Law

Sec. 2251.203. ESTABLISHMENT OF OTHER STANDARD RATE INDEXES. The commissioner may compute and establish standard rate indexes other than the rate index required under Section 2251.202(a) for any of the personal automobile insurance coverages listed under that subsection as necessary to implement this subchapter. (V.T.I.C. Art. 5.13-2, Sec. 13(d).)

Source Law

> (d) The commissioner may compute and establish standard rate indexes other than the rate index required under Subsection (b) of this section for any of the personal automobile insurance coverages listed under that subsection as necessary to implement this section.

Revised Law

Sec. 2251.204. APPLICATION TO CERTAIN COUNTY MUTUAL INSURANCE COMPANIES. (a) For purposes of this subsection, a "nonstandard rate" is a rate that is 30 percent or more above the standard rate index as determined by the commissioner under this subchapter. A county mutual insurance company that issues personal automobile insurance policies only at nonstandard rates is subject to filing requirements, as determined by the commissioner by rule, if the insurance company and the company's affiliated companies or group has a market share of less than 3.5 percent.

(b) In setting rates, a county mutual insurance company subject to this section must comply with the rating standards established under Subchapter B. The commissioner may inspect the books and records of the company at any time to ensure compliance

with the rating standards.

(c) Not later than the first day any change in the rates of a county mutual insurance company subject to this section takes effect, the company shall file for informational purposes those rates and any additional information required by the department. The commissioner by rule shall determine the information required to be provided in the filing under this subsection.

(d) A county mutual insurance company described by Subsection (a) is subject to Chapter 2254. A county mutual insurance company not described by Subsection (a) is:

(1) subject to Chapter 2151; and

(2) required to comply with the other filing requirements of this chapter and any other provision of this code applicable to a county mutual insurance company. (V.T.I.C. Art. 5.13-2, Secs. 13(e), (f).)

Source Law

(e) For purposes of this section, "nonstandard rates" means rates that are 30 percent or more above the standard rate index as determined by the commissioner under this section.

(f) A county mutual insurance company that issues personal automobile insurance policies only at nonstandard rates is subject to filing requirements as determined by the commissioner by rule if the insurer and the insurer's affiliated companies or group have a market share of less than 3.5 percent. In setting rates, an insurance company subject to this subsection must comply with the rating standards established by this article. Not later than the first day on which any change in the rates becomes effective, the company shall for informational purposes file the rates and any additional information required by the department. The commissioner by rule shall determine the information required to be provided in the filing under this subsection. The commissioner may inspect the books and records of the company at any time to ensure compliance with the rating standards. An insurance company described by this subsection is subject to Article 5.144 of this code. A county mutual insurance company not described by this section is subject to Article 21.81 of this code and is required to comply with the filing requirements of this article and any other provision of this code applicable to a county mutual insurance company.

Revisor's Note

Section 13(f), V.T.I.C. Article 5.13-2, refers to rating standards established by, and the filing

requirements of, "this article," meaning Article 5.13-2. The revised law substitutes references to the rating standards established under "Subchapter B" and the filing requirements of "this chapter" for the reasons stated in the revisor's note to Section 2251.103.

[Sections 2251.205-2251.250 reserved for expansion]

SUBCHAPTER F. EXEMPTIONS FOR CERTAIN INSURERS FROM RATE FILING AND APPROVAL REQUIREMENTS

Revised Law

Sec. 2251.251. APPLICABILITY OF SUBCHAPTER. This subchapter applies to:

(1) an insurer, including an insurance company, a reciprocal or interinsurance exchange, a mutual insurance company, a capital stock insurance company, a county mutual insurance company, a Lloyd's plan, or any other legal entity authorized to write residential property insurance in this state; and

(2) an insurer's affiliate, as described by this code, if the affiliate is authorized to write residential property insurance. (V.T.I.C. Art. 5.13-2C, Sec. 1(1).)

Source Law

Art. 5.13-2C
Sec. 1. In this article:
(1) "Insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, or other legal entity authorized to write residential property insurance in this state. The term includes an affiliate, as described by this code, if that affiliate is authorized to write residential property insurance.

Revised Law

Sec. 2251.252. EXEMPTION FROM CERTAIN OTHER LAW. (a) Except as provided by Subsections (b) and (c), an insurer is exempt from the rate filing and approval requirements of this chapter if the insurer, during the calendar year preceding the date filing is otherwise required under this chapter, issued residential property insurance policies in this state that accounted for less than two

percent of the total amount of premiums collected by insurers for residential property insurance policies issued in this state, more than 50 percent of which cover property:

(1) valued at less than $100,000; and

(2) located in an area designated by the commissioner as underserved for residential property insurance under Chapter 2004.

(b) If an insurer described by Subsection (a) is a member of an affiliated insurance group, this subchapter applies to the insurer only if the total aggregate premium collected by the group accounts for less than two percent of the total amount of premiums collected by insurers for residential property insurance policies issued in this state.

(c) An insurer described by Subsection (a) that proposes to increase the premium rates charged policyholders for a residential property insurance product by an amount that is 10 percent or more over the amount the insurer charged policyholders for the same or an equivalent residential property insurance product during the preceding calendar year must file the insurer's proposed rates in accordance with this chapter and, if applicable, obtain approval of the proposed rates as provided by this chapter. (V.T.I.C. Art. 5.13-2C, Secs. 2, 3(a), (b).)

Source Law

Sec. 2. (a) Except as provided by Subsection (b) of this section, this article applies only to an insurer that, during the calendar year preceding the date filing is otherwise required under Article 5.13-2 or 5.142 of this code, issued residential property insurance policies in this state that accounted for less than two percent of the total amount of premiums collected by insurers for residential property insurance policies issued in this state, more than 50 percent of which cover property:

(1) valued at less than $100,000; and

(2) located in an area designated by the commissioner as underserved for residential property insurance under Article 5.35-3 of this code.

(b) If an insurer described by Subsection (a) of this section is a member of an affiliated insurance group, this article applies to the insurer only if the total aggregate premium collected by the group accounts for less than two percent of the total amount of premiums collected by insurers for residential property insurance policies issued in this state.

Sec. 3. (a) Except as provided by Subsection (b) of this section, an insurer described by Section 2 of this article is exempt from the rate filing and approval requirements of Article 5.142 and of Article 5.13-2 of this code.

(b) An insurer described by Section 2 of this article that proposes to increase the premium rates charged policyholders for a residential property insurance product by 10 percent or more than the amount the insurer charged policyholders for the same or an equivalent residential property insurance product during the preceding calendar year must file the insurer's proposed rates in accordance with Article 5.142 or 5.13-2 of this code, as applicable, and obtain approval of the proposed rates as provided by the applicable article.

Revisor's Note

Sections 2(a) and 3(a) and (b), V.T.I.C. Article 5.13-2C, refer to certain requirements of "[V.T.I.C.] Article 5.142." Section 3(c), Article 5.13-2C, exempts certain insurers from the application of Article 5.142. Article 5.142 expired effective December 1, 2004, as provided by Section 17 of that article. Therefore, the revised law omits as unnecessary the references to Article 5.142 in Sections 2(a) and 3(a) and (b) and omits Section 3(c) in its entirety. The omitted subsection reads:

> (c) Except as provided by Subsection (b) of this section, Article 5.142 of this code does not apply to an insurer described by Section 2 of this article.

CHAPTER 2252. RATE ADMINISTRATION

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CHAPTER 2252. RATE ADMINISTRATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2252.001. APPLICABILITY OF CHAPTER. (a) Except as provided by Subsections (b) and (c), this chapter applies to an insurer, including a corporation, reciprocal or interinsurance exchange, mutual insurance company, association, Lloyd's plan, or other organization, writing casualty insurance or writing fidelity, surety, or guaranty bonds, on risks or operations in this state.

(b) This chapter does not apply to:

(1) a farm mutual insurance company or association regulated under Chapter 911; or

(2) a county mutual insurance company regulated under Chapter 912.

(c) This chapter does not apply to the writing of:

(1) automobile insurance;

(2) life, health, or accident insurance;

(3) professional liability insurance;

(4) reinsurance;

(5) aircraft insurance;

(6) fraternal benefit insurance;

(7) fire insurance;

(8) workers' compensation insurance;

(9) marine insurance, including noncommercial inland marine insurance and ocean marine insurance;

(10) title insurance;

(11) explosion insurance, except insurance against loss from personal injury or property damage resulting accidentally from:

(A) a steam boiler;

(B) a heater or pressure vessel;

(C) an electrical device;

(D) an engine; or

(E) all machinery and appliances used in connection with or in the operation of a boiler, heater, vessel, electrical device, or engine described by Paragraphs (A)-(D); or

(12) insurance coverage for any of the following conditions or risks:

(A) weather or climatic conditions, including lightning, tornado, windstorm, hail, cyclone, rain, or frost and freeze;

(B) earthquake or volcanic eruption;

(C) smoke or smudge;

(D) excess or deficiency of moisture;

(E) flood;

(F) the rising water of an ocean or an ocean's tributary;

(G) bombardment, invasion, insurrection, riot, civil war or commotion, military or usurped power, or any order of a civil authority made to prevent the spread of a conflagration, epidemic or catastrophe;

(H) vandalism or malicious mischief;

(I) strike or lockout;

(J) water or other fluid or substance resulting from:

(i) the breakage or leakage of a sprinkler,

pump, or other apparatus erected for extinguishing fire, or a water pipe or other conduit or container; or

(ii) casual water entering a building through a leak or opening in the building or by seepage through building walls; or

(K) accidental damage to a sprinkler, pump, fire apparatus, pipe, or other conduit or container described by Paragraph (J)(i). (V.T.I.C. Art. 5.13, Secs. (a) (part), (b), (c).)

Source Law

> Art. 5.13. (a) This subchapter applies to every insurance company, corporation, interinsurance exchange, mutual, reciprocal, association, Lloyd's plan, or other organization or insurer writing any of the characters of insurance business herein set forth, hereinafter called "Insurer"; provided that nothing in this entire subchapter shall be construed to apply to any county or farm mutual insurance company or association, as regulated under Chapters 911 and 912 of this code, . . . .
>
> (b) This subchapter applies to the writing of casualty insurance and the writing of fidelity, surety, and guaranty bonds, on risks or operations in this State except as herein stated.
>
> (c) Except as otherwise provided by this subchapter, this subchapter does not apply to the writing of motor vehicle, life, health, accident, professional liability, reinsurance, aircraft, fraternal benefit, 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, 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, or resulting from casual water entering through leaks or opening in buildings or by seepage through building walls, including insurance against accidental injury of such sprinklers, pumps, fire apparatus, conduits or container, workers' compensation, noncommercial inland marine, ocean marine, marine, or title insurance; nor does this subchapter apply to the writing of explosion insurance, except insurance against loss from injury to person or property which results accidentally from steam boilers, heaters or pressure vessels, electrical devices, engines and all machinery and appliances used in connection therewith or operation thereby.

Revisor's Note

(1) V.T.I.C. Article 5.13 refers to "this subchapter," meaning Subchapter B, V.T.I.C. Chapter 5. Subchapter B, Chapter 5, is revised in various chapters in this title. Throughout this subchapter, the revised law substitutes references to "this chapter" for the references to "this subchapter" because the applicability of Article 5.13 is separately maintained for each of the chapters of this title in which other articles from Subchapter B, V.T.I.C. Chapter 5, are revised.

(2) Section (a), V.T.I.C. Article 5.13, states that the law revised in this chapter applies to each "interinsurance exchange . . . [and] reciprocal." The revised law substitutes "reciprocal or interinsurance exchange" because that is the term used in Chapter 942 of this code, which regulates reciprocal and interinsurance exchanges.

(3) Section (a), V.T.I.C. Article 5.13, states that the law revised in this chapter does not apply to a "county or farm mutual insurance company or association, as regulated under Chapters 911 and 912 of this code." The only applicable references to an "association" are in Chapter 911 of this code, which regulates farm mutual insurance companies. The revised law is drafted accordingly.

(4) Section (c), V.T.I.C. Article 5.13, states that "[e]xcept as otherwise provided by this subchapter," meaning Subchapter B, V.T.I.C. Chapter 5, "this subchapter" does not apply to the writing of certain insurance, including "motor vehicle" insurance. The revised law omits the reference to "[e]xcept as otherwise provided by this subchapter" as unnecessary because the portions of Subchapter B,

Chapter 5, that are codified in this chapter do not contain any exception to the general statement of inapplicability. The revised law also substitutes "automobile insurance" for the reference to motor vehicle insurance for consistency with terminology used in this code and because "automobile insurance" is the term more commonly used to describe the kind of insurance that provides coverage for motor vehicles.

Revised Law

Sec. 2252.002. CONSTRUCTION OF CHAPTER. This chapter does not limit in any manner the kinds or classes of insurance that an insurer may write under an appropriate statute or the insurer's charter or certificate of authority. (V.T.I.C. Art. 5.13, Sec. (d).)

Source Law

(d) This subchapter shall not be construed as limiting in any manner the types or classes of insurance which may be written by the several types of insurers under appropriate statutes or their charters or permits.

Revisor's Note

Section (d), V.T.I.C. Article 5.13, refers to the kinds or classes of insurance that an insurer may write under the insurer's charter or permit. The revised law substitutes "certificate of authority" for "permit" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

[Sections 2252.003-2252.050 reserved for expansion]

SUBCHAPTER B. RATING SYSTEMS

Revised Law

Sec. 2252.051. INSURER TO PROVIDE RATE INFORMATION. (a) An insurer shall provide all information relevant to a rate used by the insurer to:

(1) any person who is or will be affected by the rate or by a modification of the rate; or

(2) the authorized representative of a person described by Subdivision (1).

(b) The insurer shall provide the information within a reasonable time after receipt of a written request for the information and on payment of any reasonable charge set by the insurer. (V.T.I.C. Art. 5.18, Sec. (a).)

Source Law

> Art. 5.18. (a) Every insurer subject to this subchapter shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charges as it may make, furnish to any person then or thereafter affected by a rate used by the insurer or any modification thereof properly made, or to the authorized representative of such person, all information pertinent thereto.

Revisor's Note

> Section (a), V.T.I.C. Article 5.18, refers to "a rate . . . or any modification thereof properly made." The reference to "properly made" is omitted from the revised law as unnecessary because it is presumed that any modification to a rate is made properly.

Revised Law

Sec. 2252.052. RIGHT TO HEARING ON RATING SYSTEM. (a) An insurer shall provide within this state reasonable means by which a person aggrieved by the application of the insurer's rating system may be heard on written request to review the manner in which the rating system has been applied in connection with the insurance afforded the person.

(b) The person may be heard under this section in person or through the person's authorized representative. (V.T.I.C. Art. 5.18, Sec. (b) (part).)

Source Law

> (b) Every insurer subject to this subchapter shall provide within this State reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by his authorized representative, on his written request to review the manner in which such rating system has been applied in connection with the insurance afforded him. . . .

Revised Law

Sec. 2252.053. APPEAL OF DECISION ON RATING SYSTEM. Any party affected by an action taken by an insurer or rating organization in response to a request for a hearing under Section 2252.052 may appeal that action to the commissioner not later than the 10th day after the date the party receives written notice of the action. (V.T.I.C. Art. 5.18, Sec. (b) (part).)

Source Law

> (b) . . . Any party affected by the action of such rating organization or such insurer on such request may, within ten (10) days after written notice of such action, appeal to the Board.

Revisor's Note

Section (b), V.T.I.C. Article 5.18, refers to the "Board," meaning 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. Throughout this chapter, references to the "Board" have been changed appropriately.

[Sections 2252.054-2252.100 reserved for expansion]

SUBCHAPTER C. LOSS AND EXPENSE EXPERIENCE

Revised Law

Sec. 2252.101. RECORDING AND REPORTING OF LOSS AND EXPENSE EXPERIENCE AND OTHER DATA. (a) The commissioner shall adopt reasonable rules and statistical plans for the recording and reporting of loss experience and other required data by insurers. The rules and plans must ensure that each insurer's total loss and expense experience is made available at least as frequently as

biennially in the form and with the detail necessary to aid in determining whether rating plans comply with the standards provided by this chapter, Chapter 1901, Chapter 2251, or Subchapter B, Chapter 5.

(b) In adopting the rules and statistical plans, the commissioner shall have due regard for:

(1) the rating plans used under this chapter, Chapter 1901, Chapter 2251, or Subchapter B, Chapter 5; and

(2) the rules and forms of plans used in other states to ensure that the rules and plans are as uniform as is practicable.

(c) Each insurer shall use the statistical plans adopted under this section to record and report loss experience and other required data in accordance with the rules adopted by the commissioner.

(d) The commissioner may designate other agencies to gather and compile the loss experience and other data.

(e) The commissioner may adopt modifications to statistical plans adopted under this section. (V.T.I.C. Art. 5.19, Sec. (a).)

Source Law

Art. 5.19. (a) Recording and Reporting of Loss Experience and Other Data. The Board shall, after due consideration, promulgate reasonable rules and statistical plans which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss experience and such other data as may be required, in order that the total loss and expense experience of all insurers may be made available at least biennially in such form and detail as may be necessary to aid in determining whether rating plans comply with the standards set forth in this subchapter. In promulgating such rules and plans, the Board shall have due regard for the rating plans used under this subchapter, and in order that such rules and plans may be as uniform as is practicable, to the rules and to the form of the plans used in other states. The Board may designate other agencies to gather and compile such experience.

Revisor's Note

(1) Section (a), V.T.I.C. Article 5.19, requires the commissioner of insurance to adopt reasonable rules and statistical plans "after due consideration." The revised law omits "after due

consideration" as unnecessary because the requirement that a rule or a plan be reasonable implies that the commissioner will give the rule or plan due consideration before adopting that rule or plan.

(2) Section (a), V.T.I.C. Article 5.19, requires the adoption of "rules and statistical plans which may be modified from time to time." The revised law omits the authorization to modify a rule because the authority to adopt a rule includes the authority to modify that rule. The revised law also omits "from time to time" with respect to the modification of statistical plans because without an express limitation, the authority to modify includes the authority to modify from time to time.

(3) Section (a), V.T.I.C. Article 5.19, refers to rate standards and rating plans set forth in or used under "this subchapter," meaning Subchapter B, V.T.I.C. Chapter 5. The revised law adds references to standards or plans provided by or used under this chapter, Chapter 1901, or Chapter 2251 to include citations to other provisions in which relevant portions of Subchapter B, Chapter 5, are revised.

Revised Law

Sec. 2252.102. RULES AND PLANS REQUIRING INTERCHANGE OF LOSS EXPERIENCE. The commissioner may adopt reasonable rules and plans requiring the interchange of loss experience necessary for the application of rating plans. (V.T.I.C. Art. 5.19, Sec. (b).)

Source Law

(b) Interchange of Rating Plan Data.--Reasonable rules and plans may be promulgated by the Board after due consideration, requiring the interchange of loss experience necessary for the application of rating plans.

Revisor's Note

Section (b), V.T.I.C. Article 5.19, authorizes the commissioner of insurance to adopt certain

reasonable rules "after due consideration." The revised law omits the quoted language for the reason stated in Revisor's Note (1) to Section 2252.101.

Revised Law

Sec. 2252.103. EXCHANGE OF RATE INFORMATION WITH OTHER STATES. To further the uniform administration of rating laws, the department or an insurer may:

(1) exchange information and experience data with insurance supervisory officials, insurers, and rating organizations in other states; and

(2) consult and cooperate with the individuals or entities described by Subdivision (1) with respect to ratemaking and the application of rating systems. (V.T.I.C. Art. 5.19, Sec. (c).)

Source Law

(c) Consultation with Other States. In order to further uniform administration of rating laws, the Board and every insurer may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult and cooperate with them with respect to rate making and the application of rating systems.

[Sections 2252.104-2252.150 reserved for expansion]

SUBCHAPTER D. PROHIBITED ACTS

Revised Law

Sec. 2252.151. PROHIBITED CONDUCT RELATED TO RATES AND PREMIUMS. (a) A person or organization may not knowingly give false or misleading information to the department or commissioner, an insurer, or any other entity that will in any manner affect the proper determination of rates or premiums.

(b) An insurer or agent who knowingly misrepresents the actual or replacement value of real or personal property to achieve an unfair competitive rate advantage commits an offense. (V.T.I.C. Art. 5.21.)

Source Law

Art. 5.21. No person or organization shall knowingly give false or misleading information to the Board, to any insurer, or to any other entity, which

will in any manner affect the proper determination of rates or premiums.

An insurer or agent who knowingly misrepresents the actual or replacement value of real or personal property for the purpose of achieving an unfair competitive rate advantage commits an offense.

Revisor's Note
(End of Chapter)

Section (e), V.T.I.C. Article 5.13, states that the regulatory power conferred in this chapter is vested in the commissioner of insurance. The revised law omits this statement as unnecessary. Section 31.021 of this code provides that the commissioner "is the department's chief executive and administrative officer" and "has the powers and duties vested in the department by this code." The omitted law reads:

> (e) The regulatory power herein conferred is vested in the commissioner.

CHAPTER 2253. RATING TERRITORIES

Sec. 2253.001. RATING TERRITORIES . . . . . 1585

CHAPTER 2253. RATING TERRITORIES

Revised Law

Sec. 2253.001. RATING TERRITORIES. (a) Notwithstanding any other provision of this code, an insurer may use rating territories that subdivide a county only if:

(1) the county is subdivided; and

(2) the rate for any subdivision in the county is not greater than 15 percent higher than the rate used in any other subdivision in the county by that insurer.

(b) For residential property insurance or personal automobile insurance, the commissioner by rule may allow a greater rate difference than the rate difference specified by Subsection (a). (V.T.I.C. Art. 5.171.)

Source Law

> Art. 5.171. Notwithstanding any other provision of this code, an insurer may not use rating territories that subdivide a county unless the county is subdivided and the rate for any subdivisions within that county is not greater than 15 percent higher than the rate used in any other subdivisions in the county by that insurer, except that the commissioner may by

rule allow a greater rate difference for residential property insurance or personal automobile insurance.

Revisor's Note
(End of Chapter)

V.T.I.C. Article 5.172 exempts certain insurers from the application of Subchapter U, V.T.I.C. Chapter 5, revised as this chapter, before January 1, 2004. The revised law omits that provision as executed. The omitted law reads as follows:

> Art. 5.172. Notwithstanding Sections 912.002, 941.003, 942.003, or any other provision of this code, this subchapter does not apply to a county mutual insurance company, a Lloyd's plan, and a reciprocal or interinsurance exchange, before January 1, 2004.

CHAPTER 2254. PREMIUM REFUND FOR CERTAIN PERSONAL LINES

Sec. 2254.001. DEFINITIONS . . . . . 1586
Sec. 2254.002. INAPPLICABILITY OF CHAPTER . . . . . 1588
Sec. 2254.003. REFUND OR DISCOUNT BASED ON EXCESSIVE OR UNFAIRLY DISCRIMINATORY PREMIUM RATES . . . . . 1588
Sec. 2254.004. RATE HEARING BY STATE OFFICE OF ADMINISTRATIVE HEARINGS . . . . . 1590

CHAPTER 2254. PREMIUM REFUND FOR CERTAIN PERSONAL LINES

Revised Law

Sec. 2254.001. DEFINITIONS. In this chapter:

(1) "Insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, or other legal entity authorized to write residential property insurance or personal automobile insurance in this state. The term includes an affiliate, as described by this code, that is authorized to write residential property insurance. The term does not include:

(A) the Texas Windstorm Insurance Association under Chapter 2210; or

(B) the FAIR Plan Association under Chapter 2211.

(2) "Personal automobile insurance" means motor vehicle insurance coverage for the ownership, maintenance, or use of a private passenger, utility, or miscellaneous type motor vehicle, including a motor home, trailer, or recreational vehicle, that is:

(A) owned or leased by one or more individuals; and

(B) not used primarily for the delivery of goods, materials, or services, other than for use in farm or ranch operations.

(3) "Residential property insurance" means insurance coverage against loss to real or tangible personal property at a fixed location that is provided through:

(A) a homeowners policy, including a tenants policy;

(B) a condominium owners policy; or

(C) a residential fire and allied lines policy.

(V.T.I.C. Art. 5.144, Sec. (a).)

Source Law

Art. 5.144. (a) In this article:

(1) "Insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, or other legal entity authorized to write residential property insurance or personal automobile insurance in this state. The term includes an affiliate, as described by this code, if that affiliate is authorized to write residential property insurance. The term does not include:

(A) the Texas Windstorm Insurance Association under Article 21.49 of this code; or

(B) the FAIR Plan Association under Article 21.49A of this code.

(2) "Personal automobile insurance" means motor vehicle insurance coverage for the ownership, maintenance, or use of a private passenger, utility, or miscellaneous type motor vehicle, including a motor home, trailer, or recreational vehicle, that is:

(A) owned or leased by an individual or individuals; and

(B) not primarily used for the delivery of goods, materials, or services, other than for use in farm or ranch operations.

(3) "Residential property insurance" means insurance coverage against loss to real or tangible personal property at a fixed location that is provided through a homeowners policy, including a

tenants policy, a condominium owners policy, or a residential fire and allied lines policy.

Revisor's Note

Section (a)(1)(B), V.T.I.C. Article 5.144, refers to the FAIR Plan Association under V.T.I.C. Article 21.49A. Article 21.49A is revised in Chapter 2211 of this code. That chapter also contains provisions derived from V.T.I.C. Article 21.49A-1, which relates to the issuance of public securities to provide residential property insurance through the association. The revised law appropriately refers to Chapter 2211 in its entirety because the provisions of that chapter that are derived from Article 21.49A-1 are related to the operation of the FAIR Plan Association.

Revised Law

Sec. 2254.002. INAPPLICABILITY OF CHAPTER. This chapter does not apply to rates for personal automobile insurance or residential property insurance for which an insurer obtains prior rate approval under Subchapter D, Chapter 2251. (V.T.I.C. Art. 5.144, Sec. (f).)

Source Law

(f) This article does not apply to rates for personal automobile insurance or residential property insurance for which an insurer has obtained prior approval of those rates under Section 5A, Article 5.13-2 of this code.

Revised Law

Sec. 2254.003. REFUND OR DISCOUNT BASED ON EXCESSIVE OR UNFAIRLY DISCRIMINATORY PREMIUM RATES. (a) This section applies to a rate filed on or after the effective date of Chapter 206, Acts of the 78th Legislature, Regular Session, 2003.

(b) Except as provided by Section 2254.004(c), if the commissioner determines that an insurer has charged a rate for personal automobile insurance or residential property insurance that is excessive or unfairly discriminatory, as described by Section 2251.051, the commissioner may:

(1) order the insurer to refund directly to each affected policyholder the portion of the premium that is excessive or unfairly discriminatory, if that portion of the premium is at least 7.5 percent of the total premium charged for the coverage; or

(2) if that portion of the premium is less than 7.5 percent of the total premium, order the insurer to provide, to each affected policyholder:

(A) who renews the policy, a future premium discount equal to the amount of the excessive or unfairly discriminatory portion of the premium; and

(B) who does not renew or whose coverage is otherwise terminated, a refund in the amount described by Subdivision (1). (V.T.I.C. Art. 5.144, Secs. (b), (g).)

Source Law

(b) Except as provided by Subsection (d) of this article, if the commissioner determines that an insurer has charged a rate for personal automobile insurance or residential property insurance that is excessive or unfairly discriminatory, as described by Article 5.13-2 or 5.101 of this code, the commissioner may order the insurer to:

(1) issue a refund of the excessive or unfairly discriminatory portion of the premium directly to each affected policyholder if the amount of that portion of the premium is at least 7.5 percent of the total premium charged for the coverage; or

(2) if the amount of that portion of the premium is less than 7.5 percent:

(A) provide each affected policyholder who renews the policy a future premium discount in the amount of the excessive or unfairly discriminatory portion of the premium; and

(B) provide each affected policyholder who does not renew or whose coverage is otherwise terminated a refund in the amount described by Subdivision (1) of this subsection.

(g) Subsection (b) of this section applies prospectively to a rate filed on or after the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003.

Revisor's Note

(1) Section (b), V.T.I.C. Article 5.144, refers to a premium rate described as excessive or unfairly discriminatory by V.T.I.C. Article 5.101. Section 7, V.T.I.C. Article 5.101, provides that the article expires December 1, 2004. Accordingly, the revised

law omits the reference to Article 5.101.

(2) Section (g), V.T.I.C. Article 5.144, states that Subsection (b) of that section (meaning Section (b) of that article), revised as Section 2254.003(b), applies "prospectively to a rate filed on or after the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003." The revised law omits the reference to "prospectively" as unnecessary because under Section 311.022, Government Code (Code Construction Act), applicable to the revised law, a statute is presumed to operate prospectively.

Revised Law

Sec. 2254.004. RATE HEARING BY STATE OFFICE OF ADMINISTRATIVE HEARINGS. (a) Not later than the 20th day after the date of an order under Section 2254.003, the insurer may request that the State Office of Administrative Hearings conduct a rate hearing to determine whether the rate that is subject to the order is excessive or unfairly discriminatory.

(b) The office of public insurance counsel may participate in and present evidence at the hearing.

(c) After completion of the hearing, the administrative law judge shall:

(1) prepare a proposal for decision under Section 40.058; and

(2) remand the matter to the commissioner recommending that the commissioner affirm the order or that:

(A) the commissioner complete an additional review of the order not later than the 10th day after the date the commissioner receives the proposal;

(B) the parties enter into negotiations; or

(C) the commissioner take within a period specified by the administrative law judge other appropriate action with respect to the order.

(d) The commissioner's action or failure to act on a

proposal or recommendation under Subsection (c) is subject to judicial review under Subchapter D, Chapter 36. (V.T.I.C. Art. 5.144, Secs. (c), (d), (e).)

Source Law

(c) On or before the 20th day after the date an order is issued under this article, an insurer may request a rate hearing to be conducted by the State Office of Administrative Hearings to determine whether the rate that is subject to the order is excessive and discriminatory. The office of public insurance counsel may participate in a hearing conducted under this subsection and present evidence at the hearings.

(d) After completion of the rate hearing under Subsection (c) of this section, the administrative law judge shall prepare a proposal for decision under Section 40.058 of this code and remand the case to the commissioner recommending:

(1) that the commissioner affirm the commissioner's order; or

(2) additional review of the order by the commissioner to be completed not later than the 10th day after the date the commissioner receives the administrative law judge's proposal, that the parties enter into negotiations, or that the commissioner take other appropriate action with respect to the order within a time period specified by the administrative law judge.

(e) An action or failure to act of the commissioner under Subsection (d) of this section is subject to appeal under Subchapter D, Chapter 36 of this code.

Revisor's Note

(1) Section (c), V.T.I.C. Article 5.144, provides that an insurer may request that the State Office of Administrative Hearings conduct a rate hearing to determine whether a rate subject to an order of the commissioner of insurance under Subsection (b) of that article, revised in this chapter as Section 2254.003(b), is "excessive and discriminatory." Section 2254.003(b) authorizes the commissioner to order an insurer to take certain actions if the commissioner determines that the insurer charges a rate that is either excessive or unfairly discriminatory. Accordingly, the revised law substitutes "excessive or unfairly discriminatory" for "excessive and discriminatory" for consistency of terminology.

(2) Section (e), V.T.I.C. Article 5.144, provides that an action or a failure to act by the commissioner of insurance is subject to "appeal" under Subchapter D, Chapter 36, of this code. The revised law substitutes "judicial review" for "appeal" because "judicial review" more accurately describes the procedures available under Subchapter D, Chapter 36.

Revisor's Note
(End of Subtitle)

V.T.I.C. Article 5.131 provides for a temporary rate rollback for certain lines of insurance. The article addresses the legislature's intent in providing for temporary rate rollbacks, the procedure for applying a rate rollback, and the process by which an insurer may seek administrative relief from a rate rollback. Section 6, V.T.I.C. Article 5.131, states that temporary rate rollbacks provided by that article that have not otherwise been removed remain in effect until January 1, 2001. The revised law omits Article 5.131 as executed. The omitted law reads:

> Art. 5.131
> Sec. 1. The legislature finds that:
> (1) the cost of litigation against insureds and their insurers, the possibility of large and unjust judgments, and the uncertainty created by a litigious environment within this state have been significant factors in the high cost of certain lines of insurance;
> (2) legislation enacted by regular sessions of the 73rd and 74th legislatures, which may be aided by legislation under consideration by the 104th Congress of the United States, is intended to meaningfully reform the civil justice system of this state and will result in reductions in the cost of litigation and in the size of judgments;
> (3) while the monetary effect of the legislative changes can be actuarially determined within a reasonable degree of certainty, insurers will delay implementation of rate reductions until they have data evidencing actual loss experience;
> (4) the delay described by Subdivision (3) of this section will result in a windfall for the insurers benefited by

the legislation described by Subdivision (2) of this section, and this benefit should be passed on to their insureds; and

(5) legislative action in the public interest and within the police power of the state is required to eliminate unnecessary delays to pass these benefits on to the insured public of this state.

Sec. 2. (a) This article applies to any insurer that is authorized to do business in this state and that is authorized to write any of the types of coverages or lines and sublines listed in Subsection (b) of this section, including:

(1) a capital stock company;

(2) a mutual company;

(3) a Lloyd's plan company; and

(4) a reciprocal or interinsurance exchange.

(b) It is the intent of the legislature that all insurers, including county mutual insurers, joint underwriting associations, and others whose rates are not regulated, pass through the savings that accrue from the legislation described by Section 1 of this article to their policyholders on a prospective basis. To monitor compliance with this legislative directive, the commissioner may require information in rate filings, special data calls, informational hearings, and any other means consistent with other provisions of this code applicable to the affected insurers. Information provided under this subsection is privileged and confidential to the same extent as the information is privileged and confidential under this code or other laws for other insurers licensed and writing the same line of insurance in this state. The information remains privileged and confidential unless and until introduced into evidence at an administrative hearing or in a court of competent jurisdiction. Sections 3 and 4 of this subchapter do not apply to the nonrate regulated insurers covered by this subsection.

(c) This article applies only to policies or coverages in the following lines or sublines that are issued, issued for delivery, or renewed on and after January 1, 1996:

(1) professional liability insurance for a physician, other health care provider, or hospital;

(2) commercial liability insurance for damages arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product or for completed operations coverage;

(3) private passenger automobile liability insurance for bodily injury;

(4) commercial automobile liability insurance for bodily injury;

(5) private umbrella and excess liability insurance;

(6) the liability portion of commercial multi-peril insurance;

(7) the liability portion of homeowner's, farm and ranch owner's, and renter's insurance;

(8) the employer's liability portion of workers' compensation insurance; and

(9) other commercial liability insurance, including the following lines and sublines:

(A) premises medical;

(B) fire legal liability;

(C) personal advertising injury;

(D) contractual liability;

(E) liability for all premises;

(F) pollution liability;

(G) owners and contractors protective liability;

(H) railroad protective liability;

(I) liquor liability;

(J) farm liability;

(K) commercial umbrella and excess liability;

(L) professional liability other than insurance described by Subdivision (1) of this subsection; and

(M) garage liability.

Sec. 3. (a) Notwithstanding Article 1.33B of this code, on or before September 1 of each year, the commissioner shall hold a rulemaking hearing under Chapter 2001, Government Code, to determine the percentage of equitable across-the-board reductions in insurance rates required of insurers writing the lines and sublines of liability coverage described by Section 2(c) of this article.

(b) Not later than October 1, 1995, the commissioner shall issue rules mandating the appropriate rate reductions to rates for the lines and sublines of liability coverage described by Section 2(c) of this article and developed without consideration of the effect of the legislation described by Section 1 of this article.

(c) The commissioner may set the percentage of the rate reduction by line and subline within any of the coverages described by Section 2(c) of this article and may set a percentage either above or below the percentages listed in Subsection (e) of this section. The commissioner's order establishing the rate reductions must be based on the evidence adduced at the rulemaking hearing. It is the intent of the legislature that the rates resulting from the rate reductions imposed by this article be reasonable, adequate, not unfairly discriminatory, nonconfiscatory, and not excessive.

(d) The rate reductions adopted under this section are applicable to each policy

or coverage issued, issued for delivery, or renewed on and after January 1, 1996, and to each policy or coverage issued, issued for delivery, or renewed on and after the 90th day after the date of each subsequent rule adopted under Subsection (a) of this section.

(e) Notwithstanding Subsection (d) of this section, if, on January 1, 1996, the commissioner has not issued an order establishing rate reductions for a line or subline under this section, the following reductions, as measured from the base rates in effect on April 1, 1995, apply to each insurer for each affected policy or coverage issued, issued for delivery, or renewed on and after January 1, 1996:

| LINE or SUBLINE | PERCENTAGE REDUCTION |
|---|---|
| (1) professional liability insurance for physician, other health care provider, or hospital: | 30% |
| (2) commercial liability insurance for damage arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product or for completed operations coverage: | 25% |
| (3) private passenger automobile liability insurance for bodily injury: | 15% |
| (4) commercial automobile liability insurance for bodily injury: | 20% |
| (5) private umbrella and excess liability insurance: | 20% |
| (6) the liability portion of commercial multi-peril insurance: | 10% |
| (7) the liability portion of homeowner's, farm and ranch owner's, and renter's insurance: | 5% |
| (8) the employer's liability portion of workers' compensation insurance: | 10% |
| (9) all lines and sublines of other commercial liability insurance: | 15% |

(f) Any rule or order of the commissioner which determines, approves, or sets a rate reduction under this section and

is appealed or challenged shall be and remain in effect during the pendency of the appeal or challenge. During the pendency of the appeal or challenge, an insurer shall use the rate reduction provided in the order being appealed or challenged. Such rate reduction shall be lawful and valid during such appeal or challenge.

(g) The commissioner shall consider the effect of the legislation described by Section 1 of this article in determining rates under Section 5 of Article 21.81 of this code.

Sec. 4. (a) Except as provided by Subsection (b) of this section, a rate filed as to a line or subline of insurance coverage affected by this article on and after January 1, 1996, and a rate filed on and after the 90th day following the effective date of a subsequent rule adopted under Section 3(a) of this article, shall reflect the rate reduction imposed by Section 3 of this article. The commissioner shall disapprove a rate, subject to the procedures established by Section 7, Article 5.13-2, of this code if the commissioner finds that the filed rate does not reflect that reduction.

(b) The commissioner is not required to disapprove a filed rate that reflects less than the full amount of the rate reduction imposed by Section 3 of this article if:

(1) the commissioner determines that based on clear and convincing evidence that an insurer will be financially unable in a particular line of insurance to continue writing that line; or

(2) the rate reduction required by Section 3 of this article would likely result in placing the insurer in a hazardous financial condition described by Section 2, Article 1.32, of this code.

Sec. 5. The commissioner shall, by order, declare this article inapplicable to a line or subline of insurance otherwise subject to this article at the time the commissioner finds, based on actuarially credible data, that rates in that line or subline reflect the actual experience under the legislation described by Section 1 of this article.

Sec. 6. Unless the commissioner grants relief under Section 4 or 5 of this article, each rate resulting from the reduction required under Section 3 of this article remains in effect until January 1, 2001.

Sec. 7. The commissioner may, by bulletin or directive, based on the evidence accumulated by the commissioner before the bulletin or directive is issued, modify a rate reduction mandated by the commissioner under this article if a final, unappealable judgment of a court with appropriate jurisdiction stays the effect of, enjoins, or otherwise modifies or declares unconstitutional any of the

legislation described by Section 1 of this article on which the commissioner based the rate reduction.

Sec. 8. Notwithstanding Article 1.33B of this code, a rulemaking hearing under this article shall be held before the commissioner or the commissioner's designee. Article 1.09-5 of this code does not apply to hearings under this article. The rulemaking procedures established by this section do not apply to any other rate promulgation proceeding.

Sec. 9. A rate filed pursuant to a commissioner's order issued before May 1, 1995, is not subject to the rate reductions required by this article before January 1, 1996.

Sec. 10. The commissioner shall assemble information, conduct hearings, and take other appropriate measures to assess and evaluate changes in the marketplace resulting from the implementation of this article and to report findings and recommendations to the legislature.

[Chapters 2255-2300 reserved for expansion]

SUBTITLE I. POLICY FORMS IN GENERAL

CHAPTER 2301. POLICY FORMS

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CHAPTER 2301. POLICY FORMS

SUBCHAPTER A. POLICY FORMS GENERALLY

Revised Law

Sec. 2301.001. PURPOSE. The purposes of this subchapter are to:

(1) promote the availability of insurance;

(2) regulate the insurance forms used for lines of insurance to which this subchapter applies to ensure that the forms are not unjust, unfair, inequitable, misleading, or deceptive; and

(3) provide regulatory procedures for the maintenance of appropriate information reporting systems. (V.T.I.C. Art. 5.13-2, Sec. 1 (part).)

Source Law

> Sec. 1. . . . The purposes of this article are to:
>
> . . .
>
> (2) promote availability of insurance;
>
> . . .
>
> (5) regulate the insurance forms used for lines of insurance subject to this article to ensure that they are not unjust, unfair, inequitable, misleading, or deceptive; and
>
> (6) provide regulatory procedures for the maintenance of appropriate information reporting systems.

Revisor's Note

Section 1, V.T.I.C. Article 5.13-2, refers to "this article," meaning V.T.I.C. Article 5.13-2. Portions of Article 5.13-2 are revised in this chapter and Chapter 2251 of this code. The revised law substitutes a reference to "this subchapter" for the reference to "this article" because the substance of the relevant portions of Article 5.13-2 is repeated in Chapter 2251. Throughout this subchapter, references to "this article" have been changed accordingly.

Revised Law

Sec. 2301.002. DEFINITIONS. In this subchapter:

(1) "Form" means an insurance policy form or a printed endorsement form.

(2) "Residential property insurance" means insurance coverage against loss to real or tangible personal property at a fixed location that is provided through a homeowners insurance policy, including a tenants insurance policy, a condominium owners insurance policy, or a residential fire and allied lines insurance policy.

(3) "Supporting information" means any information required by the department to be filed. (V.T.I.C. Art. 5.13-2, Secs. 3(a)(7), (9) (part); New.)

Source Law

Sec. 3. (a) In this article:

> (7) "Residential property insurance" means insurance coverage against loss to real or tangible personal property at a fixed location that is provided through a homeowners policy, including a tenants policy, a condominium owners policy, or a residential fire and allied lines policy.
>
> (9) "Supporting information" means:
>
> . . .
>
> (D) any other information required by the department to be filed.

Revisor's Note

The definition of "form" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 2301.003. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to:

(1) an insurer to which Article 5.13 applies, other than the Texas Windstorm Insurance Association, the FAIR Plan Association, and the Texas Automobile Insurance Plan Association; and

(2) except as provided by Subsections (c) and (d), a

Lloyd's plan, reciprocal or interinsurance exchange, and county mutual insurance company with respect to the lines of insurance described by Subsection (b).

(b) This subchapter applies to all lines of the following kinds of insurance written under an insurance policy or contract issued by an insurer authorized to engage in the business of insurance in this state:

(1) general liability insurance;

(2) residential and commercial property insurance, including farm and ranch insurance and farm and ranch owners insurance;

(3) personal and commercial casualty insurance, except as provided by Section 2301.005;

(4) medical professional liability insurance;

(5) fidelity and surety bonds other than criminal court appearance bonds;

(6) personal umbrella insurance;

(7) personal liability insurance;

(8) guaranteed auto protection (GAP) insurance;

(9) involuntary unemployment insurance;

(10) financial guaranty insurance;

(11) inland marine insurance;

(12) rain insurance;

(13) hail insurance on farm crops; and

(14) personal and commercial automobile insurance.

(c) Section 2301.009 does not apply to a Lloyd's plan or a reciprocal or interinsurance exchange with respect to commercial property insurance.

(d) This subchapter does not apply to a Lloyd's plan or reciprocal or interinsurance exchange with respect to inland marine insurance, rain insurance, or hail insurance on farm crops. (V.T.I.C. Art. 5.13-2, Secs. 1 (part), 2(a), 3(a)(3).)

Source Law

Art. 5.13-2

Sec. 1. This article governs the regulation of insurance described by Section 2 of this article. . . .

Sec. 2. (a) This article applies to all lines of the following insurance written under policies or contracts of insurance issued by an insurer authorized to engage in the business of insurance in this state:

(1) general liability insurance;

(2) residential and commercial property insurance, including farm and ranch insurance and farm and ranch owners insurance;

(3) personal and commercial casualty insurance, except as provided by Subsection (b) of this section;

(4) medical professional liability insurance;

(5) fidelity and surety bonds other than criminal court appearance bonds;

(6) personal umbrella insurance;

(7) personal liability insurance;

(8) guaranteed auto protection (GAP) insurance;

(9) involuntary unemployment insurance;

(10) financial guaranty insurance;

(11) inland marine insurance;

(12) rain insurance;

(13) hail insurance on farm crops; and

(14) personal and commercial automobile insurance.

Sec. 3. (a) In this article:

(3) "Insurer" means an insurer to which Article 5.13 of this code applies, but does not include the Texas Windstorm Insurance Association or the Texas FAIR Plan Association, or the Texas Automobile Insurance Plan Association. All provisions of this article shall apply to Lloyd's plans, reciprocals and interinsurance exchanges, and county mutual insurance companies with respect to the lines of insurance described in Section 2 of this article, except that the provisions of Sections 4, 5, 6, and 7 of this article shall not apply to Lloyd's or reciprocals with respect to commercial property insurance, and the provisions of Sections 4, 5, 6, 7, and 8 of this article shall not apply to Lloyd's or reciprocals with respect to inland marine insurance, rain insurance, or hail insurance on farm crops.

Revisor's Note

(1) Section 3(a)(3), V.T.I.C. Article 5.13-2, refers to "Lloyd's" or "reciprocals." The revised law substitutes "Lloyd's plan" for "Lloyd's" because that is the term used in Chapter 941 of this code, which regulates Lloyd's plans. The revised law substitutes "reciprocal or interinsurance exchange" for "reciprocals" because that is the term used in Chapter 942 of this code, which regulates reciprocal and interinsurance exchanges.

(2) Section 3(a)(3), V.T.I.C. Article 5.13-2, refers to Sections 4, 5, 6, 7, and 8, Article 5.13-2. The revised law omits the references to Sections 4, 5, and 7 as unnecessary in this context because those sections relate only to rates and are revised in Chapter 2251 of this code, and that chapter contains a provision derived from Section 3(a)(3) that corresponds to this section. The revised law substitutes a reference to "this subchapter" for the reference to Section 8 because the substance of that section relates to forms and is revised in this subchapter.

Revised Law

Sec. 2301.004. EXEMPTION FOR LARGE RISKS. Sections 2301.006, 2301.007(a) and (b), and 2301.008 do not apply to forms for use with an insured that has:

(1) total insured property values of $5 million or more;

(2) total annual gross revenues of $10 million or more; or

(3) a total premium of $25,000 or more for property insurance, $25,000 or more for general liability insurance, or $50,000 or more for multiperil insurance. (V.T.I.C. Art. 5.13-2, Sec. 8(f).)

Source Law

(f) Policy forms for use with large risks are exempt from the requirements of Subsections (a), (b), and (e) of this section. For purposes of this subsection, "large risk" means:

(1) an insured that has total insured property values of $5 million or more;

(2) an insured that has total annual gross revenues of $10 million or more; or

(3) an insured that has a total premium of $25,000 or more for property insurance, $25,000 or more for general liability insurance, or $50,000 or more for multiperil insurance.

Revised Law

Sec. 2301.005. REGULATION OF INLAND MARINE FORMS. The

commissioner shall adopt rules governing the manner in which forms for the various classifications of risks insured under inland marine insurance, as determined by the commissioner, are regulated. (V.T.I.C. Art. 5.13-2, Sec. 2(b) (part).)

Source Law

> (b) The commissioner shall adopt rules governing the manner in which forms and . . . for the various classifications of risks insured under inland marine insurance, as determined by the commissioner, are regulated.

Revised Law

Sec. 2301.006. FILING AND APPROVAL OF FORMS. (a) Except as provided by Section 2301.008, an insurer may not deliver or issue for delivery in this state a form for use in writing insurance described by Section 2301.003 unless the form has been filed with and approved by the commissioner.

(b) An insurer must file the form not later than the 60th day before the date an insurer uses the form or delivers the form for use.

(c) A filed form is approved at the expiration of 60 days after the date the form is filed unless the commissioner by order approves or disapproves the form during the 60-day period. The commissioner's approval of a filed form constitutes a waiver of any unexpired portion of the 60-day period.

(d) The commissioner may extend by not more than 10 days the 60-day period described by Subsection (c) during which the commissioner may approve or disapprove a form filed by an insurer. The commissioner shall notify the insurer of the extension before the expiration of the 60-day period.

(e) A filed form for which an extension has been granted under Subsection (d) is considered approved at the expiration of the extension period described by that subsection absent an earlier approval or disapproval of the form. (V.T.I.C. Art. 5.13-2, Secs. 8(a), (b) (part).)

Source Law

> Sec. 8. (a) An insurance policy or printed

endorsement form for use in writing the types of insurance subject to this article may not be delivered or issued for delivery in this state unless the form has been filed with and approved by the commissioner.

(b) Each filing shall be made not later than the 60th day before the date of any use or delivery for use. At the expiration of the 60-day period a filed form is approved unless, before the expiration of the 60 days, the commissioner approves or disapproves the form by order. Approval of a form by the commissioner constitutes a waiver of any unexpired portion of the 60-day period. The commissioner may extend by not more than an additional 10 days the period during which it may approve or disapprove a form by giving notice to the filer of the extension before the expiration of the initial period. At the expiration of any extension and in the absence of any earlier approval or disapproval, the form shall be considered approved. . . .

Revisor's Note

(1) Section 8(a), V.T.I.C. Article 5.13-2, requires that an insurer file insurance policy forms and printed endorsement forms with the commissioner of insurance for approval before using those forms. Section 8(e), Article 5.13-2, however, allows an insurer to use standard forms promulgated by the commissioner instead of the insurer's own forms. For the convenience of the reader, the revised law adds a cross-reference to the exception contained in Section 8(e), revised in this chapter as Section 2301.008.

(2) Section 8(b), V.T.I.C. Article 5.13-2, refers to a "filer" with respect to an insurance policy form or printed endorsement form. Section 3(a)(2), Article 5.13-2, revised as Section 2251.002(2) of this code and applicable to Section 8(b), defines "filer" as "an insurer that files rates, prospective loss costs, or supplementary rating information" under that article. From the context of some provisions of Article 5.13-2, including Section 8(b), it is clear that "filer" also includes an insurer filing a form. Consequently, in those contexts throughout this subchapter, the revised law substitutes "insurer" for "filer."

Revised Law

Sec. 2301.007. DISAPPROVAL OF FORMS; WITHDRAWAL OF APPROVAL. (a) The commissioner may disapprove a form filed under Section 2301.006 or withdraw approval of a form if the form:

(1) violates any law, including a rule adopted under this code; or

(2) contains a provision or has a title or heading that is unjust or deceptive, encourages misrepresentation, or violates public policy.

(b) For good cause shown, the commissioner may withdraw approval of a form after notice and hearing.

(c) An order issued by the commissioner disapproving a form, or a notice of the commissioner's intention to withdraw approval of a form, must state the grounds for the disapproval or withdrawal of approval in sufficient detail to reasonably inform the insurer of those grounds.

(d) An order of withdrawal of approval of a form takes effect on the date prescribed by the commissioner in the order. The commissioner may not prescribe a date earlier than the 30th day after the effective date of the order, as prescribed by the commissioner.

(e) An insurer may not use a form in this state after the commissioner disapproves the form or withdraws approval of the form. (V.T.I.C. Art. 5.13-2, Secs. 8(b) (part), (c), (d), (e) (part).)

Source Law

> (b) . . . For good cause shown, the commissioner may withdraw the commissioner's approval at any time after notice and a hearing.
>
> (c) A commissioner's order disapproving any form or any notice of the commissioner's intention to withdraw a previous approval must state the grounds for the disapproval in enough detail to reasonably inform the filer of the grounds. An order of withdrawal of a previously approved form takes effect on the expiration of the prescribed period, but not sooner than the 30th day after the effective date of the withdrawal order, as prescribed by the commissioner.
>
> (d) An insurer may not use in this state any form after disapproval of the form or withdrawal of

approval by the commissioner.

(e) . . . The commissioner may disapprove a form or endorsement filed under this section, or withdraw any previous approval thereof, if the form or endorsement:

(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, are deceptive, or violate public policy.

Revisor's Note

(1) Section 8(b), V.T.I.C. Article 5.13-2, states that "at any time" after notice and hearing and with good cause, the commissioner of insurance may withdraw approval of an insurance policy form or printed endorsement form. Throughout this chapter, the revised law omits "at any time" as unnecessary because the authority to take an action, absent an express limitation, includes the authority to take that action at any time.

(2) Sections 8(c) and (e), V.T.I.C. Article 5.13-2, refer to "previous" approval of an insurance policy form or printed endorsement form by the commissioner of insurance and Section 8(c) further refers to a form "previously" approved by the commissioner. Throughout this subchapter, with respect to the approval of forms, the revised law omits the references to "previous" and "previously" as unnecessary because a form that is approved has necessarily been "previously" approved.

(3) Section 8(e)(1), V.T.I.C. Article 5.13-2, refers to the disapproval of an insurance policy form or printed endorsement form that "violates or does not comply" with this code or any "valid" rule relating to this code that is "duly" adopted by the commissioner of insurance or a form that is "otherwise contrary to law." The revised law omits the reference to "does not

comply" as included within the meaning of "violates" and omits the reference to "this code" as included within the meaning of "law." Furthermore, the revised law omits the reference to "valid" with respect to a rule because to have any legal effect, a rule must be valid. The revised law also omits "duly" with respect to the adoption of a rule because the word does not add to the clear meaning of the law.

Revised Law

Sec. 2301.008. ADOPTION AND USE OF STANDARD FORMS. The commissioner may adopt standard insurance policy forms, printed endorsement forms, and related forms other than insurance policy forms and printed endorsement forms, that an insurer may use instead of the insurer's own forms in writing insurance subject to this subchapter. (V.T.I.C. Art. 5.13-2, Sec. 8(e) (part).)

Source Law

> (e) The commissioner may promulgate standard insurance policy forms, endorsements, and other related forms that may be used, at the discretion of the insurer, by an insurer instead of the insurer's own forms in writing insurance subject to this article. . . .

Revised Law

Sec. 2301.009. PUBLIC INSPECTION OF INFORMATION. Each filing made, and any supporting information filed, under this subchapter is open to public inspection as of the date of the filing. (V.T.I.C. Art. 5.13-2, Sec. 6.)

Source Law

> Sec. 6. Each filing and any supporting information filed under this article is open to public inspection as of the date of the filing.

[Sections 2301.010-2301.050 reserved for expansion]

SUBCHAPTER B. POLICY FORMS FOR PERSONAL AUTOMOBILE INSURANCE COVERAGE AND RESIDENTIAL PROPERTY INSURANCE COVERAGE

Revised Law

Sec. 2301.051. DEFINITIONS. In this subchapter:

(1) "Insurer" means an insurance company, reciprocal

or interinsurance exchange, mutual insurance company, capital stock insurance company, county mutual insurance company, Lloyd's plan, or other legal entity authorized to write personal automobile insurance or residential property insurance in this state. The term includes an affiliate, as described by this code, that is authorized to write and is writing personal automobile insurance or residential property insurance in this state. The term does not include:

(A) the Texas Windstorm Insurance Association;

(B) the FAIR Plan Association; or

(C) the Texas Automobile Insurance Plan Association.

(2) "Personal automobile insurance" means automobile insurance coverage for the ownership, maintenance, or use of a private passenger, utility, or miscellaneous type motor vehicle, including a motor home, trailer, or recreational vehicle, that is:

(A) owned or leased by one or more individuals; and

(B) not primarily used for the delivery of goods, materials, or services, other than for use in farm or ranch operations.

(3) "Residential property insurance" means insurance coverage against loss to tangible personal property or to residential real property at a fixed location that is provided through a homeowners insurance policy, including a tenants insurance policy, a condominium owners insurance policy, or a residential fire and allied lines insurance policy. (V.T.I.C. Art. 5.145, Sec. 1.)

Source Law

Art. 5.145
Sec. 1. In this article:
(1) "Insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, or other legal entity authorized to write personal automobile insurance or residential property insurance in this state. The term includes an affiliate, as described by

this code, if that affiliate is authorized to write and is writing personal automobile insurance or residential property insurance in this state. The term does not include:

(A) the Texas Windstorm Insurance Association under Article 21.49 of this code;

(B) the FAIR Plan Association under Article 21.49A of this code; or

(C) the Texas Automobile Insurance Plan Association under Article 21.81 of this code.

(2) "Personal automobile insurance" means motor vehicle insurance coverage for the ownership, maintenance, or use of a private passenger, utility, or miscellaneous type motor vehicle, including a motor home, trailer, or recreational vehicle, that is:

(A) owned or leased by an individual or individuals; and

(B) not primarily used for the delivery of goods, materials, or services, other than for use in farm or ranch operations.

(3) "Residential property insurance" means insurance coverage against loss to residential real property at a fixed location, or tangible personal property, that is provided in a homeowners policy, including a tenants policy, a condominium owners policy, or a residential fire and allied lines policy.

Revisor's Note

Section 1(2), V.T.I.C. Article 5.145, refers to "motor vehicle insurance." The revised law substitutes "automobile insurance" for the reference to motor vehicle insurance for consistency with terminology used in this code and because "automobile insurance" is the term more commonly used to describe the kind of insurance that provides coverage for motor vehicles.

Revised Law

Sec. 2301.052. REGULATION OF POLICY FORMS AND ENDORSEMENTS. (a) Notwithstanding any other provision of this code and except as provided by this section, Subchapter A applies to an insurer with respect to insurance policy forms and endorsements for personal automobile insurance and residential property insurance.

(b) An insurer may continue to use an insurance policy form or endorsement promulgated, approved, or adopted under Article 5.06 or 5.35 before June 11, 2003, on written notification to the commissioner that the insurer will continue to use the form or endorsement. (V.T.I.C. Art. 5.145, Sec. 2.)

Source Law

Sec. 2. (a) Notwithstanding any other provision in this code and except as provided by this section, an insurer is governed by the provisions of Section 8, Article 5.13-2 of this code, relating to policy forms and endorsements for personal automobile insurance and residential property insurance.

(b) An insurer may continue to use the policy forms and endorsements promulgated, approved, or adopted under Articles 5.06 and 5.35 of this code on notification to the commissioner in writing that the insurer will continue to use those forms.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 5.13-2, states that an insurer is governed by Section 8, Article 5.13-2, relating to policy forms and endorsements for personal automobile insurance and residential property insurance. The revised law substitutes a reference to Subchapter A of this chapter for the reference to Section 8, Article 5.13-2, because Section 8, Article 5.13-2, is revised in that subchapter. Although some provisions of Subchapter A are derived from provisions of Article 5.13-2 other than Section 8, those provisions are necessary to interpret the provisions derived from Section 8, and it is therefore appropriate to include those provisions in the substituted reference.

(2) Section 2(b), V.T.I.C. Article 5.13-2, states that an insurer may continue to use policy forms and endorsements promulgated, approved, or adopted under V.T.I.C. Article 5.06 or 5.35. The revised law substitutes a reference to "Article 5.06 or 5.35 before June 11, 2003," for the reference to "Articles 5.06 and 5.35." Under Articles 5.06 and 5.35, the commissioner of insurance promulgated, approved, and adopted policy forms and endorsements for various lines of insurance. Sections 21.07 and 21.22, Chapter 206, Acts of the 78th Legislature, Regular Session, 2003, amended Articles 5.06 and 5.35 to provide that,

effective June 11, 2003, policy forms and endorsements for residential property insurance and personal automobile insurance are regulated under Article 5.13-2, the relevant provisions of which are revised in this chapter as Subchapter A. Consequently, any forms or endorsements promulgated, approved, or adopted under Article 5.06 or 5.35 to which Section 2(b) is referring necessarily were promulgated, approved, or adopted before June 11, 2003, and the revised law is drafted accordingly.

Revised Law

Sec. 2301.053. REQUIREMENTS FOR FORMS; PLAIN-LANGUAGE REQUIREMENT. (a) Each form filed in accordance with this subchapter must comply with applicable state and federal law.

(b) Each form for a personal automobile insurance policy must provide the coverages mandated under Subchapters C and D, Chapter 1952, unless the coverages are rejected by the named insured in the manner provided by those subchapters.

(c) A form may not be used unless the form is written in plain language. For purposes of this section, a form is written in plain language if:

(1) the form achieves the minimum score established by the commissioner on the Flesch reading ease test or an equivalent test selected by the commissioner; or

(2) at the commissioner's option, the form conforms to the language requirements in a National Association of Insurance Commissioners model act relating to plain language.

(d) Subsection (c) does not apply to policy language that is mandated by state or federal law. (V.T.I.C. Art. 5.145, Sec. 3.)

Source Law

Sec. 3. (a) Each form filed under this article must comply with applicable state and federal law.

(b) Each form for a policy of personal automobile insurance must provide the coverages mandated under Articles 5.06-1 and 5.06-3 of this code unless the coverages are rejected by the named insured in the manner provided by those articles.

(c) A form may not be used if it is not in plain language. For the purposes of this section, a 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 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 section does not apply to policy language that is mandated by state or federal law.

Revisor's Note

Section 3(c), V.T.I.C. Article 5.13-2, states that Section 3 "does not apply to policy language that is mandated by state or federal law." The revised law substitutes a reference to the portion of Section 3 that is revised in Section 2301.053(c) and contains a plain-language requirement because it is clear from the context of Section 3 that the statement of inapplicability refers only to the plain-language requirement contained in Section 3(c).

Revised Law

Sec. 2301.054. CERTAIN CONTRACTS OR AGREEMENTS PROHIBITED; REVOCATION OF CERTIFICATE OF AUTHORITY. (a) A contract or agreement that is not written into an application for personal automobile insurance coverage and the personal automobile insurance policy is void and violates this code.

(b) A contract or agreement described by Subsection (a) constitutes grounds for the revocation of an insurer's certificate of authority to write personal automobile insurance in this state. (V.T.I.C. Art. 5.145, Sec. 4.)

Source Law

Sec. 4. (a) A contract or agreement that is not written into the application for insurance coverage and the personal automobile insurance policy:

(1) is void and of no effect; and

(2) violates this article and Subchapter A of this chapter.

(b) A contract or agreement described by Subsection (a) of this section constitutes grounds for the revocation of the certificate of authority of an insurer to write personal automobile insurance in this state.

Revisor's Note

(1) Section 4(a)(1), V.T.I.C. Article 5.145, refers to a contract or agreement that is "void and of no effect." The revised law omits the reference to "of no effect" as unnecessary because the phrase is included in the meaning of "void."

(2) Section 4(a)(2), V.T.I.C. Article 5.145, states that a contract or agreement that is not written into an application for personal automobile insurance coverage and the personal automobile insurance policy violates "this article and Subchapter A of this chapter," meaning V.T.I.C. Article 5.145 and Subchapter A, V.T.I.C. Chapter 5. The revised law substitutes "this code" for the quoted references because the legal effect of violating Article 5.145 or Subchapter A, Chapter 5, is the same as the legal effect of violating this code. The penalties for violating Article 5.145, Subchapter A, Chapter 5, or any other provision in this code are the penalties set out in Subtitle B, Title 2, of this code. The only applicable penalty that is not contained in Subtitle B, Title 2, of this code is contained in V.T.I.C. Article 5.12-1, revised in this code as Section 1951.004. The penalty under Section 1951.004 applies by its own terms to a violation of the law revised in this section.

Revised Law

Sec. 2301.055. RULES. The commissioner may adopt reasonable and necessary rules to implement this subchapter. (V.T.I.C. Art. 5.145, Sec. 6.)

Source Law

Sec. 6. The commissioner may adopt reasonable and necessary rules to implement this article.

Revisor's Note

Section 6, V.T.I.C. Article 5.145, authorizes the commissioner of insurance to adopt reasonable and necessary rules to implement Article 5.145. In addition to Section 6, Sections 1, 2, 3, and 4 of that article are revised as this subchapter, and Section 5 is revised as Section 501.159 of this code. The revised law substitutes "this subchapter" for "this article" and does not refer to Section 501.159 because the substance of Section 6 is repeated in Section 501.159.

TITLE 12. OTHER COVERAGE

CHAPTER 3501. CREDIT INVOLUNTARY UNEMPLOYMENT INSURANCE
CHAPTER 3502. MORTGAGE GUARANTY INSURANCE
CHAPTER 3503. SURETY BONDS AND RELATED INSTRUMENTS

TITLE 12. OTHER COVERAGE

CHAPTER 3501. CREDIT INVOLUNTARY UNEMPLOYMENT INSURANCE

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CHAPTER 3501. CREDIT INVOLUNTARY UNEMPLOYMENT INSURANCE

Revised Law

Sec. 3501.001. DEFINITION. In this chapter, "credit involuntary unemployment insurance" means insurance that indemnifies a debtor for installment or other periodic payments on an indebtedness while the debtor is involuntarily unemployed. The term includes policy forms and endorsements that define involuntary unemployment to provide coverage and a premium charge for interruption or reduction of a debtor's income during periods of leave, whether paid or unpaid, authorized by the federal Family and Medical Leave Act of 1993 (29 U.S.C. Section 2601 et seq.), as amended, or other state or federal law. (V.T.I.C. Art. 21.79E (part).)

Source Law

> Art. 21.79E. [Any insurer authorized to write any form of casualty insurance in this state shall also be authorized to write group or individual] credit involuntary unemployment insurance indemnifying a debtor for installment or other periodic payments on the indebtedness while the debtor is involuntarily unemployed, including policy forms and endorsements which define involuntary unemployment to provide coverage and a premium charge for interruption or reduction of a debtor's income during periods of leave (paid or otherwise) authorized by the Federal Family and Medical Leave Act of 1993 (29 U.S.C. Section 2601 et seq.), as amended, or other state or federal laws. . . .

Revisor's Note

The definition of "credit involuntary unemployment insurance" is added to the revised law for drafting convenience and to eliminate unnecessary repetition of the substance of the definition.

Revised Law

Sec. 3501.002. AUTHORIZATION. (a) Any insurer authorized to write any form of casualty insurance in this state may also write group or individual credit involuntary unemployment insurance.

(b) Credit involuntary unemployment insurance may be written alone or in conjunction with credit life insurance, credit accident and health insurance, or both, in a policy issued by an authorized insurer.

(c) Credit involuntary unemployment insurance may not be written in contravention of Chapter 15, Business & Commerce Code. (V.T.I.C. Art. 21.79E (part).)

Source Law

> Art. 21.79E. Any insurer authorized to write any form of casualty insurance in this state shall also be authorized to write group or individual credit involuntary unemployment insurance . . . . Such insurance may be written alone or in conjunction with credit life insurance, credit accident and health insurance, or both, in policies issued by any authorized insurer, but not in contravention of the Texas Free Enterprise and Antitrust Act of 1983 (Chapter 15, Business & Commerce Code). . . .

Revised Law

Sec. 3501.003. RATES AND FORMS. Rates and forms for credit involuntary unemployment insurance must be set and filed in

accordance with Chapters 2251 and 2301 and Article 5.13-2. (V.T.I.C. Art. 21.79E (part).)

Source Law

> Art. 21.79E. . . . Rates and forms for such insurance may be made and filed in accordance with Article 5.13-2 of this code.

Revisor's Note

V.T.I.C. Article 21.79E states that rates and forms for credit involuntary unemployment insurance "may be made and filed" in accordance with V.T.I.C. Article 5.13-2, revised in part in Chapters 2251 and 2301 of this code. Although Chapter 2251 is also derived in part from V.T.I.C. Article 5.13-2C and Chapter 2301 is also derived in part from V.T.I.C. Article 5.145, the revised law appropriately refers to both chapters in their entirety because Article 5.13-2C relates only to certain insurers writing residential property insurance and Article 5.145 relates only to personal automobile and residential property insurance; therefore, the provisions of Chapters 2251 and 2301 derived from Articles 5.13-2C and 5.145 are inapplicable by their own terms to rates and forms for credit involuntary unemployment insurance.

In addition, the revised law substitutes "must" for "may" because Article 5.13-2 was amended by Chapter 206, Acts of the 78th Legislature, Regular Session, 2003, to list involuntary unemployment insurance as a type of insurance to which that article applies. As a result, it is clear that rates and forms for credit involuntary unemployment insurance are required to be set and filed in accordance with Article 5.13-2, and the revised law is drafted accordingly.

CHAPTER 3502. MORTGAGE GUARANTY INSURANCE

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CHAPTER 3502. MORTGAGE GUARANTY INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 3502.001. APPLICABILITY OF CHAPTER. This chapter applies only to mortgage guaranty insurance and does not affect any other provision of this code. (V.T.I.C. Art. 21.50, Sec. 1A(a).)

Source Law

> Sec. 1A. (a) The procedures as set forth herein shall govern mortgage guaranty insurance as defined in this article but shall not affect any other of the provisions of this code.

Revised Law

Sec. 3502.002. APPLICABILITY OF OTHER LAW. (a) This code and other state laws apply to the business of mortgage guaranty insurance.

(b) This chapter controls to the extent of any conflict with another provision of this code or other state law. (V.T.I.C. Art. 21.50, Sec. 10.)

Source Law

> Sec. 10. All the applicable provisions of this Code and of other statutes of this State, except as the same may be in conflict herewith, shall apply to the operation and conduct of mortgage guaranty insurance business.

Revised Law

Sec. 3502.003. MORTGAGE GUARANTY INSURANCE DEFINED. In this chapter, "mortgage guaranty insurance" means insurance against:

(1) financial loss because of nonpayment of principal, interest, and other amounts agreed to be paid under the terms of a note, bond, or other evidence of indebtedness that is secured by an

authorized real estate security, provided the improvement on the real estate is:

(A) one or more residential buildings designed to be occupied by not more than four families;

(B) a condominium unit; or

(C) one or more buildings designed to be occupied by five or more families or for industrial or commercial purposes; or

(2) financial loss because of nonpayment of rent and other amounts agreed to be paid under the terms of a written lease for the possession, use, or occupancy of real estate, provided the improvement on the real estate is one or more buildings designed to be occupied for industrial or commercial purposes. (V.T.I.C. Art. 21.50, Sec. 1 (part).)

Source Law

Art. 21.50

Sec. 1. The definitions set forth herein shall govern the construction of the terms used in this Article but shall not affect any other provisions of this Code.

(a) "Mortgage guaranty insurance" means:

(1) Insurance against financial loss by reason of nonpayment of principal, interest and other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by an authorized real estate security constituting a lien or charge on real estate, provided the improvement on such real estate is a residential building or buildings designed for occupancy by not more than four families, or a condominium unit.

(2) Insurance against financial loss by reason of nonpayment of principal, interest and other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by an authorized real estate security constituting a lien or charge on real estate, provided the improvement on such real estate is a building or buildings designed for occupancy by five or more families or designed to be occupied for industrial or commercial purposes.

(3) Insurance against financial loss by reason of nonpayment of rent and other sums agreed to be paid under the terms of a written lease for the possession, use or occupancy of real estate, provided the improvement on such real estate is a building or buildings designed to be occupied for industrial or commercial purposes.

. . .

Revisor's Note

Section 1(a), V.T.I.C. Article 21.50, refers to

evidence of indebtedness secured by an authorized real estate security "constituting a lien or charge on real estate." The revised law omits the quoted language as duplicative of the definition of "authorized real estate security" in Section 1(b), V.T.I.C. Article 21.50, revised in pertinent part as Section 3502.004(a)(2). That section requires that an evidence of indebtedness constitute or be considered a first lien or charge on real estate for the evidence of indebtedness to be an authorized real estate security.

Revised Law

Sec. 3502.004. AUTHORIZED REAL ESTATE SECURITY DEFINED. (a) In this chapter, "authorized real estate security" means:

(1) a proprietary lease and a stock membership certificate issued to a tenant stockholder or resident member of a fee simple cooperative housing corporation as defined in Section 216, Internal Revenue Code of 1986; or

(2) a mortgage, deed of trust, wraparound mortgage, or other instrument that constitutes a first lien or charge on real estate or is considered to be the equivalent of a first lien or charge on real estate by the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, the Federal Housing Finance Board, a successor of one of those entities, an agency of this state, or a federal agency, provided:

(A) the improvement on the real estate is a building or buildings designed to be occupied as specified by Section 3502.003(1); and

(B) the real estate loan is a type of loan that is:

(i) authorized to be made by a bank, savings and loan association, credit union, or insurer that is supervised and regulated by a department of this state or a federal agency;

(ii) authorized to be made by a mortgage

banker that is an approved seller-servicer of the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, or a successor of one of those entities; or

(iii) approved by the federal secretary of housing and urban development for participation in a mortgage insurance program.

(b) The lien on real estate described by Subsection (a)(2) may be subject and subordinate to:

(1) the lien of a public bond, assessment, or tax if there is not a delinquent installment, call, or payment of or under the bond, assessment, or tax;

(2) an outstanding mineral, oil, or timber right, right-of-way, easement or right-of-way support, sewer right, building restriction, other restriction or covenant, or other condition or regulation of use; or

(3) an outstanding lease on the real estate under which rents or profits are reserved to the owner. (V.T.I.C. Art. 21.50, Sec. 1 (part).)

Source Law

Sec. 1. The definitions set forth herein shall govern the construction of the terms used in this Article but shall not affect any other provisions of this Code.

. . .

(b) "Authorized real estate security" for the purposes of Paragraphs (1) and (2) of Subdivision (a) of this section means either:

(1) A note, bond or other evidence of indebtedness, secured by a mortgage, deed of trust, wraparound mortgage or other instrument which constitutes or is considered by the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, the Federal Home Loan Bank Board, their successors, or agency of this State or of the federal government to be the equivalent of a first lien or charge on real estate; provided:

(A) The real estate loan secured in such manner is a type of loan which a bank, savings and loan association, credit union or an insurance company, which is supervised and regulated by a department of this State or an agency of the federal government or a mortgage banker which is an approved seller-servicer of the Federal National Mortgage Association, Federal Home Loan Mortgage Corporation, or their successors, is authorized to make, or a type of loan which is approved by the Secretary of Housing and Urban Development for participation in any mortgage insurance program.

(B) The improvement on such real estate is a building or buildings designed for occupancy as specified by Paragraphs (1) and (2) of Subdivision (a) of this section.

(C) The lien on such real estate may be subject and subordinate to the following:

(i) The lien of any public bond, assessment, or tax, when no installment, call or payment of or under such bond, assessment or tax is delinquent.

(ii) Outstanding mineral, oil or timber rights, rights-of-way, easements or rights-of-way support, sewer rights, building restrictions or other restrictions or covenants, conditions or regulations of use, or outstanding leases upon such real property under which rents or profits are reserved to the owner thereof.

(2) A note, bond or other evidence of indebtedness secured by a proprietary lease and a stock membership certificate issued to a tenant stockholder or resident member of a fee simple cooperative housing corporation as defined in Section 216 of the United States Internal Revenue Code.

. . .

Revisor's Note

(1) Section 1(b), V.T.I.C. Article 21.50, defines "authorized real estate security" for the purposes of the definition of "mortgage guaranty insurance" provided by Section 1(a), V.T.I.C. Article 21.50, revised in this chapter as Section 3502.003. The revised law applies the definition throughout this chapter because in context it is clear that the legislature intended "authorized real estate security" to have the same meaning throughout Article 21.50, revised as this chapter.

(2) Section 1(b), V.T.I.C. Article 21.50, defines "authorized real estate security," in part, as "[a] note, bond or other evidence of indebtedness, secured by" specified instruments. The revised law omits the quoted language as duplicative and inaccurate. As used in this chapter, "authorized real estate security" refers to the specified instruments that secure the evidence of indebtedness and not to the evidence of indebtedness itself. See, for example, the use of the term in Section 1(a), V.T.I.C. Article 21.50, revised in this chapter in pertinent part as

Section 3502.003(1).

(3) Section 1(b)(1), V.T.I.C. Article 21.50, refers to the Federal Home Loan Bank Board. Sections 401 and 703 of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (Pub. L. No. 101-73) abolished the Federal Home Loan Bank Board. Section 702 of that act (codified as 12 U.S.C. Section 1422a) established the Federal Housing Finance Board, "which shall succeed to the authority of the Federal Home Loan Bank Board with respect to the Federal Home Loan Banks." The revised law is drafted accordingly.

[Sections 3502.005-3502.050 reserved for expansion]

SUBCHAPTER B. MORTGAGE GUARANTY INSURERS

Revised Law

Sec. 3502.051. GENERAL ELIGIBILITY TO WRITE MORTGAGE GUARANTY INSURANCE. (a) An insurer that writes anywhere any class of insurance other than mortgage guaranty insurance may not be issued or continue to hold a certificate of authority to write mortgage guaranty insurance in this state.

(b) A mortgage guaranty insurer that writes anywhere the class of mortgage guaranty insurance described by Section 3502.003(1)(C) or (2) may not be issued or continue to hold a certificate of authority to write in this state the class of mortgage guaranty insurance described by Section 3502.003(1)(A) or (B). (V.T.I.C. Art. 21.50, Sec. 2 (part).)

Source Law

Sec. 2. Qualifications for mortgage guaranty insurers shall be as follows:

. . .

(3) A mortgage guaranty insurer which anywhere transacts any class of insurance other than mortgage guaranty insurance is not eligible for the issuance of a certificate of authority to transact mortgage guaranty insurance in this State nor for the renewal or continuance thereof.

(4) A mortgage guaranty insurer which anywhere transacts the classes of insurance defined in Paragraphs (2) and (3) of Subdivision (a) of Section 1 is not eligible for the issuance or continuance of a certificate of authority to transact in this State the class of mortgage guaranty insurance defined in

Paragraph (1) of Subdivision (a) of Section 1.

Revisor's Note

Section 2, V.T.I.C. Article 21.50, refers to the renewal of a certificate of authority to write mortgage guaranty insurance. The revised law omits the provisions in Section 2, Article 21.50, relating to the renewal of a certificate of authority because there is no explicit authority for the Texas Department of Insurance to renew a certificate of authority for mortgage guaranty insurance, and under Section 801.053 of this code a certificate of authority is valid until it is suspended or revoked.

Revised Law

Sec. 3502.052. ELIGIBILITY OF FOREIGN OR ALIEN INSURER TO WRITE MORTGAGE GUARANTY INSURANCE. The department may not issue a certificate of authority to a foreign or alien insurer writing mortgage guaranty insurance unless the insurer demonstrates a satisfactory operating experience in the insurer's state of domicile. (V.T.I.C. Art. 21.50, Sec. 2 (part).)

Source Law

Sec. 2. Qualifications for mortgage guaranty insurers shall be as follows:

. . .

(2) A foreign or alien insurer writing mortgage guaranty insurance shall not be eligible for the issuance of a certificate of authority in Texas unless it has demonstrated a satisfactory operating experience in its state of domicile.

. . .

Revised Law

Sec. 3502.053. DISCRIMINATION PROHIBITED. In extending or issuing mortgage guaranty insurance, a mortgage guaranty insurer may not discriminate on the basis of the applicant's sex, marital status, race, color, creed, national origin, disability, or age or solely on the basis of the geographic location of the property to be insured unless:

(1) the discrimination related to geographic location is for a business purpose that is not a mere pretext for unfair

discrimination; or

(2) the refusal, cancellation, or limitation of the insurance is required by law or regulatory mandate. (V.T.I.C. Art. 21.50, Sec. 1A(l) (part).)

Source Law

> (l) . . . Mortgage guaranty insurers are prohibited from discrimination in the issuance or extension of mortgage guaranty insurance on the basis of the applicant's sex, marital status, race, color, creed, national origin, disability, age, or solely on the geographic location of the property unless (1) the discrimination related to geographic location of the property is for a business purpose that is not a mere pretext for unfair discrimination; or (2) the refusal, cancellation, or limitation is required by law or regulatory mandate.

[Sections 3502.054-3502.100 reserved for expansion]

SUBCHAPTER C. FORMS AND RATES

Revised Law

Sec. 3502.101. RATE FILINGS. (a) Not later than the 15th day before the date a mortgage guaranty insurer uses a rate or supplementary rate information in this state, the insurer must file the rate and supplementary rate information, and any changes to the rate or supplementary rate information, with the department.

(b) The rate filing must include adequate supporting data, including:

(1) information on:

(A) past and prospective loss experience in this state and outside the state;

(B) catastrophe hazards;

(C) expenses of operation; and

(D) a reasonable margin for profit and contingencies;

(2) an explanation of the insurer's interpretation of any statistical data on which the insurer relied;

(3) an explanation and description of the methods used in making the rates; and

(4) certification by an appropriate official of the insurer relating to the appropriateness of the charges, rates, or

rating plans based on reasonable assumptions and accompanied by adequate supporting information. (V.T.I.C. Art. 21.50, Secs. 1A(f) (part), (g).)

Source Law

(f) A mortgage guaranty insurer shall file with the board all rates and supplementary rate information and all changes and amendments thereto which are to be used in this state at least 15 days before they are to become effective. . . .

(g) On any filing of rates or changes and amendments to these rates, the insurer shall file adequate supporting data, including:

(1) information on past and prospective loss experience within and outside the state, on catastrophe hazards, on expenses of operation, on a reasonable margin for profit and contingencies;

(2) an explanation of the filer's interpretation of any statistical data relied on by it;

(3) an explanation and description of the methods used in making the rates;

(4) certification by an appropriate official of the insurer relating to the appropriateness of the charges, rates or rating plans based on reasonable assumptions and accompanied by adequate supporting information.

Revisor's Note

(1) Section 1A(f), V.T.I.C. Article 21.50, 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 1A(f), V.T.I.C. Article 21.50, requires a mortgage guaranty insurer to file with the Texas Department of Insurance the insurer's rates, supplementary rate information, and "all changes and amendments thereto." The revised law omits the reference to "amendments" because it is included in the meaning of "changes."

Revised Law

Sec. 3502.102. RATE STANDARDS. (a) A mortgage guaranty

insurance rate, rating plan, or charge may not be excessive, inadequate, or unfairly discriminatory and must be reasonable with respect to the benefits provided.

(b) This chapter does not require the department to:

(1) establish standard and absolute rates or a single and uniform rate for each risk or risks; or

(2) compel all insurers to adhere to rates previously filed by other insurers.

(c) The department may accept different rates for different insurers for the same risk or risks on mortgage guaranty insurance. The department may accept different rates for different insurers as filed by any authorized insurer unless the department finds that the filing does not meet the requirements of this chapter. (V.T.I.C. Art. 21.50, Secs. 1A(f) (part), (j).)

Source Law

> (f) . . . Rates, rating plans, and charges shall not be excessive, inadequate, or unfairly discriminatory and shall be reasonable with respect to the benefits provided.
>
> (j) Nothing in this Act shall be considered as compelling the State Board of Insurance to establish standard and absolute rates and the board is specifically authorized, in its discretion, to accept different rates for different insurers for the same risk or risks on the types of insurance covered by this article; nor shall this article be construed as to require the board to establish a single and uniform rate for each risk or risks or to compel all insurers to adhere to such rates previously filed by other insurers; and the board is empowered to accept such different rates for different insurers as filed by any qualified insurer unless it finds that such filing does not meet the requirements of this article.

Revisor's Note

Section 1A(j), V.T.I.C. Article 21.50, refers to a "qualified insurer." An insurer is "qualified" if the insurer holds a certificate of authority, and "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business. For that reason and for consistency of terminology throughout this code, the revised law substitutes "authorized" for "qualified."

Revised Law

Sec. 3502.103. RECORDING AND REPORTING OF LOSS AND EXPENSE EXPERIENCE AND OTHER DATA. (a) The commissioner shall adopt reasonable rules and statistical plans for the recording and reporting of loss experience and other required data by a mortgage guaranty insurer. The rules and plans must ensure that each insurer's total loss and expense experience is made available in the form and with the detail the commissioner considers necessary.

(b) Each mortgage guaranty insurer shall use the statistical plans adopted under this section to record and report loss experience and other required data in accordance with the rules adopted by the commissioner.

(c) The commissioner may modify statistical plans adopted under this section. (V.T.I.C. Art. 21.50, Sec. 1A(i).)

Source Law

(i) The board shall, after due consideration, promulgate reasonable rules and statistical plans which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss experience and such other data as may be required, in order that the total loss and expense experience of all insurers may be made available in such form and detail as may be deemed necessary by the board.

Revisor's Note

(1) Section 1A(i), V.T.I.C. Article 21.50, requires the commissioner of insurance to adopt reasonable rules and statistical plans "after due consideration." The revised law omits "after due consideration" as unnecessary because the requirement that a rule or a plan be reasonable implies that the commissioner will give the rule or plan due consideration before adopting that rule or plan.

(2) Section 1A(i), V.T.I.C. Article 21.50, requires the adoption of "rules and statistical plans which may be modified from time to time." The revised law omits the authorization to modify a rule because the authority to adopt a rule includes the authority to

modify that rule. The revised law also omits "from time to time" with respect to the modification of statistical plans because without an express limitation, the authority to modify includes the authority to modify from time to time.

Revised Law

Sec. 3502.104. POLICY FORM FILINGS. (a) Except as provided by Subsection (b), not later than the 15th day before the date a mortgage guaranty insurer uses a policy form, related form, classification, or rule in this state, the insurer must file the form, classification, or rule with the department.

(b) This subsection applies only to a policy form, related form, classification, or rule a mortgage guaranty insurer uses in this state for a policy that provides coverage for a pool or group of loans in connection with the issuance of mortgage-backed securities or bonds. Not later than the 15th day after the date the insurer uses the form, classification, or rule, the insurer shall file the form, classification, or rule with the department. (V.T.I.C. Art. 21.50, Secs. 1A(b) (part), (l) (part).)

Source Law

> (b) [All policy forms, related forms, classifications, and rules used by a mortgage guaranty insurer in this state shall be exempt from approval by the board, but] all such policy forms, related forms, classifications, and rules which are to be used in this state, except those filed under Subsection (l), shall be filed with the board at least 15 days before they are to become effective. . . .
>
> (l) Policies providing coverage for a pool or group of loans in connection with the issuance of mortgage-backed securities or bonds . . . all such policy forms, related forms, classifications, and rules which are to be used in this state shall be filed with the board at least 15 days after they are to become effective. . . .

Revised Law

Sec. 3502.105. POLICY FORM STANDARDS. The commissioner shall disapprove a mortgage guaranty insurance policy form if the form:

(1) violates this code or rules adopted by the

commissioner; or

(2) contains a provision that encourages misrepresentation or is unjust, unfair, inequitable, misleading, deceptive, or contrary to law or to the public policy of this state. (V.T.I.C. Art. 21.50, Sec. 1A(c) (part).)

Source Law

> (c) [No policy of mortgage guaranty insurance] . . . The commissioner shall disapprove any such form if:
>
> (1) It is in any respect in violation of or does not comply with this code or rules adopted by the commissioner.
>
> (2) It contains provisions which encourage misrepresentation or are unjust, unfair, inequitable, misleading, deceptive, or contrary to law or to the public policy of this state.

Revised Law

Sec. 3502.106. CLAIM AGAINST RESIDENTIAL BORROWER. A mortgage guaranty insurance policy may not contain a provision that allows subrogation rights or any other claim by the insurer against the borrower for a deficiency arising from a foreclosure sale of a single-family dwelling that is occupied by the borrower as the borrower's principal residence. (V.T.I.C. Art. 21.50, Sec. 1A(c) (part).)

Source Law

> (c) No policy of mortgage guaranty insurance shall contain a provision which allows subrogation rights or any other claim by the insurer against the borrower for a deficiency arising from a foreclosure sale of a single-family dwelling occupied by the borrower as the principal residence of the borrower. . . .

Revised Law

Sec. 3502.107. EXEMPTION; WITHDRAWAL OF APPROVAL. (a) A policy form, related form, classification, or rule a mortgage guaranty insurer uses in this state, including for a policy described by Section 3502.104(b), is exempt from department approval.

(b) If the commissioner finds, after notice and hearing, that the filing of a policy form, related form, classification, or rule is no longer in the best interest of the public, the

commissioner may issue an order:

(1) suspending the exemption under Subsection (a) with respect to one or more insurers that filed the form, classification, or rule; and

(2) requiring each affected insurer to cease and desist using the form, classification, or rule, as the commissioner specifies.

(c) If the commissioner finds, after notice and hearing, that a filed policy form or rate no longer meets the requirements of this code, the commissioner may issue an order withdrawing approval of the form or rate. The order must specify the reasons the form or rate no longer meets the requirements. An order under this subsection may not take effect until the 30th day after the date the commissioner issues the order.

(d) The commissioner must provide to each insurer that filed a form, classification, rule, or rate that is the subject of a hearing under this section notice of the hearing not later than the 20th day before the date of the hearing. The notice must specify the matters to be considered at the hearing. (V.T.I.C. Art. 21.50, Secs. 1A(b) (part), (k), (l) (part).)

Source Law

> (b) All policy forms, related forms, classifications, and rules used by a mortgage guaranty insurer in this state shall be exempt from approval by the board, but . . . . The board may, after a hearing held on not less than 20 days' notice, specifying the matters to be considered at such hearing, to every insurer which made such filing, and upon finding that such filing is no longer in the best interest of the public of this state, issue an order suspending such exemption as to any or all insurers which made such filings and ordering such insurers to cease and desist from the use of such policy forms, related forms, classifications, and rules as the board may specify in its order.
>
> (k) If at any time the board finds that a policy form or rate filing no longer meets the requirements of this code, it may, after a hearing held on not less than 20 days' notice, specifying the matters to be considered at such hearing, to every insurer which made such filing, issue an order withdrawing its approval thereof. Said order shall specify in what respects the board finds that such filing no longer meets the requirements of this code and shall be effective not less than 30 days after its issuance.

(l) [Policies providing coverage for a pool or group of loans in connection with the issuance of mortgage-backed securities or bonds] shall be exempt from approval by the board under Subsection (b) of this section, but . . . .

Revised Law

Sec. 3502.108. RULES. (a) The commissioner may, after notice and hearing, adopt reasonable rules:

(1) relating to the minimum standards for coverage under policy forms consistent with the purpose of this chapter and the public policy of this state; and

(2) necessary to establish guidelines, procedures, methods, standards, and criteria by which the types of forms and documents submitted to the department are to be reviewed and acted on by the department.

(b) The department may establish requirements for data and information filed under this chapter. (V.T.I.C. Art. 21.50, Secs. 1A(d), (e), (h).)

Source Law

(d) The commissioner may, after notice and hearing, adopt reasonable rules relating to the minimum standards for coverage under such policy forms consistent with the purpose of this article and the public policy of this state.

(e) The board may, after notice and hearing, adopt reasonable rules and amendments to rules that are necessary for it to establish guidelines, procedures, methods, standards, and criteria by which the various and different types of forms and documents submitted to the board are to be reviewed and acted on by the board.

(h) The board may establish requirements for data and information to be filed under this article.

Revisor's Note

Section 1A(e), V.T.I.C. Article 21.50, permits the commissioner of insurance to adopt rules "and amendments to rules." The revised law omits the quoted language for the reason stated in Revisor's Note (2) to Section 3502.103.

[Sections 3502.109-3502.150 reserved for expansion]

SUBCHAPTER D. FINANCIAL REQUIREMENTS

Revised Law

Sec. 3502.151. DEFINITION. In this subchapter, "contingency reserve" means an additional premium reserve established to protect policyholders against the effect of adverse economic cycles or losses. (V.T.I.C. Art. 21.50, Sec. 1(c).)

Source Law

(c) "Contingency reserve" means an additional premium reserve established for the protection of policyholders against the effect of adverse economic cycles or losses.

Revised Law

Sec. 3502.152. CAPITAL AND SURPLUS REQUIREMENTS. An insurer may not write mortgage guaranty insurance unless the insurer has the minimum capital and surplus required by Chapter 861 for a general casualty company. (V.T.I.C. Art 21.50, Sec. 2. (part).)

Source Law

Sec. 2. Qualifications for mortgage guaranty insurers shall be as follows:

(1) An insurer, in order to qualify for writing mortgage guaranty insurance, must have the same minimum capital and surplus as that required of a company by Chapter 8, Texas Insurance Code.

. . .

Revisor's Note

Section 2(1), V.T.I.C. Article 21.50, requires a mortgage guaranty insurer to have the same minimum capital and surplus "required of a company by Chapter 8, Texas Insurance Code." V.T.I.C. Chapter 8 was revised as Chapter 861 of this code, which governs general casualty companies, and as Chapter 984 of this code, which governs Mexican casualty insurance companies. The revised law refers only to Chapter 861 because the applicable minimum capital and surplus requirements are specified by that chapter.

Revised Law

Sec. 3502.153. UNEARNED PREMIUM RESERVE. (a) Except as

provided by Subsection (b), the unearned premium reserve on mortgage guaranty insurance must be computed in accordance with this code.

(b) For a policy covering a risk period of more than one year, the unearned premium reserve must be computed in accordance with standards adopted by the commissioner after appropriate hearings. (V.T.I.C. Art. 21.50, Sec. 3.)

Source Law

> Sec. 3. The unearned premium reserve on mortgage guaranty insurance shall be computed in accordance with the other applicable sections of this Code, except that on all policies covering a risk period of more than one year the unearned premium reserve shall be computed in accordance with standards promulgated by the State Board of Insurance after appropriate hearings.

Revised Law

Sec. 3502.154. LOSS RESERVE. A mortgage guaranty insurer shall determine the loss reserve using the case basis method. The loss reserve must include a reserve for claims incurred but not reported. (V.T.I.C. Art. 21.50, Sec. 4.)

Source Law

> Sec. 4. On such insurance, the case basis method shall be used to determine the loss reserve, which shall include a reserve for claims incurred but not reported.

Revised Law

Sec. 3502.155. CONTINGENCY RESERVE. (a) In addition to the capital, surplus, and reserves required by Sections 3502.152, 3502.153, and 3502.154, a mortgage guaranty insurer shall establish a contingency reserve and report the contingency reserve as a liability in the insurer's financial statements.

(b) To establish and maintain the contingency reserve, the mortgage guaranty insurer shall annually contribute to the contingency reserve 50 percent of the earned premiums on the insurer's mortgage guaranty insurance business. The reserved earned premiums may be released to the insurer's surplus annually after the premiums have been maintained for 120 months.

(c) In addition, the mortgage guaranty insurer may withdraw

premiums from the contingency reserve in any year for which the insurer can demonstrate to the department that the incurred losses for that year exceed 35 percent of the corresponding earned premiums for that year. The insurer shall reduce any subsequent annual release to surplus from the established contingency reserve by an amount equal to the amount withdrawn and released for the losses. The insurer shall deduct from subsequent annual releases any balance that exceeds the normal annual release from the contingency reserve. (V.T.I.C. Art. 21.50, Sec. 5.)

Source Law

> Sec. 5. In addition to the capital, surplus and reserves specified in Sections 2, 3 and 4 hereof, each mortgage guaranty insurer shall establish a contingency reserve, which shall be reported as a liability in the insurer's financial statements. To provide for and maintain such reserve, the company shall annually contribute to such reserve fifty per cent (50%) of the earned premiums on its mortgage guaranty insurance business. The earned premiums so reserved may be released to the insurer's surplus, annually, after they have been so maintained for 120 months. However, withdrawals may be made from such reserve by the insurer in any given year in which the insurer can demonstrate to the State Board of Insurance that the incurred losses for such year exceed thirty-five per cent (35%) of the corresponding earned premiums for such year. The amount so withdrawn and released for such losses shall reduce any subsequent annual release to surplus from the established contingency reserve by an amount equal to the amount so withdrawn, and any balance in excess of the normal annual release from such reserve shall carry over and be deducted from subsequent annual releases.

Revised Law

Sec. 3502.156. OUTSTANDING TOTAL LIABILITY. (a) A mortgage guaranty insurer may not at any time have outstanding under the insurer's aggregate mortgage guaranty insurance policies a total liability, net of reinsurance, that exceeds the sum of the insurer's capital, surplus, and contingency reserve, multiplied by 25.

(b) A mortgage guaranty insurer shall compute the insurer's liability for the purposes of this section on the basis of the insurer's liability under the election as provided by Section 3502.158. An insurer shall compute the insurer's liability for

leases on the basis of the insurer's liability as determined by the department.

(c) A mortgage guaranty insurer that has outstanding total liability that exceeds the amount computed under Subsection (a) may not write new mortgage guaranty insurance business until the insurer's total liability no longer exceeds that amount. (V.T.I.C. Art. 21.50, Sec. 6.)

Source Law

> Sec. 6. A mortgage guaranty insurer shall not at any time have outstanding a total liability, net of reinsurance, under its aggregate mortgage guaranty insurance policies exceeding 25 times its capital, surplus and contingency reserve, such liability to be computed on the basis of the insurer's liability under its election as provided in Section 7 and such liability for leases to be computed on the basis of the insurer's liability as determined by the State Board of Insurance. In the event that any insurer has outstanding total liability exceeding 25 times its capital, surplus and contingency reserve, it shall cease transacting new mortgage guaranty business until such time as its total liability no longer exceeds 25 times its capital, surplus and contingency reserve.

Revised Law

Sec. 3502.157. LIMIT ON INSURANCE OF CERTAIN LOANS. (a) In this section, "contiguous" means not separated by more than one-half mile.

(b) A mortgage guaranty insurer may not insure loans secured by properties in a single housing tract or a contiguous tract in an amount that exceeds 10 percent of the insurer's capital, surplus, and contingency reserve.

(c) In determining the amount of risk under this section, a mortgage guaranty insurer shall deduct from the total direct risk insured any applicable reinsurance in an assuming insurer authorized to engage in the business of mortgage guaranty insurance in this state. (V.T.I.C. Art. 21.50, Sec. 8.)

Source Law

> Sec. 8. A mortgage guaranty insurer shall not insure loans secured by properties in a single housing tract or a contiguous tract in excess of ten per cent (10%) of the insurer's capital, surplus and contingency reserve. In determining the amount of such risk, applicable reinsurance in any assuming insurer authorized to transact mortgage guaranty

insurance in this State shall be deducted from the total direct risk insured. "Contiguous," for the purposes of this section, means not separated by more than one-half mile.

Revised Law

Sec. 3502.158. LIMIT ON COVERAGE FOR CERTAIN INSUREDS. For the classes of insurance described by Section 3502.003(1), a mortgage guaranty insurer shall elect to:

(1) limit the insurer's coverage, net of reinsurance, to a maximum of 25 percent of the entire indebtedness to the insured; or

(2) pay the entire indebtedness to the insured and acquire title to the authorized real estate security. (V.T.I.C. Art. 21.50, Sec. 7.)

Source Law

Sec. 7. A mortgage guaranty insurer shall limit its coverage, net of reinsurance, for the class of insurance defined in Paragraphs (1) and (2) of Subdivision (a) of Section 1 to a maximum of twenty-five per cent (25%) of the entire indebtedness to the insured, or in lieu thereof, a mortgage guaranty insurer may elect to pay the entire indebtedness to the insured and acquire title to the authorized real estate security.

[Sections 3502.159-3502.200 reserved for expansion]

SUBCHAPTER E. LENDER POWERS AND DUTIES

Revised Law

Sec. 3502.201. DEFINITION. In this subchapter, "lender" has the meaning assigned by Section 549.001. (V.T.I.C. Art. 21.50, Sec. 1B(d).)

Source Law

(d) In this section, "lender" has the meaning assigned by Section 1(1), Article 21.48A, of this code.

Revised Law

Sec. 3502.202. NOTICE OF BORROWER'S RIGHT TO CANCEL. (a) A lender that requires a borrower to purchase mortgage guaranty insurance shall provide annually to the borrower a copy of the following written notice printed in at least 10-point boldfaced type:

"NOTICE OF RIGHT TO CANCEL PRIVATE MORTGAGE INSURANCE: If

you currently pay private mortgage insurance premiums, you may have the right to cancel the insurance and cease paying premiums. This would permit you to make a lower total monthly mortgage payment and to possibly receive a refund of any unearned premiums on the policy. In most cases, you have the right to cancel private mortgage insurance if the principal balance of your loan is 80 percent or less of the current fair market appraised value of your home. If you want to learn whether you are eligible to cancel this insurance, please contact us at (address and telephone number of lender) or the Texas Department of Insurance consumer help line at (the appropriate toll-free telephone number)."

(b) If federal law requires a lender to provide a borrower with a written notice containing substantially the same information required by Subsection (a), a lender that provides the notice required by federal law within the period prescribed by federal law satisfies the notice requirement of Subsection (a). (V.T.I.C. Art. 21.50, Secs. 1B(a), (c).)

Source Law

Sec. 1B. (a) A lender that requires a borrower to purchase mortgage guaranty insurance shall provide annually to the borrower a copy of the following written notice printed in at least 10-point bold-faced type:

"NOTICE OF RIGHT TO CANCEL PRIVATE MORTGAGE INSURANCE: If you currently pay private mortgage insurance premiums, you may have the right to cancel the insurance and cease paying premiums. This would permit you to make a lower total monthly mortgage payment and to possibly receive a refund of any unearned premiums on the policy. In most cases, you have the right to cancel private mortgage insurance if the principal balance of your loan is 80 percent or less of the current fair market appraised value of your home. If you want to learn whether you are eligible to cancel this insurance, please contact us at (address and telephone number of lender) or the Texas Department of Insurance consumer help line at (the appropriate toll-free telephone number)."

(c) If federal law requires a lender to provide a borrower with a written notice containing substantially the same information required by Subsection (a) of this section, a lender who provides the notice required by federal law within the period prescribed by federal law satisfies the notice requirement of Subsection (a) of this section.

Revised Law

Sec. 3502.203. REFUND OF PREMIUM. A lender that receives a refund of an unearned mortgage guaranty insurance premium paid by a borrower shall remit the refund to the borrower not later than the 10th business day after the date the lender receives the refund. (V.T.I.C. Art. 21.50, Sec. 1B(b).)

Source Law

(b) If a lender receives a refund of an unearned mortgage guaranty insurance premium paid by a borrower, the lender shall remit the refund to the borrower not later than the 10th business day after the date on which the lender receives the refund.

Revised Law

Sec. 3502.204. ADVERTISING OF "INSURED LOANS." A bank, savings and loan association, insurer, or approved seller-servicer of the Federal National Mortgage Association, any of whose authorized real estate securities are insured by a mortgage guaranty insurer, may not state in a brochure, pamphlet, or report or any form of advertising that the real estate loans of the bank, savings and loan association, insurer, or seller-servicer are "insured loans" unless:

(1) the brochure, pamphlet, report, or advertising also:

(A) clearly states that the loans are insured by private insurers; and

(B) lists the names of the private insurers; and

(2) the insurance on the real estate loans is written by an insurer authorized to write that insurance in this state. (V.T.I.C. Art. 21.50, Sec. 9.)

Source Law

Sec. 9. No bank, savings and loan association or insurance company, or an approved seller-servicer of the Federal National Mortgage Association, any of whose authorized real estate securities are insured by a mortgage guaranty insurance company, may state in any brochure, pamphlet, report or any form of advertising that the real estate loans of the bank, savings and loan association, insurance company or an approved seller-servicer of the Federal National Mortgage Association are "insured loans" unless the brochure, pamphlet, report or advertising also clearly

states that the loans are insured by private insurers and the names of the private insurers are given and shall not make any such statement at all unless such insurance is by an insurer certificated to write in this State.

Revisor's Note

Section 9, V.T.I.C. Article 21.50, refers to an "insurer certificated to write [insurance] in this State." The revised law substitutes "authorized" for "certificated" for consistency of terminology in this code.

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CHAPTER 3503. SURETY BONDS AND RELATED INSTRUMENTS

SUBCHAPTER A. CERTAIN REQUIRED OR PERMITTED OBLIGATIONS

Revised Law

Sec. 3503.001. DEFINITION. In this subchapter, "obligation" means a bond, undertaking, recognizance, guaranty, or other obligation that is by law or by a charter, ordinance, or rule of a municipality, board, body, organization, court, or public officer required or permitted to be made, given, tendered, or filed to guarantee the performance of an act, duty, or obligation or the refraining from an act. (V.T.I.C. Art. 7.19-1, Sec. (a) (part).)

Source Law

> Art. 7.19-1. (a) Whenever any bond, undertaking, recognizance or other obligation is, by law or the charter, ordinances, rules and regulations of a municipality, board, body, organization, court, judge or public officer, required or permitted to be made, given, tendered or filed, and whenever the performance of any act, duty or obligation, or the refraining from any act, is required or permitted to be guaranteed, . . . .

Revisor's Note

(1) Section (a), V.T.I.C. Article 7.19-1, 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.

(2) Section (a), V.T.I.C. Article 7.19-1, refers to an obligation that is required or permitted by "a municipality, board, body, organization, court, judge or public officer" to be made, given, tendered, or filed. Throughout this chapter, the revised law omits the term "judge" in this context because a judge acts on behalf of a court and, therefore, the term "judge" is included within the meaning of "court."

Revised Law

Sec. 3503.002. EXECUTION OF OBLIGATION BY SURETY COMPANY. (a) A surety company authorized to engage in business in this state may execute an obligation.

(b) Except as provided by Section 3503.004 or 3503.005, the execution of an obligation by a surety company under Subsection (a) is in full compliance with each law, charter, ordinance, or rule that requires:

(1) the obligation to be executed by one or more sureties; or

(2) the executing sureties to possess any qualification, including the requirement that a surety be a resident, householder, or freeholder.

(c) Each municipality, board, body, organization, court, public officer, and head of department shall accept and treat an obligation executed by a surety company under Subsection (a) as fully complying with each law, charter, ordinance, or rule described by Subsection (b). (V.T.I.C. Art. 7.19-1, Sec. (a) (part).)

Source Law

Art. 7.19-1. (a) [Whenever any bond, undertaking, recognizance or other obligation is, by law or the charter, ordinances, rules and regulations of a municipality, board, body, organization, court, judge or public officer, required or permitted to be made, given, tendered or filed, and whenever the performance of any act, duty or obligation, or the refraining from any act, is required or permitted to be guaranteed,] such bond, undertaking, obligation,

recognizance or guarantee may be executed by a surety company duly authorized to do business in this state; and, except as provided by Subsection (b), (c), or (d) of this section, such execution by such company of such bond, undertaking, obligation, recognizance or guarantee shall be in all respects a full and complete compliance with every law, charter, rule or regulation that such bond, undertaking, obligation, recognizance or guarantee shall be executed by one surety or by one or more sureties, or that such sureties shall be residents, or householders, or freeholders, or either, or both, or possess any other qualification and all courts, judges, heads of departments, boards, bodies, municipalities, and public officers of every character shall accept and treat such bond, undertaking, obligation, recognizance or guarantee when so executed by such company, as conforming to, and fully and completely complying with, every requirement of every such law, charter, ordinance, rule or regulation. . . .

Revisor's Note

Section (a), V.T.I.C. Article 7.19-1, refers to "full and complete compliance with every law, charter, rule or regulation" and to "fully and completely" complying with every "such law, charter, ordinance, rule or regulation." The revised law omits the references to "complete" and "completely" as included within the meaning of "full" and "fully," respectively. In addition, the revised law adds a reference to "ordinance" to the first quoted phrase for consistency of terminology within this section.

Revised Law

Sec. 3503.003. DESIGNATION OF AGENT BY CORPORATE SURETY REQUIRED. Notwithstanding Section 3503.002, in specifications by a municipality for work or supplies for which sealed bids are required, the municipality may require that a corporate surety tender designate, in a manner satisfactory to the municipality, an agent:

(1) who is a resident of the county in which the municipality is located; and

(2) to whom any required notices may be delivered and on whom process may be served in matters arising out of the suretyship. (V.T.I.C. Art. 7.19-1, Sec. (a) (part).)

Source Law

(a) . . . Provided, however, that any municipality may require in any specifications for work or supplies, on which sealed bids are required, that any corporate surety tender shall designate, in a manner satisfactory to it, an agent resident in the county of such municipality to whom any requisite notices may be delivered and on whom service of process may be had in matters arising out of such suretyship.

Revised Law

Sec. 3503.004. WRITTEN CERTIFICATION OF REINSURANCE AS CONDITION OF ACCEPTANCE OF OBLIGATION. (a) If an obligation is in an amount that exceeds 10 percent of the surety company's capital and surplus, the municipality, board, body, organization, court, or public officer may require, as a condition of accepting the obligation, written certification that the surety company has reinsured the portion of the risk that exceeds 10 percent of the surety company's capital and surplus with one or more reinsurers who are authorized, accredited, or trusteed to engage in business in this state.

(b) The amount reinsured by a reinsurer under this section may not exceed 10 percent of the reinsurer's capital and surplus.

(c) On request, the department shall provide the amount of the allowed capital and surplus, as of the date of the last annual statutory financial statement, for a surety company or reinsurer authorized to engage in business in this state. (V.T.I.C. Art. 7.19-1, Sec. (b).)

Source Law

(b) If any bond, undertaking, recognizance, or other obligation described in Subsection (a) of this section is in an amount in excess of 10 percent of the surety company's capital and surplus, the municipality, board, body, organization, court, judge, or public officer may require, as a condition to accepting the bond, undertaking, obligation, recognizance, or other obligation, written certification that the surety company has reinsured the portion of the risk that exceeds 10 percent of the surety company's capital and surplus with one or more reinsurers who are duly authorized, accredited, or trusteed to do business in this state. For the purposes of this subsection, the amount reinsured by any reinsurer may not exceed 10 percent of the reinsurer's capital and surplus. The State Board of Insurance shall furnish, on request, the amount of the allowed capital and surplus as of the date of the last annual statutory financial statement for a surety

company or reinsurer authorized and admitted to do business in this state.

Revisor's Note

(1) Section (b), V.T.I.C. Article 7.19-1, 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. Accordingly, the revised law substitutes a reference to the department for the reference to the board.

(2) Section (b), V.T.I.C. Article 7.19-1, refers to a surety company or reinsurer "authorized and admitted to do business in this state." Throughout this chapter, the revised law omits references to a company or reinsurer being "admitted" as unnecessary because a company or reinsurer that is authorized to engage in business in this state is necessarily admitted to engage in that business.

Revised Law

Sec. 3503.005. ADDITIONAL REQUIREMENTS FOR CERTAIN BONDS. (a) A bond that is made, given, tendered, or filed under Chapter 53, Property Code, or Chapter 2253, Government Code, may be executed only by a surety company that is authorized to write surety bonds in this state. If the amount of the bond exceeds $100,000, the surety company must also:

(1) hold a certificate of authority from the United States secretary of the treasury to qualify as a surety on obligations permitted or required under federal law; or

(2) have obtained reinsurance for any liability in excess of $100,000 from a reinsurer that:

(A) is an authorized reinsurer in this state; and

(B) holds a certificate of authority from the United States secretary of the treasury to qualify as a surety or reinsurer on obligations permitted or required under federal law.

(b) To determine whether the surety on the bond or the reinsurer holds a certificate of authority from the United States secretary of the treasury, a party may conclusively rely on the list published in the Federal Register by the United States Department of the Treasury, covering the date on which the bond was executed, of the companies holding certificates of authority as acceptable sureties on federal bonds and as acceptable reinsuring companies. A purchaser, insurer of title, or lender acquiring or insuring an interest in or title to real property may also conclusively rely on, and is protected by, a statement on a recorded bond or a sworn, recorded statement by the surety that refers to the specific recorded bond and states that, at the time the bond was executed, the surety complied with Subsection (a)(1) or (2). (V.T.I.C. Art. 7.19-1, Secs. (c), (d).)

Source Law

> (c) A bond that is made, given, tendered, or filed under Chapter 53, Property Code, or Chapter 2253, Government Code, may be executed only by a surety company that is authorized and admitted to write surety bonds in this state. If the amount of the bond exceeds $100,000, the surety must also:
>
> (1) hold a certificate of authority from the United States secretary of the treasury to qualify as a surety on obligations permitted or required under federal law; or
>
> (2) have obtained reinsurance for any liability in excess of $100,000 from a reinsurer that is authorized and admitted as a reinsurer in this state and is the holder of a certificate of authority from the United States secretary of the treasury to qualify as a surety or reinsurer on obligations permitted or required under federal law.
>
> (d) In determining whether the surety on the bond or the reinsurer holds a certificate of authority from the United States secretary of the treasury, a party may conclusively rely on the list of companies holding certificates of authority as acceptable sureties on federal bonds and as acceptable reinsuring companies published in the Federal Register by the United States Department of the Treasury covering the date on which the bond was executed. A purchaser, insurer of title, or lender acquiring or insuring an interest or title to real property may also conclusively rely on and is protected by a statement on a recorded bond or a sworn statement by the surety that is recorded and refers to the specific recorded bond and that states that, at the time the bond was executed, the surety:
>
> (1) was a holder of a certificate of authority from the United States secretary of the treasury to qualify as a surety on obligations permitted or required under federal law; or

(2) had reinsured any liability in excess of $100,000 by a reinsurer holding a certificate of authority described by Subdivision (1) of this subsection.

[Sections 3503.006-3503.050 reserved for expansion]

SUBCHAPTER B. PROMPT PAYMENT OF CONSTRUCTION PAYMENT BONDS

Revised Law

Sec. 3503.051. DEFINITIONS. In this subchapter:

(1) "Claimant" means a person directly entitled to payment under a construction payment bond.

(2) "Construction payment bond" means a surety agreement or obligation issued to guarantee or assure payment by a principal obligor for work performed or materials supplied or specially fabricated for a public or private construction project.

(3) "Notice of claim" means a written notification by a claimant who makes a claim for payment from the surety company. The term does not include a routine statutory notice required by Section 53.056(b), 53.057, 53.058, 53.252(b), or 53.253, Property Code, or Section 2253.047, Government Code.

(4) "Surety company" means an authorized surety or guaranty company that executes and delivers a construction payment bond as a surety for a principal obligor. (V.T.I.C. Art. 7.20, Sec. 1.)

Source Law

Sec. 1. In this article:

(1) "Claimant" means a person directly entitled to payment under a construction payment bond.

(2) "Construction payment bond" means a surety agreement or obligation issued to guarantee or assure payment by a principal obligor for work performed or materials supplied or specially fabricated for a public or private construction project.

(3) "Notice of claim" means a written notification by a claimant who makes a claim for payment from the surety company. The term does not include a routine statutory notice required by Section 53.056(b), 53.057, 53.058, 53.252(b), or 53.253, Property Code, or Section 2253.047, Government Code.

(4) "Surety company" means a licensed surety or guaranty company that executes and delivers a construction payment bond as a surety for a principal obligor.

Revised Law

Sec. 3503.052. CONSTRUCTION OF SUBCHAPTER. (a) This

subchapter shall be construed to encourage prompt payment of just claims made under construction payment bonds of surety companies. This subchapter does not foreclose any other remedy available to a claimant by law or contract.

(b) This subchapter may not be construed to:

(1) create a private cause of action;

(2) be a precondition to judicially enforcing an obligation under a construction payment bond;

(3) diminish any other obligation of a surety company that exists by law; or

(4) prohibit a surety company from asserting a defense against a construction payment bond claim in a proceeding to enforce a claim. (V.T.I.C. Art. 7.20, Sec. 6.)

Source Law

Sec. 6. (a) This article shall be construed to encourage prompt payment of just claims made under construction payment bonds of surety companies. This article does not foreclose any other remedy available to a claimant by law or contract.

(b) This article may not be construed to:

(1) create a private cause of action;

(2) be a precondition to judicially enforcing obligations under a construction payment bond;

(3) diminish any other obligation of a surety company that exists by law; or

(4) prohibit a surety company from asserting a defense against a construction payment bond claim in a proceeding to enforce a claim.

Revised Law

Sec. 3503.053. CERTAIN TERMS VOID. A term contained in a construction payment bond that is inconsistent with this subchapter is void. (V.T.I.C. Art. 7.20, Sec. 7.)

Source Law

Sec. 7. Any term contained in a construction payment bond that is inconsistent with this article is void.

Revised Law

Sec. 3503.054. NOTICE OF CLAIM; ACKNOWLEDGMENT AND INVESTIGATION. (a) A surety company that issues a construction payment bond shall, not later than the 15th day after the date of receipt of notice of claim under the bond:

(1) acknowledge receipt of the claim;

(2) begin any review or investigation necessary to determine whether the surety company is obligated to satisfy the claim under the bond; and

(3) request from the claimant each document, item of information, accounting, statement, or form that the surety company reasonably believes, at that time, will be required from the claimant.

(b) If a construction payment bond provides an address to which a notice of claim under the bond should be submitted, the notice is effective on the date the notice is received at that address.

(c) This subchapter does not exempt a claimant from complying with any applicable statutory or contractual notice requirement. (V.T.I.C. Art. 7.20, Sec. 2.)

Source Law

Sec. 2. (a) A surety company that has issued a construction payment bond shall, not later than the 15th day after the date of receipt of notice of claim under the bond:

(1) acknowledge receipt of the claim;

(2) begin any review or investigation necessary to determine whether the surety company is obligated to satisfy the claim under the bond; and

(3) request from the claimant each document, item of information, accounting, statement, or form that the surety company then reasonably believes will be required from the claimant.

(b) Nothing in this article exempts a claimant from compliance with any applicable statutory or contractual notice requirement.

(c) If the construction payment bond provides an address of the surety company to which claims should be submitted, the notice of claim is effective on receipt of the notice at that address.

Revised Law

Sec. 3503.055. NOTICE OF ACCEPTANCE OR REJECTION OF CLAIM. (a) Except as provided by Subsection (c), a surety company shall notify a claimant in writing of the acceptance or rejection of a claim not later than the 30th day after the date the company receives all documents, items of information, accountings, statements, and forms requested by the company under Section 3503.054.

(b) If the surety company rejects all or part of the claim, the notice required by Subsection (a) must state in specific terms the reasons for the rejection that are known by the company at the time of the rejection.

(c) If the surety company is unable to accept or reject the claim within the period specified by Subsection (a), the company, in that same period, shall notify the claimant in writing that the company is unable to accept or reject the claim. The notice provided under this subsection must:

(1) state the reasons for which the company needs additional time to accept or reject the claim; and

(2) include a request for any additional information the company reasonably needs to process the claim.

(d) Not later than the 30th day after the date a surety company notifies a claimant under Subsection (c), the company shall notify the claimant in writing of the acceptance or rejection of the claim. If the company rejects all or part of the claim, the company shall state in specific terms the reasons for the rejection that are known by the company at the time of the rejection.

(e) In addition to any other contractual or statutory basis for denying a claim, the surety company may reject all or part of a claim:

(1) that is the subject of a legitimate dispute between the principal obligor and the claimant; or

(2) for which the claimant has failed to provide supporting documents or information the company reasonably requested.

(f) The time limits provided by this section and Section 3503.054 may be varied by any statute requiring a construction payment bond.

(g) This section does not preclude a surety company from asserting any defense in an action brought by a claimant on a construction payment bond if the company makes a good faith effort to inform the claimant in accordance with this section of the

reasons for rejecting all or part of the claim. (V.T.I.C. Art. 7.20, Sec. 3.)

Source Law

Sec. 3. (a) Except as provided by Subsection (c) of this section, a surety company shall notify a claimant in writing of the acceptance or rejection of a claim not later than the 30th day after the date the surety company receives all documents, items of information, accountings, statements, and forms requested by the surety company as provided by Section 2 of this article.

(b) If the surety company rejects all or part of the claim, the notice required by Subsection (a) of this section must state in specific terms the reasons for the rejection known to the surety company at that time.

(c) If the surety company is unable to accept or reject the claim within the period specified by Subsection (a) of this section, the surety company shall provide written notice to the claimant, not later than the date specified under Subsection (a), that the surety company is unable to accept or reject the claim within that period. The notice provided under this subsection must:

(1) state the reasons for which the surety company needs additional time to accept or reject the claim; and

(2) include a request for any additional information reasonably needed by the surety company to process the claim.

(d) Not later than the 30th day after the date a surety company notifies a claimant under Subsection (c) of this section, the surety company shall notify the claimant in writing of the acceptance or rejection of the claim. If the surety company rejects all or part of the claim, the surety company shall state in specific terms the reasons for the rejection known to the surety company at that time.

(e) In addition to any other contractual or statutory basis for denying a claim, the surety company may reject all or any part of a claim:

(1) that is the subject of a legitimate dispute between the principal obligor and the claimant; or

(2) for which the claimant has failed to provide supporting documents or information reasonably requested by the surety company.

(f) The time limits provided by this section and Section 2 of this article may be varied by any statute requiring a construction payment bond.

(g) This section does not preclude a surety company from asserting any defense in any action brought by a claimant against the construction payment bond if a good faith effort is made to inform the claimant in accordance with this section of reasons for rejecting all or part of the claim.

Revised Law

Sec. 3503.056. PAYMENT OF CLAIM. (a) If a surety company notifies a claimant under Section 3503.055 that the company accepts a claim or part of a claim, the company shall pay the claim not later

than the 15th day after the date of the notice.

(b) If payment of the claim or part of the claim is conditioned on the execution of a document or performance of an act by the claimant, the surety company shall pay the claim not later than the seventh day after the date the company receives the executed document or evidence that the act has been performed.

(c) For purposes of this section, payment of a claim occurs when the surety company places the company's check or draft in the United States mail properly addressed to the claimant or the claimant's representative. (V.T.I.C. Art. 7.20, Sec. 4.)

Source Law

> Sec. 4. (a) If a surety company notifies a claimant under Section 3 of this article that the surety company accepts a claim or part of a claim, the surety company shall pay the claim not later than the 15th day after the date of the notice.
>
> (b) If payment of the claim or part of the claim is conditioned on the execution of a document or performance of an act by the claimant, the surety company shall pay the claim not later than the seventh day after the date the surety company receives the executed document or evidence that the act has been performed.
>
> (c) For purposes of this section, payment of a claim occurs when the surety company places the surety company's check or draft in the United States mail properly addressed to the claimant or the claimant's representative.

Revised Law

Sec. 3503.057. RULES. The commissioner may adopt rules enforcing this subchapter in cases in which a surety company violates this subchapter as a general business practice. (V.T.I.C. Art. 7.20, Sec. 5.)

Source Law

> Sec. 5. The commissioner may adopt rules enforcing this article in cases in which a surety company violates this article as a general business practice.

[Sections 3503.058-3503.100 reserved for expansion]

SUBCHAPTER C. OTHER BONDS

Revised Law

Sec. 3503.101. BAIL BOND CERTIFICATES. (a) In any year, an insurance company authorized to engage in fidelity and surety

insurance business in this state may become surety in an amount not to exceed $200 with respect to each bail bond certificate issued in that year by:

(1) an automobile club authorized to transact business in this state; or

(2) a truck and bus association incorporated in this state.

(b) The bail bond certificate must be a printed card or other certificate that:

(1) is issued by:

(A) an automobile club authorized to transact business within this state; or

(B) a truck and bus association incorporated in this state;

(2) is issued to a member of the club or association and signed by the member of the club or association; and

(3) contains a printed statement that:

(A) a fidelity and surety company authorized to engage in business in this state guarantees the appearance of the member whose signature appears on the card or certificate; and

(B) if the member fails to appear in court at the time of trial, the fidelity and surety company will pay any fine or forfeiture imposed on the member in an amount not to exceed $200. (V.T.I.C. Art. 7.20-1.)

Source Law

Art. 7.20-1. Any insurance company which has qualified to transact fidelity and surety insurance business in this state may, in any year, become surety in an amount not to exceed $200 with respect to each bail bond certificate issued in such year by an automobile club, duly licensed to transact business within this state, or by any truck and bus association incorporated in this state. Bail bond certificate means a printed card or other certificate issued by an automobile club, authorized to transact business within this state, or by any truck and bus association incorporated in this state to any of its members, which is signed by such member, and contains a printed statement that a fidelity and surety company authorized to do business in this state guarantees the appearance of the person whose signature appears on the card or certificate, and that such company will, in

the event of the failure of said person to appear in court at the time of trial, pay any fine or forfeiture imposed on such person in an amount not to exceed $200.

Revisor's Note

V.T.I.C. Article 7.20-1 refers to an automobile club "licensed to transact business in this state." The revised law substitutes "authorized" for "licensed" because "certificate of authority" is the term used in Chapter 722, Transportation Code, in relation to an automobile club's authority to engage in business.

[Sections 3503.102-3503.150 reserved for expansion]

SUBCHAPTER D. SUIT ON CERTAIN BONDS OR OTHER OBLIGATIONS

Revised Law

Sec. 3503.151. VENUE OF SUIT ON CERTAIN BONDS OR OTHER OBLIGATIONS. (a) This section applies to:

(1) a bond or other obligation of an insurance company authorized to engage in business in this state and to act as surety and guarantor of the fidelity of employees, trustees, executors, administrators, guardians, or others appointed to, or assuming the performance of, any public or private trust under appointment of a court or tribunal, or under contract between private individuals or corporations; or

(2) a bond that may be required:

(A) to be filed in a judicial proceeding;

(B) to guarantee a contract or undertaking between:

(i) individuals;

(ii) private corporations;

(iii) individuals and corporations; or

(iv) individuals or private corporations and the state, a municipal corporation, or a county; or

(C) of a state, county, municipal, or district official, including a school district official.

(b) A proper court in the county in which a bond or other

obligation described by Subsection (a) is filed has jurisdiction of a suit instituted on the bond or obligation. (V.T.I.C. Art. 7.01 (part).)

Source Law

> Art. 7.01. If any suit shall be instituted upon any bond or obligation of any insurance company licensed in this State and having authority to act as surety and guarantor of the fidelity of employees, trustees, executors, administrators, guardians or others appointed to, or assuming the performance of any trust, public or private, under appointment of any court or tribunal, or under contract between private individuals or corporations, or upon any bond or bonds that may be required to be filed in any judicial proceedings, or to guarantee any contract or undertaking between individuals, or between private corporations, or between individuals or private corporations and the State and municipal corporations or counties or between corporations and individuals, or on any bond or bonds that may be required of any state official, district official, county official or official of any school district or of any municipality, the proper court of the county wherein said bond is filed shall have jurisdiction of said cause. . . .

Revisor's Note

(1) V.T.I.C. Article 7.01 refers to an insurance company "licensed" in this state. Throughout this chapter, the revised law substitutes "authorized" for "licensed" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

(2) V.T.I.C. Article 7.01 provides for jurisdiction of certain suits on bonds and obligations. The Texas Supreme Court held the article unconstitutional in C. Hayman Construction Company v. American Indemnity Company, 471 S.W.2d 564 (Tex. 1971), because Chapter 39, Acts of the 56th Legislature, 2nd Called Session, 1959, which enacted Article 7.01, violated Article III, Section 35, Texas Constitution, which at that time provided that "[n]o bill . . . shall contain more than one subject, which shall be expressed in its title." However, Article 7.01 is revised in this chapter because in 1987, the

legislature enacted Chapter 46, Acts of the 70th Legislature, Regular Session, which amended and had the effect of reinstating Article 7.01.

Revised Law

Sec. 3503.152. RESIDENCE OF INSURANCE COMPANY. An insurance company described by Section 3503.151 is a resident of a county in which the company engages in business. (V.T.I.C. Art. 7.01 (part).)

Source Law

> Art. 7.01. . . . Such guaranty, fidelity and surety companies shall be deemed resident of the counties wherever they may do business, and . . . .

Revised Law

Sec. 3503.153. SERVICE OF PROCESS. In a suit described by Section 3503.151, process shall be served in accordance with Sections 804.003, 804.101, 804.102, 804.103, 804.201, 804.202, 804.203(a), (c), and (d), and 804.204, as applicable. (V.T.I.C. Art. 7.01 (part).)

Source Law

> Art. 7.01. . . . Service therein shall be had as provided by Section 2, 3, or 4, Article 1.36 of this code, as applicable. . . .

Revised Law

Sec. 3503.154. ACCEPTANCE OF SUBCHAPTER. The doing or performance of any business in any county is considered an acceptance of the provisions of this subchapter. (V.T.I.C. Art. 7.01 (part).)

Source Law

> Art. 7.01. . . . the doing or performing of any business in any county shall be deemed an acceptance of the provisions of this Act.

Revisor's Note

V.T.I.C. Article 7.01 refers to the provisions of "this Act." Article 7.01 was enacted by Chapter 39, Acts of the 56th Legislature, 2nd Called Session, 1959. Because that act did not add, amend, or repeal any other laws, it is clear that the reference to "this

Act" is a reference to Article 7.01, which is revised as this subchapter. Accordingly, the revised law substitutes a reference to "this subchapter" for the reference to "this Act."

[Sections 3503.155-3503.200 reserved for expansion]

SUBCHAPTER E. REGULATION OF SURETY COMPANY

Revised Law

Sec. 3503.201. MERGER OR CONSOLIDATION OF CERTAIN COMPANIES. When two or more companies authorized to write fidelity, guaranty, and surety insurance in this state merge or consolidate and, incident to the merger or consolidation, enter into a total reinsurance contract under which the merged or ceding company is dissolved and that company's assets are acquired and liabilities are assumed by the new or surviving company, the commissioner, on finding that the contracting companies have on deposit with the comptroller two or more deposits made for the same or similar purposes under former Article 7.03, repealed by Chapter 388, Acts of the 55th Legislature, Regular Session, 1957, or under Section 861.252, shall authorize the comptroller to:

(1) retain for a single purpose only the deposit of the greatest amount and value; and

(2) permit the new or surviving company, on proper showing that there is duplication of deposits and that the new or surviving company is the owner of those deposits, to withdraw a duplicate or excessive deposit. (V.T.I.C. Art. 7.02.)

Source Law

Art. 7.02. When two or more companies authorized to write fidelity, guaranty and surety insurance in the State of Texas merge or consolidate, and, incident to such merger or consolidation, enter into a total reinsurance contract by which the merged or ceding company is dissolved, and its assets acquired and liabilities assumed by the new or surviving company, the Commissioner of Insurance, upon finding that the contracting companies have on deposit with the comptroller two or more deposits made for the same or similar purposes under either former Article 7.03 (repealed by Acts 1957, 55th Legislature, Regular Session, Chapter 388, p. 1162) or Article 8.05 of the Insurance Code of Texas, shall authorize the comptroller to retain for a single purpose only the

deposit of greater or greatest amount and value and to permit the new or surviving reinsuring company, upon proper showing that there is such duplication of deposits and that the new or surviving company is the owner thereof, to withdraw any or all duplicate or excessive deposits.

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CHAPTER 4202. INDEPENDENT REVIEW ORGANIZATIONS

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CHAPTER 4201. UTILIZATION REVIEW AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 4201.001. PURPOSE. The purpose of this chapter is to:

(1) promote the delivery of quality health care in a cost-effective manner;

(2) ensure that a utilization review agent adheres to reasonable standards for conducting utilization review;

(3) foster greater coordination and cooperation between a health care provider and utilization review agent;

(4) improve communications and knowledge of benefits among all parties concerned before an expense is incurred; and

(5) ensure that a utilization review agent maintains the confidentiality of medical records in accordance with applicable law. (V.T.I.C. Art. 21.58A, Sec. 1.)

Source Law

Art. 21.58A

Sec. 1. The purpose of this article is to:

(1) promote the delivery of quality health care in a cost-effective manner;

(2) assure that utilization review agents adhere to reasonable standards for conducting utilization reviews;

(3) foster greater coordination and cooperation between health care providers and utilization review agents;

(4) improve communications and knowledge of benefits among all parties concerned before expenses are incurred; and

(5) ensure that utilization review agents maintain the confidentiality of medical records in accordance with applicable law.

Revised Law

Sec. 4201.002. DEFINITIONS. In this chapter:

(1) "Adverse determination" means a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary.

(2) "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 severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:

(A) place the individual's health in serious jeopardy;

(B) result in serious impairment to bodily functions;

(C) result in serious dysfunction of a bodily organ or part;

(D) result in serious disfigurement; or

(E) for a pregnant woman, result in serious jeopardy to the health of the fetus.

(3) "Enrollee" means an individual covered by a health insurance policy or health benefit plan. The term includes an individual who is covered as an eligible dependent of another individual.

(4) "Health benefit plan" means a plan of benefits, other than a health insurance policy, that:

(A) defines the coverage provisions for health care for enrollees; and

(B) is offered or provided by a public or private organization.

(5) "Health care provider" means a person, corporation, facility, or institution that is:

(A) licensed by a state to provide or is

otherwise lawfully providing health care services; and

(B) eligible for independent reimbursement for those health care services.

(6) "Health insurance policy" means an insurance policy, including a policy written by a corporation subject to Chapter 842, that provides coverage for medical or surgical expenses incurred as a result of accident or sickness.

(7) "Life-threatening" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(8) "Nurse" means a professional or registered nurse, a licensed vocational nurse, or a licensed practical nurse.

(9) "Patient" means the enrollee or an eligible dependent of the enrollee under a health benefit plan or health insurance policy.

(10) "Payor" means:

(A) an insurer that writes health insurance policies;

(B) a preferred provider organization, health maintenance organization, or self-insurance plan; or

(C) any other person or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a health care provider in this state under a policy, plan, or contract.

(11) "Physician" means a licensed doctor of medicine or a doctor of osteopathy.

(12) "Provider of record" means the physician or other health care provider with primary responsibility for the care, treatment, and services provided to an enrollee. The term includes a health care facility if treatment is provided on an inpatient or outpatient basis.

(13) "Utilization review" means a system for prospective or concurrent review of the medical necessity and appropriateness of health care services being provided or proposed

to be provided to an individual in this state. The term does not include a review in response to an elective request for clarification of coverage.

(14) "Utilization review agent" means an entity that conducts utilization review for:

(A) an employer with employees in this state who are covered under a health benefit plan or health insurance policy;

(B) a payor; or

(C) an administrator holding a certificate of authority under Chapter 4151.

(15) "Utilization review plan" means the screening criteria and utilization review procedures of a utilization review agent.

(16) "Working day" means a weekday that is not a legal holiday. (V.T.I.C. Art. 21.58A, Sec. 2 (part).)

Source Law

Sec. 2. In this article:

. . .

(2) "Administrator" means a person holding a certificate of authority under Article 21.07-6 of this code.

(3) "Adverse determination" means a determination by a utilization review agent that the health care services furnished or proposed to be furnished to a patient are not medically necessary.

. . .

(6) "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 his or her 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.

. . .

(8) "Enrollee" means a person covered by a health insurance policy or plan and includes a person who is covered as an eligible dependent of another person.

(9) "Health benefit plan" means a plan of benefits that defines the coverage provisions for

health care for enrollees offered or provided by any organization, public or private, other than health insurance.

(10) "Health care provider" means any person, corporation, facility, or institution licensed by a state to provide or otherwise lawfully providing health care services that is eligible for independent reimbursement for those services.

(11) "Health insurance policy" means an insurance policy, including a policy written by a company subject to Chapter 20 of this code, that provides coverage for medical or surgical expenses incurred as a result of accident or sickness.

(12) "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.

(13) "Nurse" means a professional or registered nurse, a licensed vocational nurse, or a licensed practical nurse.

. . .

(16) "Patient" means the enrollee or an eligible dependent of the enrollee under a health benefit plan or health insurance plan.

(17) "Payor" means:

(A) an insurer writing health insurance policies;

(B) any preferred provider organization, health maintenance organization, self-insurance plan; or

(C) any other person or entity which provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to persons treated by a health care provider in this state pursuant to any policy, plan, or contract.

(18) "Physician" means a licensed doctor of medicine or a doctor of osteopathy.

(19) "Provider of record" means the physician or other health care provider that has primary responsibility for the care, treatment, and services rendered to the enrollee and includes any health care facility when treatment is rendered on an inpatient or outpatient basis.

(20) "Utilization review" means a system for prospective or concurrent review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an individual within this state. Utilization review shall not include elective requests for clarification of coverage.

(21) "Utilization review agent" means an entity that conducts utilization review for:

(A) an employer with employees in this state who are covered under a health benefit plan or health insurance policy;

(B) a payor; or

(C) an administrator.

(22) "Utilization review plan" means the screening criteria and utilization review procedures of a utilization review agent.

(23) "Working day" means a weekday, excluding a legal holiday.

Revisor's Note

(1) Section 2(1), V.T.I.C. Article 21.58A, defines "administrative procedure act." The revised

law omits the definition as unnecessary and substitutes a reference to Chapter 2001, Government Code, which is the Administrative Procedure Act, for references to the "administrative procedure act" throughout this chapter. The omitted law reads:

> (1) "Administrative procedure act" means Chapter 2001, Government Code.

(2) Section 2(2), V.T.I.C. Article 21.58A, defines "administrator." The revised law incorporates the substance of the definition of "administrator" into the definition of "utilization review agent" provided by Section 2(21), V.T.I.C. Article 21.58A, revised in this chapter as Section 4201.002(14), because that is the only other use of the term "administrator" in V.T.I.C. Article 21.58A, revised as this chapter. In addition, the definition of "administrator" in Section 2(2) includes a reference to "a certificate of authority under Article 21.07-6." V.T.I.C. Article 21.07-6 is revised in various chapters in this code. The relevant provisions are revised in Chapter 4151 of this code, and the revised law is drafted accordingly.

(3) Section 2(4), V.T.I.C. Article 21.58A, in part defines "certificate" for purposes of Article 21.58A to mean a certificate of registration. The revised law omits the provision as unnecessary and substitutes a reference to a "certificate of registration" for references to a "certificate" throughout this chapter. The omitted law reads:

> (4) "Certificate" means a certificate of registration . . . .

(4) Section 2(5), V.T.I.C. Article 21.58A, defines "commissioner" to mean the commissioner of insurance. The revised law omits the definition as unnecessary because 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:

> (5) "Commissioner" means the commissioner of insurance.

(5) Section 2(6), V.T.I.C. Article 21.58A, refers to "including but not limited to." "[B]ut not limited to" is omitted as unnecessary because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, 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.

(6) Section 2(7), V.T.I.C. Article 21.58A, defines the term "dental plan." The revised law omits the term as unnecessary because V.T.I.C. Article 21.58A does not use the defined term. The omitted law reads:

> (7) "Dental plan" means an insurance policy or health benefit plan, including a policy written by a company subject to Chapter 20 of this code, that provides coverage for expenses for dental services.

(7) Section 2(8), V.T.I.C. Article 21.58A, defines the term "enrollee" in part by referring to an individual covered by a health insurance policy or "plan." The revised law substitutes a reference to "health benefit plan" for "plan" because "health benefit plan" is the defined term under Section 2(9), V.T.I.C. Article 21.58A, revised in this chapter as Section 4201.002(4).

(8) Section 2(9), V.T.I.C. Article 21.58A, refers to a health benefit plan other than "health insurance," and Section 2(16), V.T.I.C. Article 21.58A, defines the term "patient" in part by

referring to "a health benefit plan or health insurance plan." The revised law substitutes a reference to a "health insurance policy" for the references to "health insurance" and "health insurance plan" because "health insurance policy," rather than "health insurance" or "health insurance plan," is the defined term under Section 2(11), V.T.I.C. Article 21.58A, revised in this chapter as Section 4201.002(6).

(9) Section 2(14), V.T.I.C. Article 21.58A, defines "open meetings law" to mean Chapter 551, Government Code. The revised law omits the definition as unnecessary and substitutes a reference to Chapter 551, Government Code, which is the open meetings law, for references to the "open meetings law" throughout this chapter. The omitted law reads:

> (14) "Open meetings law" means Chapter 551, Government Code.

(10) Section 2(15), V.T.I.C. Article 21.58A, defines "open records law" to mean 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." The revised law omits the definition as unnecessary and substitutes a reference to Chapter 552, Government Code, which is the public information law, for references to the "open records law" throughout this chapter. The omitted law reads:

> (15) "Open records law" means Chapter 552, Government Code.

Revised Law

Sec. 4201.003. RULES. (a) The commissioner may adopt rules to implement this chapter.

(b) A rule adopted under this chapter relates only to a

person or entity subject to this chapter.

(c) The commissioner shall appoint an advisory committee to advise the commissioner on development of rules regarding the administration of this chapter, as authorized by Section 2001.031, Government Code. The committee includes:

(1) the public counsel appointed under Chapter 501; and

(2) one representative for each of the following:

(A) insurers;

(B) health maintenance organizations;

(C) group hospital service corporations;

(D) utilization review agents;

(E) employers;

(F) consumer organizations;

(G) physicians;

(H) dentists;

(I) hospitals;

(J) registered nurses; and

(K) other health care providers.

(d) The advisory committee's deliberations are subject to Chapter 551, Government Code. (V.T.I.C. Art. 21.58A, Secs. 13, 14(f).)

Source Law

Sec. 13. The commissioner may have the authority to adopt rules and regulations to implement the provisions of this article. The commissioner shall appoint an advisory committee to advise the commissioner in developing rules and regulations to administer this article as authorized by Section 2001.031, Government Code. The committee's deliberations shall be subject to the open meetings law. The committee shall include the public counsel and one representative for each of the following: insurance companies, health maintenance organizations, group hospital service corporations, utilization review agents, employers, consumer organizations, physicians, dentists, hospitals, registered nurses, and other health care providers.

[Sec. 14]

(f) Any regulations promulgated pursuant to this article shall relate only to persons or entities subject to this article.

Revisor's Note

(1) Section 13, V.T.I.C. Article 21.58A, refers to "rules and regulations." Throughout this chapter, the reference to "regulations" is omitted from the revised law because under Section 311.005(5), Government Code (Code Construction Act), applicable to the revised law, a rule is defined to include a regulation.

(2) Section 13, V.T.I.C. Article 21.58A, refers to "the public counsel." For the convenience of the reader, the revised law adds "appointed under Chapter 501" when referring to the public counsel because the public counsel is appointed under that chapter to serve as the executive director of the office of public insurance counsel.

(3) Section 14(f), V.T.I.C. Article 21.58A, refers to "regulations" adopted under Article 21.58A. The revised law substitutes "rules" for "regulations" because, in this context, the terms are synonymous and because of the reason stated in Revisor's Note (1) to this section.

Revised Law

Sec. 4201.004. TELEPHONE ACCESS. (a) A utilization review agent shall:

(1) have appropriate personnel reasonably available, by toll-free telephone at least 40 hours per week during normal business hours in this state, to discuss patients' care and allow response to telephone review requests;

(2) have a telephone system capable, during hours other than normal business hours, of accepting or recording incoming telephone calls or of providing instructions to a caller; and

(3) respond to a call made during hours other than normal business hours not later than the second working day after

the later of:

(A) the date the call was received; or

(B) the date the details necessary to respond have been received from the caller.

(b) A utilization review agent must provide to the commissioner a written description of the procedures to be used when responding with respect to poststabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider. (V.T.I.C. Art. 21.58A, Sec. 7.)

Source Law

Sec. 7. (a) A utilization review agent shall have appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in Texas to discuss patients' care and allow response to telephone review requests.

(b) A utilization review agent must have a telephone system capable of accepting or recording or providing instructions to incoming phone calls during other than normal business hours and shall respond to such calls not later than two working days of the later of the date on which the call was received or the date the details necessary to respond have been received from the caller.

(c) A utilization review agent must provide a written description to the commissioner setting forth the procedures to be used when responding to poststabilization care subsequent to emergency treatment as requested by a treating physician or health care provider.

[Sections 4201.005-4201.050 reserved for expansion]

SUBCHAPTER B. APPLICABILITY OF CHAPTER

Revised Law

Sec. 4201.051. PERSONS PROVIDING INFORMATION ABOUT SCOPE OF COVERAGE OR BENEFITS. This chapter does not apply to a person who:

(1) provides information to an enrollee about scope of coverage or benefits provided under a health insurance policy or health benefit plan; and

(2) does not determine whether a particular health care service provided or to be provided to an enrollee is medically necessary or appropriate. (V.T.I.C. Art. 21.58A, Sec. 14(a).)

Source Law

Sec. 14. (a) This article shall not apply to a person who provides information to enrollees about scope of coverage or benefits provided under a health

insurance policy or health benefit plan and who does not determine whether particular health care services provided or to be provided to an enrollee are medically necessary or appropriate.

Revised Law

Sec. 4201.052. CERTAIN CONTRACTS WITH FEDERAL GOVERNMENT. This chapter does not apply to a contract with the federal government to provide utilization review with respect to a patient who is eligible for services under Title XVIII or XIX of the Social Security Act (42 U.S.C. Section 1395 et seq. or Section 1396 et seq.). (V.T.I.C. Art. 21.58A, Sec. 14(b)(1).)

Source Law

(b)(1) This article shall not apply to any contract with the federal government for utilization review of patients eligible for services under Title XVIII or XIX of the Social Security Act (42 U.S.C. Section 1395 et seq. or Section 1396 et seq.).

Revised Law

Sec. 4201.053. MEDICAID AND CERTAIN OTHER STATE HEALTH OR MENTAL HEALTH PROGRAMS. Except as provided by Section 4201.057, this chapter does not apply to:

(1) the state Medicaid program;

(2) the services program for children with special health care needs under Chapter 35, Health and Safety Code;

(3) a program administered under Title 2, Human Resources Code;

(4) a program of the Department of State Health Services relating to mental health services;

(5) a program of the Department of Aging and Disability Services relating to mental retardation services; or

(6) a program of the Texas Department of Criminal Justice. (V.T.I.C. Art. 21.58A, Sec. 14(b)(2).)

Source Law

(2) Except as provided by Subsection (g) of this section, this article shall not apply to the Texas Medicaid Program, the services program for children with special health care needs created pursuant to Chapter 35, Health and Safety Code, any program administered under Title 2, Human Resources Code, any program of the Texas Department of Mental Health and Mental Retardation, or any program of the Texas Department of Criminal Justice.

Revisor's Note

Section 14(b)(2), V.T.I.C. Article 21.58A, refers to a program of the Texas Department of Mental Health and Mental Retardation. In Chapter 198, Acts of the 78th Legislature, Regular Session, 2003, the legislature directed the consolidation of health and human services agencies and programs. Under the authority of Section 1.26 of that act, the Texas Department of Mental Health and Mental Retardation was abolished. The programs and functions of that department were transferred under Sections 1.19 and 1.20 of the act to the Department of State Health Services and the Department of Aging and Disability Services, respectively. The revised law is drafted accordingly.

Revised Law

Sec. 4201.054. WORKERS' COMPENSATION BENEFITS. (a) Except as provided by this section, this chapter applies to utilization review of a health care service provided to a person eligible for workers' compensation medical benefits under Title 5, Labor Code. The commissioner shall regulate as provided by this chapter a person who performs utilization review of a medical benefit provided under Chapter 408, Labor Code.

(b) This section does not affect the authority of the Texas Workers' Compensation Commission to exercise the powers granted to that commission under Title 5, Labor Code.

(c) Title 5, Labor Code, prevails in the event of a conflict between this chapter and Title 5, Labor Code.

(d) The commissioner and the Texas Workers' Compensation Commission may adopt rules and enter into memoranda of understanding as necessary to implement this section. (V.T.I.C. Art. 21.58A, Sec. 14(c).)

Source Law

(c) Except as otherwise provided by this

subsection, this article applies to utilization review of health care services provided to persons eligible for workers' compensation medical benefits under Title 5, Labor Code. The commissioner shall regulate in the manner provided by this article a person who performs review of a medical benefit provided under Chapter 408, Labor Code. This subsection does not affect the authority of the Texas Workers' Compensation Commission to exercise the powers granted to that commission under Title 5, Labor Code. In the event of a conflict between this article and Title 5, Labor Code, Title 5, Labor Code, prevails. The commissioner and the Texas Workers' Compensation Commission may adopt rules and enter into memoranda of understanding as necessary to implement this subsection.

Revised Law

Sec. 4201.055. HEALTH CARE SERVICE PROVIDED UNDER AUTOMOBILE INSURANCE POLICY. This chapter does not apply to utilization review of a health care service provided under an automobile insurance policy or contract that is authorized under Chapter 2301 or Article 5.13-2 or that is issued under Chapter 981. (V.T.I.C. Art. 21.58A, Sec. 14(d).)

Source Law

(d) This article shall not apply to utilization review of health care services provided under a policy or contract of automobile insurance promulgated by the board under Subchapter A, Chapter 5 of this code or issued pursuant to Article 1.14-2 of this code.

Revisor's Note

(1) Section 14(d), V.T.I.C. Article 21.58A, refers to "a policy or contract of automobile insurance promulgated by the board," meaning the State Board of Insurance, "under Subchapter A, Chapter 5 of this code." 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.

Before the regular session of the 78th Legislature, the commissioner adopted policy forms and endorsements for automobile insurance under V.T.I.C. Article 5.06. Chapter 206, Acts of the 78th

Legislature, Regular Session, 2003, amended Article 5.06 to provide that, effective June 11, 2003, forms for automobile insurance are regulated under V.T.I.C. Article 5.13-2, which is revised in part as Subchapter A, Chapter 2301. That act also amended Article 5.06 and V.T.I.C. Article 5.145, revised in relevant part as Subchapter B, Chapter 2301, to authorize insurers to continue to use policy forms and endorsements for personal automobile insurance promulgated, approved, or adopted by the commissioner under Article 5.06 before June 11, 2003, on notification to the commissioner. For that reason, the revised law substitutes a reference to "an automobile insurance policy or contract that is authorized under Chapter 2301 or Article 5.13-2" for the reference to "a policy or contract of automobile insurance promulgated . . . under Subchapter A, Chapter 5."

(2) Section 14(d), V.T.I.C. Article 21.58A, refers to an automobile insurance policy or contract "issued pursuant to Article 1.14-2 of this code." V.T.I.C. Article 1.14-2 was revised in various chapters in this code. The relevant provisions are revised in Chapter 981 of this code, and the revised law is drafted accordingly.

Revised Law

Sec. 4201.056. EMPLOYEE WELFARE BENEFIT PLANS. This chapter does not apply to the terms or benefits of an employee welfare benefit plan defined by Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)). (V.T.I.C. Art. 21.58A, Sec. 14(e).)

Source Law

(e) This article shall not apply to the terms or benefits of employee welfare benefit plans as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)).

Revised Law

Sec. 4201.057. HEALTH MAINTENANCE ORGANIZATIONS. (a) In this section, "health maintenance organization" includes a health maintenance organization that contracts with the Health and Human Services Commission or with an agency operating part of the state Medicaid managed care program to provide health care services to recipients of medical assistance under Chapter 32, Human Resources Code.

(b) This chapter applies to a health maintenance organization except as expressly provided by this section.

(c) As a condition of holding a certificate of authority to engage in the business of a health maintenance organization, a health maintenance organization that performs utilization review must:

(1) comply with this chapter, except Subchapter C; and

(2) submit to assessment of a maintenance tax under Chapter 258 to cover the costs of administering compliance with this subsection.

(d) The commissioner shall adopt rules for appropriate verification and enforcement of compliance with Subsection (c).

(e) Notwithstanding Subsection (c)(1), a health maintenance organization that performs utilization review for a person or entity subject to this chapter, other than a person or entity for which the health maintenance organization is the payor, must obtain a certificate of registration under Subchapter C and shall comply with all of the provisions of this chapter.

(f) This chapter does not prohibit or limit the distribution of a portion of the savings from the reduction or elimination of unnecessary medical services, treatment, supplies, confinements, or days of confinement in a health care facility through profit sharing, bonus, or withholding arrangements to a participating physician or participating health care provider for providing health care services to an enrollee. (V.T.I.C. Art. 21.58A, Secs. 14(g), (i) (part).)

Source Law

(g) A health maintenance organization, including a health maintenance organization that contracts with the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program to provide health care services to recipients of medical assistance under Chapter 32, Human Resources Code, is subject to this article except as expressly provided in this subsection and Subsection (i) of this section. If such health maintenance organization performs utilization review as defined herein, it shall, as a condition of licensure:

(1) comply with this article, except Sections 3 and 10, and the commissioner shall promulgate rules for appropriate verification and enforcement of compliance. However, nothing in this article shall be construed to prohibit or limit the distribution of a proportion of the savings from the reduction or elimination of unnecessary medical services, treatment, supplies, confinements, or days of confinement in a health care facility through profit sharing, bonus, or withhold arrangements to participating physicians or participating health care providers for rendering health care services to enrollees; and

(2) submit to assessment of maintenance taxes under Article 20A.33, Texas Health Maintenance Organization Act (Article 20A.33, Vernon's Texas Insurance Code), to cover the costs of administering compliance of health maintenance organizations under this section.

(i) However, when . . . a health maintenance organization performs utilization review for a person or entity subject to this article other than one for which it is the payor, such . . . health maintenance organization shall be required to obtain a certificate under Section 3 of this article and comply with all the provisions of this article.

Revisor's Note

(1) Section 14(g), V.T.I.C. Article 21.58A, imposes certain duties "as a condition of licensure" on health maintenance organizations that perform utilization review. The revised law substitutes "as a condition of holding a certificate of authority to engage in the business of a health maintenance organization" for "as a condition of licensure" because under Section 843.071 of this code, a person is required to obtain a certificate of authority to operate as a health maintenance organization.

(2) Section 14(g)(1), V.T.I.C. Article 21.58A, refers to Section 10 of Article 21.58A. The revised

law omits the reference because Section 10 was repealed by Chapter 703, Acts of the 77th Legislature, Regular Session, 2001.

(3) Section 14(g)(2), V.T.I.C. Article 21.58A, refers to the assessment of maintenance taxes under "Article 20A.33, Texas Health Maintenance Organization Act (Article 20A.33, Vernon's Texas Insurance Code)." V.T.I.C. Article 20A.33 was revised in various chapters in this code. The portions of Article 20A.33 relating to imposition of maintenance taxes on health maintenance organizations are revised as Chapter 258 of this code. The revised law is drafted accordingly.

(4) Section 14(i), V.T.I.C. Article 21.58A, requires a health maintenance organization that performs utilization review for certain persons or entities to obtain a certificate of registration under Section 3, Article 21.58A, revised in this chapter as Subchapter C. The revised law adds the phrase "[n]otwithstanding Subsection (c)(1)" to this provision to clarify that the relevant portion of Section 14(i), revised as Section 4201.057(e), is an exception to the exemption from the requirement to obtain a certificate of registration that is provided by Section 14(g)(1), Article 21.58A, revised in relevant part as Section 4201.057(c)(1).

Revised Law

Sec. 4201.058. INSURERS. (a) This chapter applies to an insurer subject to this code that delivers or issues for delivery a health insurance policy in this state except as expressly provided by this section. As a condition of holding a certificate of authority to engage in the business of insurance, an insurer that performs utilization review shall comply with this chapter, except Subchapter C. The insurer is subject to assessment of a maintenance

tax under Chapter 257 to cover the costs of administering compliance with this subsection.

(b) The commissioner shall adopt rules for appropriate verification and enforcement of compliance with Subsection (a).

(c) Notwithstanding Subsection (a), an insurer subject to this code that performs utilization review for a person or entity subject to this chapter, other than a person or entity for which the insurer is the payor, must obtain a certificate of registration under Subchapter C and shall comply with all of the provisions of this chapter. (V.T.I.C. Art. 21.58A, Secs. 14(h), (i) (part).)

Source Law

> (h) An insurer which delivers or issues for delivery a health insurance policy in Texas and is subject to this code is subject to this article except as expressly provided in this subsection and Subsection (i) of this section. If an insurer performs utilization review as defined herein it shall, as a condition of licensure, comply with this article, except Sections 3 and 10, and the commissioner shall promulgate rules for appropriate verification and enforcement of compliance. Such insurers shall be subject to assessment of maintenance tax under Article 4.17 of this code to cover the costs of administering compliance of insurers under this section.
>
> (i) However, when an insurer subject to this code or . . . performs utilization review for a person or entity subject to this article other than one for which it is the payor, such insurer or . . . shall be required to obtain a certificate under Section 3 of this article and comply with all the provisions of this article.

Revisor's Note

(1) Section 14(h), V.T.I.C. Article 21.58A, imposes certain duties "as a condition of licensure" on certain insurers that perform utilization review. The revised law substitutes "[a]s a condition of holding a certificate of authority to engage in the business of insurance" for "[a]s a condition of licensure" because, under this code, an insurer is required to obtain a certificate of authority to engage in the business of insurance in this state.

(2) Section 14(h), V.T.I.C. Article 21.58A, refers to Section 10 of Article 21.58A. The revised

law omits the reference for the reason stated in Revisor's Note (2) to Section 4201.057.

(3) Section 14(h), V.T.I.C. Article 21.58A, refers to the assessment of a maintenance tax under "Article 4.17 of this code." V.T.I.C. Article 4.17 was revised in various chapters in this code. The relevant provisions are revised in Chapter 257 of this code. The revised law is drafted accordingly.

(4) Section 14(i), V.T.I.C. Article 21.58A, requires an insurer that performs utilization review for certain persons or entities to obtain a certificate of registration under Section 3, Article 21.58A, revised in this chapter as Subchapter C. The revised law adds the phrase "[n]otwithstanding Subsection (a)" to this provision to clarify that the relevant portion of Section 14(i), revised as Section 4201.058(c), is an exception to the exemption from the requirement to obtain a certificate of registration that is provided by Section 14(h), Article 21.58A, revised in relevant part as Section 4201.058(a).

[Sections 4201.059-4201.100 reserved for expansion]

SUBCHAPTER C. CERTIFICATION

Revised Law

Sec. 4201.101. CERTIFICATE OF REGISTRATION REQUIRED. A utilization review agent may not conduct utilization review unless the commissioner issues a certificate of registration to the agent under this subchapter. (V.T.I.C. Art. 21.58A, Secs. 2 (part), 3(a).)

Source Law

Sec. 2. [In this article:]

. . .

(4) ["Certificate" means a certificate of registration] granted by the commissioner to a utilization review agent.

. . .

Sec. 3. (a) A utilization review agent may not conduct utilization review of health care provided in

this state unless the commissioner has granted the utilization review agent a certificate pursuant to this article.

Revisor's Note

Section 3(a), V.T.I.C. Article 21.58A, refers to utilization review of "health care provided in this state." The revised law omits the quoted phrase because it duplicates the definition of "utilization review" in Section 2(20), V.T.I.C. Article 21.58A, revised in this chapter as Section 4201.002(13).

Revised Law

Sec. 4201.102. REQUIREMENTS FOR CERTIFICATION. (a) The commissioner may issue a certificate of registration only to an applicant who has met all the requirements of this chapter and all applicable rules adopted by the commissioner.

(b) As a condition of holding a certificate of registration or renewal of a certificate, a utilization review agent must maintain compliance with Subchapters D, E, and F. (V.T.I.C. Art. 21.58A, Secs. 3(b), 4(a).)

Source Law

[Sec. 3]

(b) The commissioner may only issue a certificate to an applicant that has met all the requirements of this article and all applicable rules and regulations of the commissioner.

Sec. 4. (a) As a condition of certification or renewal thereof, a utilization review agent shall be required to maintain compliance with the provisions of this section.

Revised Law

Sec. 4201.103. CERTIFICATE RENEWAL. Certification may be renewed biennially by filing, not later than March 1, a renewal form with the commissioner accompanied by a fee in an amount set by the commissioner. (V.T.I.C. Art. 21.58A, Sec. 3(d).)

Source Law

(d) Certification may be renewed biennially by filing, not later than March 1, a renewal form with the commissioner accompanied by a renewal fee in an amount set by the commissioner.

Revised Law

Sec. 4201.104. CERTIFICATION AND RENEWAL FORMS. (a) The commissioner shall promulgate forms to be filed under this subchapter for initial certification and for a renewal certificate of registration. The form for initial certification must require:

(1) the utilization review agent's name, address, telephone number, and normal business hours;

(2) the name and address of an agent for service of process in this state;

(3) a summary of the utilization review plan;

(4) information concerning the categories of personnel who will perform utilization review for the agent;

(5) a copy of the procedures established under Subchapter H for the appeal of an adverse determination;

(6) a certification that the agent will comply with this chapter; and

(7) a copy of the procedures for resolving oral or written complaints initiated by enrollees, patients, or health care providers as required by Section 4201.204.

(b) The commissioner may not require that the summary of the utilization review plan include proprietary details. (V.T.I.C. Art. 21.58A, Sec. 3(e).)

Source Law

(e) The commissioner shall promulgate certification and renewal forms to be filed under this section. The form for initial certification must require the following:

(1) the entity's name, address, telephone number, and normal business hours;

(2) the name and address of an agent for service of process in this state;

(3) a summary of the utilization review plan, but in no event shall proprietary details be subject to inclusion in the summary;

(4) information concerning the personnel categories that will perform utilization review for the utilization review agent;

(5) a copy of the procedure established by the utilization review agent as required by this article for appeal of an adverse determination;

(6) a certification that the utilization review agent will comply with the provisions of this article; and

(7) a copy of the procedures for handling

oral and written complaints by enrollees, patients, or health care providers.

Revisor's Note

(1) Section 3(e)(5), V.T.I.C. Article 21.58A, refers to procedures for appeal of an adverse determination established by a utilization review agent. For the reader's convenience, the revised law adds a cross-reference to Subchapter H because that subchapter, which is derived from Section 6, V.T.I.C. Article 21.58A, requires those procedures.

(2) Section 3(e)(7), V.T.I.C. Article 21.58A, refers to procedures for handling certain complaints concerning utilization review. For the reader's convenience, the revised law adds a cross-reference to Section 4201.204 because that section, which is derived from Section 4(m), V.T.I.C. Article 21.58A, requires a utilization review agent to establish those procedures.

Revised Law

Sec. 4201.105. FEES. The commissioner shall establish, administer, and enforce the fees for initial certification and certification renewal in amounts that do not exceed the amounts necessary to cover the cost of administering this chapter. (V.T.I.C. Art. 21.58A, Sec. 3(f).)

Source Law

(f) The commissioner shall establish, administer, and enforce the certification and renewal fees under this section in amounts not greater than that necessary to cover the cost of administration of this article.

Revised Law

Sec. 4201.106. CERTIFICATE NOT TRANSFERABLE. A certificate of registration is not transferable. (V.T.I.C. Art. 21.58A, Sec. 3(c).)

Source Law

(c) A certificate issued under this article is not transferable.

Revised Law

Sec. 4201.107. REPORTING MATERIAL CHANGES. A utilization review agent shall report any material change to the information disclosed in a form filed under this subchapter not later than the 30th day after the date the change takes effect. (V.T.I.C. Art. 21.58A, Sec. 3(g).)

Source Law

> (g) A utilization review agent shall report any material changes in the information in a certification or renewal form filed under this section not later than the 30th day after the date on which the change takes effect.

Revisor's Note

Section 3(g), V.T.I.C. Article 21.58A, refers to a certification or renewal form filed under "this section," meaning Section 3, V.T.I.C. Article 21.58A. Although this subchapter contains provisions derived from other sections of Article 21.58A, the revised law substitutes "this subchapter" for "this section" because the only provisions in this subchapter that relate to filing forms are derived from Section 3.

Revised Law

Sec. 4201.108. LIST OF UTILIZATION REVIEW AGENTS. (a) The commissioner shall maintain and update monthly a list of each utilization review agent to whom a certificate of registration has been issued and the renewal date of the certificate.

(b) The commissioner shall provide the list at cost to each individual or organization requesting the list. (V.T.I.C. Art. 21.58A, Sec. 12.)

Source Law

> Sec. 12. The commissioner shall maintain and update monthly a list of utilization review agents issued certificates and the renewal date for those certificates. The commissioner shall provide the list at cost to all individuals or organizations requesting the list.

[Sections 4201.109-4201.150 reserved for expansion]

SUBCHAPTER D. UTILIZATION REVIEW: GENERAL STANDARDS

Revised Law

Sec. 4201.151. UTILIZATION REVIEW PLAN. A utilization review agent's utilization review plan, including reconsideration and appeal requirements, must be reviewed by a physician and conducted in accordance with standards developed with input from appropriate health care providers and approved by a physician. (V.T.I.C. Art. 21.58A, Sec. 4(b).)

Source Law

> (b) The utilization review plan, including reconsideration and appeal requirements, shall be reviewed by a physician and conducted in accordance with standards developed with input from appropriate health care providers and approved by a physician.

Revised Law

Sec. 4201.152. UTILIZATION REVIEW UNDER DIRECTION OF PHYSICIAN. A utilization review agent shall conduct utilization review under the direction of a physician licensed to practice medicine by a state licensing agency in the United States. (V.T.I.C. Art. 21.58A, Sec. 4(h).)

Source Law

> (h) Utilization review conducted by a utilization review agent shall be under the direction of a physician licensed to practice medicine by a state licensing agency in the United States.

Revised Law

Sec. 4201.153. SCREENING CRITERIA AND REVIEW PROCEDURES. (a) A utilization review agent shall use written medically acceptable screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers.

(b) A utilization review determination shall be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria.

(c) Screening criteria must be:

(1) objective;

(2) clinically valid;

(3) compatible with established principles of health care; and

(4) flexible enough to allow a deviation from the norm when justified on a case-by-case basis.

(d) Screening criteria must be used to determine only whether to approve the requested treatment. A denial of requested treatment must be referred to an appropriate physician, dentist, or other health care provider to determine medical necessity. (V.T.I.C. Art. 21.58A, Sec. 4(i) (part).)

Source Law

> (i) Each utilization review agent shall utilize written medically acceptable screening criteria and review procedures which are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers. Utilization review decisions shall be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Screening criteria must be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norms when justified on a case-by-case basis. Screening criteria must be used to determine only whether to approve the requested treatment. Denials must be referred to an appropriate physician, dentist, or other health care provider to determine medical necessity. . . .

Revised Law

Sec. 4201.154. REVIEW AND INSPECTION OF SCREENING CRITERIA AND REVIEW PROCEDURES. (a) A utilization review agent's written screening criteria and review procedures shall be made available for:

(1) review and inspection to determine appropriateness and compliance as considered necessary by the commissioner; and

(2) copying as necessary for the commissioner to accomplish the commissioner's duties under this code.

(b) Any information obtained or acquired under the authority of this section, Section 4201.153, and this chapter is confidential and privileged and is not subject to Chapter 552, Government Code, or to subpoena except to the extent necessary for the commissioner to enforce this chapter. (V.T.I.C. Art. 21.58A, Sec. 4(i) (part).)

Source Law

> (i) . . . Such written screening criteria and review procedures shall be available for review and inspection to determine appropriateness and compliance as deemed necessary by the commissioner and copying as necessary for the commissioner to carry out his or her lawful duties under this code, provided, however, that any information obtained or acquired under the authority of this subsection and article is confidential and privileged and not subject to the open records law or subpoena except to the extent necessary for the commissioner to enforce this article.

Revisor's Note

Section 4(i), V.T.I.C. Article 21.58A, refers to the "lawful duties" of the commissioner of insurance. The revised law omits "lawful" as unnecessary because all of a public official's duties are imposed by law.

Revised Law

Sec. 4201.155. LIMITATION ON NOTICE REQUIREMENTS AND REVIEW PROCEDURES. A utilization review agent may not establish or impose a notice requirement or other review procedure that is contrary to the requirements of the health insurance policy or health benefit plan. (V.T.I.C. Art. 21.58A, Sec. 4(d).)

Source Law

> (d) A utilization review agent shall not set or impose any notice or other review procedures contrary to the requirements of the health insurance policy or health benefit plan.

[Sections 4201.156-4201.200 reserved for expansion]

SUBCHAPTER E. UTILIZATION REVIEW: RELATIONS WITH PATIENTS AND HEALTH CARE PROVIDERS

Revised Law

Sec. 4201.201. REPETITIVE CONTACTS WITH HEALTH CARE PROVIDER OR PATIENT; FREQUENCY OF REVIEWS. A utilization review

agent:

(1) may not engage in unnecessary or unreasonable repetitive contacts with a health care provider or patient; and

(2) shall base the frequency of contacts or reviews on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity. (V.T.I.C. Art. 21.58A, Sec. 4(j).)

Source Law

(j) A utilization review agent may not engage in unnecessary or unreasonable repetitive contacts with the health care provider or patient and shall base the frequency of contacts or reviews on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

Revised Law

Sec. 4201.202. OBSERVING OR PARTICIPATING IN PATIENT'S CARE. (a) Unless approved for an individual patient by the provider of record or modified by contract, a utilization review agent shall be prohibited from observing, participating in, or otherwise being present during a patient's examination, treatment, procedure, or therapy.

(b) This subchapter, Subchapters D and F, and Section 4201.102(b) may not be construed to otherwise limit or deny contact with a patient for purposes of conducting utilization review unless otherwise specifically prohibited by law. (V.T.I.C. Art. 21.58A, Sec. 4(e).)

Source Law

(e) Unless approved for an individual patient by the provider of record or modified by contract, a utilization review agent shall be prohibited from observing, participating in, or otherwise being present during a patient's examination, treatment, procedure, or therapy. In no event shall this section otherwise be construed to limit or deny contact with a patient for purposes of conducting utilization review unless otherwise specifically prohibited by law.

Revised Law

Sec. 4201.203. MENTAL HEALTH THERAPY. (a) A utilization review agent may not require, as a condition of treatment approval or for any other reason, the observation of a psychotherapy session

or the submission or review of a mental health therapist's process or progress notes.

(b) Notwithstanding this section, a utilization review agent may require submission of a patient's medical record summary. (V.T.I.C. Art. 21.58A, Sec. 4(o).)

Source Law

> (o) A utilization review agent may not require, as a condition of treatment approval or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes. Notwithstanding this subsection, a utilization review agent may require submission of a patient's medical record summary.

Revised Law

Sec. 4201.204. COMPLAINT SYSTEM. (a) A utilization review agent shall establish and maintain a complaint system that provides reasonable procedures for the resolution of oral or written complaints initiated by enrollees, patients, or health care providers concerning the utilization review.

(b) The complaint procedure must include a requirement that the utilization review agent provide a written response to the complainant within 30 days.

(c) A utilization review agent shall submit to the commissioner a summary report of all complaints at the times and in the form specified by the commissioner. The agent shall allow the commissioner to examine the complaints and relevant documents at any time.

(d) A utilization review agent shall maintain a record of each complaint until the third anniversary of the date the complainant filed the complaint. (V.T.I.C. Art. 21.58A, Sec. 4(m).)

Source Law

> (m) A utilization review agent shall establish and maintain a complaint system that provides reasonable procedures for the resolution of oral or written complaints initiated by enrollees, patients, or health care providers concerning the utilization review and shall maintain records of such complaints for three years from the time the complaints are filed. The complaint procedure shall include a written response to the complainant by the agent within 30

days. The utilization review agent shall submit to the commissioner a summary report of all complaints at such times and in such forms as the commissioner may require and shall permit the commissioner to examine the complaints and all relevant documents at any time.

Revised Law

Sec. 4201.205. DESIGNATED INITIAL CONTACT. (a) A health care provider may designate one or more individuals as the initial contact or contacts for a utilization review agent seeking routine information or data.

(b) A designation made under this section may not preclude a utilization review agent or medical advisor from contacting a health care provider or the provider's employees who are not designated under this section under circumstances in which:

(1) a review might otherwise be unreasonably delayed; or

(2) the designated individual is unable to provide the necessary data or information that the agent requests. (V.T.I.C. Art. 21.58A, Sec. 4(g).)

Source Law

(g) A health care provider may designate one or more individuals as the initial contact or contacts for utilization review agents seeking routine information or data. In no event shall the designation of such an individual or individuals preclude a utilization review agent or medical advisor from contacting a health care provider or others in his or her employ where a review might otherwise be unreasonably delayed or where the designated individual is unable to provide the necessary information or data requested by the utilization review agent.

Revised Law

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. Subject to the notice requirements of Subchapter G, before a utilization review agent who questions the medical necessity or appropriateness of a health care service issues an adverse determination, the agent shall provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the agent's determination. (V.T.I.C. Art. 21.58A, Sec. 4(k).)

Source Law

(k) Subject to the notice requirements of Section 5 of this article, in any instance where the utilization review agent is questioning the medical necessity or appropriateness of health care services, the health care provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis for the utilization review agent's decision with a physician prior to issuance of an adverse determination.

Revised Law

Sec. 4201.207. CHARGES BY HEALTH CARE PROVIDER FOR PROVIDING MEDICAL INFORMATION. (a) Unless precluded or modified by contract, a utilization review agent shall reimburse a health care provider for the reasonable costs of providing medical information in writing, including the costs of copying and transmitting requested patient records or other documents.

(b) A health care provider's charges for providing medical information to a utilization review agent may not:

(1) exceed the cost of copying records as set by rules adopted by the Texas Workers' Compensation Commission; or

(2) include any costs otherwise recouped as part of the charges for health care. (V.T.I.C. Art. 21.58A, Sec. 4(l).)

Source Law

(l) Unless precluded or modified by contract, a utilization review agent shall reimburse health care providers for the reasonable costs for providing medical information in writing, including copying and transmitting any requested patient records or other documents. A health care provider's charges for providing medical information to a utilization review agent shall not exceed the cost of copying set by rule of the Texas Workers' Compensation Commission for records and may not include any costs that are otherwise recouped as a part of the charge for health care.

[Sections 4201.208-4201.250 reserved for expansion]

SUBCHAPTER F. UTILIZATION REVIEW: PERSONNEL

Revised Law

Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. A utilization review agent may delegate utilization review to qualified personnel in the hospital or other health care facility in which the health care services to be reviewed were or are to be

provided. The delegation does not release the agent from the full responsibility for compliance with this chapter, including the conduct of those to whom utilization review has been delegated. (V.T.I.C. Art. 21.58A, Sec. 4(n).)

Source Law

> (n) The utilization review agent may delegate utilization review to qualified personnel in the hospital or health care facility where the health care services were or are to be provided. However, such delegation shall not relieve the utilization review agent of full responsibility for compliance with this article, including the conduct of those to whom utilization review has been delegated.

Revised Law

Sec. 4201.252. PERSONNEL. (a) Personnel employed by or under contract with a utilization review agent to perform utilization review must be appropriately trained and qualified.

(b) Personnel, other than a physician, who obtain oral or written information directly from a patient's physician or other health care provider regarding the patient's specific medical condition, diagnosis, or treatment options or protocols must be a nurse, physician assistant, or other health care provider qualified to provide the requested service.

(c) This section may not be interpreted to require personnel who perform clerical or administrative tasks to have the qualifications prescribed by this section. (V.T.I.C. Art. 21.58A, Sec. 4(c).)

Source Law

> (c) Personnel employed by or under contract with the utilization review agent to perform utilization review shall be appropriately trained and qualified. Personnel who obtain information regarding a patient's specific medical condition, diagnosis, and treatment options or protocols directly from the physician or health care provider, either orally or in writing, and who are not physicians shall be nurses, physician assistants, or health care providers qualified to provide the service requested by the provider. This provision shall not be interpreted to require such qualifications for personnel who perform clerical or administrative tasks.

Revised Law

Sec. 4201.253. PROHIBITED BASES FOR EMPLOYMENT,

COMPENSATION, EVALUATIONS, OR PERFORMANCE STANDARDS. A utilization review agent may not permit or provide compensation or another thing of value to an employee or agent of the utilization review agent, condition employment of the agent's employees or agent evaluations, or set employee or agent performance standards, based on the amount of volume of adverse determinations, reductions of or limitations on lengths of stay, benefits, services, or charges, or the number or frequency of telephone calls or other contacts with health care providers or patients, that are inconsistent with this chapter. (V.T.I.C. Art. 21.58A, Sec. 4(f).)

Source Law

(f) A utilization review agent may not permit or provide compensation or any thing of value to its employees or agents, condition employment of its employee or agent evaluations, or set its employee or agent performance standards, based on the amount of volume of adverse determinations, reductions or limitations on lengths of stay, benefits, services, or charges or on the number or frequency of telephone calls or other contacts with health care providers or patients, which are inconsistent with the provisions of this article.

[Sections 4201.254-4201.300 reserved for expansion]

SUBCHAPTER G. NOTICE OF DETERMINATIONS

Revised Law

Sec. 4201.301. GENERAL DUTY TO NOTIFY. A utilization review agent shall provide notice of a determination made in a utilization review to:

(1) the enrollee's provider of record; and

(2) the enrollee or a person acting on the enrollee's behalf. (V.T.I.C. Art. 21.58A, Sec. 5(a).)

Source Law

Sec. 5. (a) A utilization review agent shall notify the enrollee or a person acting on behalf of the enrollee and the enrollee's provider of record of a determination made in a utilization review.

Revised Law

Sec. 4201.302. GENERAL TIME FOR NOTICE. A utilization review agent must mail or otherwise transmit the notice required by this subchapter not later than the second working day after the date

of the request for utilization review and the agent receives all information necessary to complete the review. (V.T.I.C. Art. 21.58A, Sec. 5(b).)

Source Law

(b) The notification required by this section must be mailed or otherwise transmitted not later than two working days after the date of the request for utilization review and all information necessary to complete the review is received by the agent.

Revised Law

Sec. 4201.303. ADVERSE DETERMINATION: CONTENTS OF NOTICE. (a) Notice of an adverse determination must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of or the source of the screening criteria used as guidelines in making the adverse determination; and

(4) a description of the procedure for the complaint and appeal process, including notice to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization and of the procedures to obtain that review.

(b) For an enrollee who has a life-threatening condition, the notice required by Subsection (a)(4) must include a description of the enrollee's right to an immediate review by an independent review organization and of the procedures to obtain that review. (V.T.I.C. Art. 21.58A, Sec. 5(c).)

Source Law

(c) In the event of an adverse determination, the notification by the utilization review agent must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description or the source of the screening criteria that were utilized as guidelines in making the determination; and

(4) a description of the procedure for the complaint and appeal process, including:

(A) notification to the enrollee of

the enrollee's right to appeal an adverse determination to an independent review organization;

(B) notification to the enrollee of the procedures for appealing an adverse determination to an independent review organization; and

(C) notification to an enrollee who has a life-threatening condition of the enrollee's right to an immediate review by an independent review organization and the procedures to obtain that review.

Revised Law

Sec. 4201.304. TIME FOR NOTICE OF ADVERSE DETERMINATION. A utilization review agent shall provide notice of an adverse determination required by this subchapter as follows:

(1) with respect to a patient who is hospitalized at the time of the adverse determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the adverse determination;

(2) with respect to a patient who is not hospitalized at the time of the adverse determination, within three working days in writing to the provider of record and the patient; or

(3) within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying poststabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, the agent shall provide the notice to the treating physician or other health care provider not later than one hour after the time of the request. (V.T.I.C. Art. 21.58A, Sec. 5(d).)

Source Law

(d) The notification of adverse determination required by this section shall be provided by the utilization review agent:

(1) within one working day by telephone or electronic transmission to the provider of record in the case of a patient who is hospitalized at the time of the adverse determination, to be followed by a letter notifying the patient and the provider of record of an adverse determination within three working days;

(2) within three working days in writing to the provider of record and the patient if the patient is not hospitalized at the time of the adverse determination; or

(3) 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 notification when denying poststabilization care subsequent to emergency treatment as requested by a treating physician or provider. In such circumstances, notification shall be provided to the treating physician or health care provider.

[Sections 4201.305-4201.350 reserved for expansion]

SUBCHAPTER H. APPEAL OF ADVERSE DETERMINATION

Revised Law

Sec. 4201.351. COMPLAINT AS APPEAL. For purposes of this subchapter, a complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination. (V.T.I.C. Art. 21.58A, Sec. 6(a) (part).)

Source Law

Sec. 6. (a) . . . For the purposes of this section, a complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination.

Revised Law

Sec. 4201.352. WRITTEN DESCRIPTION OF APPEAL PROCEDURES. A utilization review agent shall maintain and make available a written description of the procedures for appealing an adverse determination. (V.T.I.C. Art. 21.58A, Sec. 6(a) (part).)

Source Law

Sec. 6. (a) A utilization review agent shall maintain and make available a written description of appeal procedures involving an adverse determination. . . .

Revised Law

Sec. 4201.353. APPEAL PROCEDURES MUST BE REASONABLE. The procedures for appealing an adverse determination must be reasonable. (V.T.I.C. Art. 21.58A, Sec. 6(b) (part).)

Source Law

(b) The procedures for appeals must be reasonable and . . . .

Revised Law

Sec. 4201.354. PERSONS OR ENTITIES WHO MAY APPEAL. The procedures for appealing an adverse determination must provide that

the adverse determination may be appealed orally or in writing by:

(1) an enrollee;

(2) a person acting on the enrollee's behalf; or

(3) the enrollee's physician or other health care provider. (V.T.I.C. Art. 21.58A, Sec. 6(b) (part).)

Source Law

> (b) The procedures for appeals . . . must include the following:
>
> (1) a provision that an enrollee, a person acting on behalf of the enrollee, or the enrollee's physician or health care provider may appeal the adverse determination orally or in writing; . . . .

Revised Law

Sec. 4201.355. ACKNOWLEDGMENT OF APPEAL. (a) The procedures for appealing an adverse determination must provide that, within five working days from the date the utilization review agent receives the appeal, the agent shall send to the appealing party a letter acknowledging the date of receipt.

(b) The letter must also include a list of:

(1) the procedures required by this subchapter; and

(2) the documents that the appealing party must submit for review.

(c) When a utilization review agent receives an oral appeal of an adverse determination, the agent shall send a one-page appeal form to the appealing party. (V.T.I.C. Art. 21.58A, Sec. 6(b) (part).)

Source Law

> (b) The procedures for appeals . . . must include the following:
>
> . . .
>
> (2) a provision that, within five working days from receipt of the appeal, the utilization review agent shall send to the appealing party a letter acknowledging the date of the utilization review agent's receipt of the appeal. The letter must also include the provisions listed in this subsection and a list of the documents that the appealing party must submit for review by the utilization review agent. When the utilization review agent receives an oral appeal of adverse determination, the utilization review agent shall send a one-page appeal form to the appealing party; . . . .

Revised Law

Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY REVIEW. (a) The procedures for appealing an adverse determination must provide that a physician makes the decision on the appeal, except as provided by Subsection (b).

(b) If not later than the 10th working day after the date an appeal is denied the enrollee's health care provider states in writing good cause for having a particular type of specialty provider review the case, a health care provider who is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review shall review the decision denying the appeal. The specialty review must be completed within 15 working days of the date the health care provider's request for specialty review is received. (V.T.I.C. Art. 21.58A, Sec. 6(b) (part).)

Source Law

> (b) The procedures for appeals . . . must include the following:
>
> . . .
>
> (3) a provision that appeal decisions shall be made by a physician, provided that, if the appeal is denied and within 10 working days the health care provider sets forth in writing good cause for having a particular type of a specialty provider review the case, the denial shall be reviewed by a health care provider in the same or similar specialty as typically manages the medical or dental condition, procedure, or treatment under discussion for review of the adverse determination, and that specialty review shall be completed within 15 working days of receipt of the request; . . . .

Revised Law

Sec. 4201.357. EXPEDITED APPEAL FOR DENIAL OF EMERGENCY CARE OR CONTINUED HOSPITALIZATION. (a) The procedures for appealing an adverse determination must include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care or a denial of continued hospitalization. That procedure must include a review by a health care provider who:

(1) has not previously reviewed the case; and

(2) is of the same or a similar specialty as the health

care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

(b) The time for resolution of an expedited appeal under this section shall be based on the medical or dental immediacy of the condition, procedure, or treatment under review, provided that the resolution of the appeal may not exceed one working day from the date all information necessary to complete the appeal is received. (V.T.I.C. Art. 21.58A, Sec. 6(b) (part).)

Source Law

> (b) The procedures for appeals . . . must include the following:
>
> . . .
>
> (4) in addition to the written appeal, a method for an expedited appeal procedure for emergency care denials and denials of continued stays for hospitalized patients. That procedure must include a review by a health care provider who has not previously reviewed the case and who is of the same or a similar specialty as typically manages the medical condition, procedure, or treatment under review. The time frame in which the appeal must be completed shall be based on the medical or dental immediacy of the condition, procedure, or treatment, but may not exceed one working day from the date all information necessary to complete the appeal is received; . . . .

Revisor's Note

Section 6(b)(4), V.T.I.C. Article 21.58A, refers to a health care provider who is of the same or a similar specialty as the health care provider who would typically manage the "medical condition, procedure, or treatment under review." The revised law substitutes "medical or dental" for "medical" because it is clear from the context of the source law, including the reference in the source law to the "medical or dental" immediacy of the condition, that the case under review may involve a medical or dental condition, procedure, or treatment.

Revised Law

Sec. 4201.358. RESPONSE LETTER TO INTERESTED PERSONS. The procedures for appealing an adverse determination must provide that, after the utilization review agent has sought review of the

appeal, the agent shall issue a response letter explaining the resolution of the appeal to:

(1) the patient or a person acting on the patient's behalf; and

(2) the patient's physician or other health care provider. (V.T.I.C. Art. 21.58A, Sec. 6(b) (part).)

Source Law

> (b) The procedures for appeals . . . must include the following:
>
> . . .
>
> (5) a provision that after the utilization review agent has sought review of the appeal of the adverse determination, the utilization review agent shall issue a response letter to the patient or a person acting on behalf of the patient, and the patient's physician or health care provider, explaining the resolution of the appeal; and . . . .

Revised Law

Sec. 4201.359. NOTICE OF APPEAL. (a) The procedures for appealing an adverse determination must require written notice to the appealing party of the determination of the appeal as soon as practicable, but not later than the 30th calendar day, after the date the utilization review agent receives the appeal.

(b) If the appeal is denied, the notice must include a clear and concise statement of:

(1) the clinical basis for the denial;

(2) the specialty of the physician or other health care provider making the denial; and

(3) the appealing party's right to seek review of the denial by an independent review organization under Subchapter I and the procedures for obtaining that review. (V.T.I.C. Art. 21.58A, Sec. 6(b) (part).)

Source Law

> (b) The procedures for appeals . . . must include the following:
>
> . . .
>
> (6) written notification to the appealing party of the determination of the appeal, as soon as practical, but in no case later than the 30th calendar day after the date the utilization agent receives the appeal. If the appeal is denied, the written notification shall include a clear and concise statement of:

(A) the clinical basis for the appeal's denial;

(B) the specialty of the physician or other health care provider making the denial; and

(C) notice of the appealing party's right to seek review of the denial by an independent review organization under Section 6A of this article and the procedures for obtaining that review.

Revisor's Note

Section 6(b)(6)(C), V.T.I.C. Article 21.58A, refers to a review by an independent review organization under Section 6A, V.T.I.C. Article 21.58A. Section 6A is revised in this chapter in Subchapter I. Although the provision revised as Section 4201.402(b), which is contained in Subchapter I, is not derived from Section 6A, it is appropriate throughout this chapter to substitute references to Subchapter I in its entirety for references to Section 6A because the provision revised as Section 4201.402(b) applies certain rules and standards to a utilization review agent who provides confidential information to a utilization review organization, and that provision would apply by its own terms in an appeal to an independent review organization conducted under Section 6A.

Revised Law

Sec. 4201.360. IMMEDIATE APPEAL TO INDEPENDENT REVIEW ORGANIZATION IN LIFE-THREATENING CIRCUMSTANCES. Notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is:

(1) entitled to an immediate appeal to an independent review organization as provided by Subchapter I; and

(2) not required to comply with procedures for an internal review of the utilization review agent's adverse determination. (V.T.I.C. Art. 21.58A, Sec. 6(c).)

Source Law

(c) Notwithstanding this article or any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled

to an immediate appeal to an independent review organization as provided by Section 6A of this article and is not required to comply with procedures for an internal review of the utilization review agent's adverse determination.

[Sections 4201.361-4201.400 reserved for expansion]

SUBCHAPTER I. INDEPENDENT REVIEW OF ADVERSE DETERMINATION

Revised Law

Sec. 4201.401. REVIEW BY INDEPENDENT REVIEW ORGANIZATION; COMPLIANCE WITH INDEPENDENT DETERMINATION. (a) A utilization review agent shall allow any party whose appeal of an adverse determination is denied by the agent to seek review of that determination by an independent review organization assigned to the appeal in accordance with Chapter 4202.

(b) The utilization review agent shall comply with the independent review organization's determination regarding the medical necessity or appropriateness of health care items and services for an enrollee. (V.T.I.C. Art. 21.58A, Sec. 6A (part).)

Source Law

Sec. 6A. A utilization review agent shall:

(1) permit any party whose appeal of an adverse determination is denied by the utilization review agent to seek review of that determination by an independent review organization assigned to the appeal in accordance with Article 21.58C of this code;

. . .

(3) comply with the independent review organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee; and . . . .

Revised Law

Sec. 4201.402. INFORMATION PROVIDED TO INDEPENDENT REVIEW ORGANIZATION. (a) Not later than the third business day after the date a utilization review agent receives a request for independent review, the agent shall provide to the appropriate independent review organization:

(1) a copy of:

(A) any medical records of the enrollee that are relevant to the review;

(B) any documents used by the plan in making the determination to be reviewed;

(C) the written notification described by Section 4201.359; and

(D) any documents and other written information submitted to the agent in support of the appeal; and

(2) a list of each physician or other health care provider who:

(A) has provided care to the enrollee; and

(B) may have medical records relevant to the appeal.

(b) A utilization review agent may provide confidential information in the custody of the agent to an independent review organization, subject to rules and standards adopted by the commissioner under Chapter 4202. (V.T.I.C. Art. 21.58A, Secs. 6A (part); 8(f), as added Acts 75th Leg., R.S., Ch. 163.)

Source Law

Sec. 6A. A utilization review agent shall:

. . .

(2) provide to the appropriate independent review organization not later than the third business day after the date that the utilization review agent receives a request for review a copy of:

(A) any medical records of the enrollee that are relevant to the review;

(B) any documents used by the plan in making the determination to be reviewed by the organization;

(C) the written notification described by Section 6(b)(5) of this article;

(D) any documentation and written information submitted to the utilization review agent in support of the appeal; and

(E) a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal; . . . .

[Sec. 8]

(f) Confidential information in the custody of a utilization review agent may be provided to an independent review organization, subject to rules and standards adopted by the commissioner under Article 21.58C of this code.

Revisor's Note

Section 6A(2)(C), V.T.I.C. Article 21.58A, refers to the "written notification described by Section 6(b)(5) of this article." Section 6A, Article 21.58A, was enacted by Chapter 163, Acts of the 75th

Legislature, Regular Session, 1997. That act also amended Section 6(b)(5), Article 21.58A, in part to reflect an appealing party's right to seek independent review under Section 6A of an adverse utilization review determination. During the same legislative session, the substance of Section 6(b)(5) was amended again and renumbered as Section 6(b)(6) by Chapter 1025, Acts of the 75th Legislature, Regular Session, 1997. In 1999, Section 6 was amended and reenacted by Chapter 1456, Acts of the 76th Legislature, Regular Session, to reflect the amendments made to that section by Chapters 163 and 1025, Acts of the 75th Legislature, Regular Session, 1997. In that reenactment, the notice provision to which Section 6A(2)(C) refers was renumbered as Section 6(b)(6). Thus, the correct citation to the referenced written notice is Section 6(b)(6), revised in this chapter as Section 4201.359, not Section 6(b)(5), revised in this chapter as Section 4201.358. The revised law is drafted accordingly.

Revised Law

Sec. 4201.403. PAYMENT FOR INDEPENDENT REVIEW. A utilization review agent shall pay for an independent review conducted under this subchapter. (V.T.I.C. Art. 21.58A, Sec. 6A (part).)

Source Law

Sec. 6A. A utilization review agent shall:

. . .

(4) pay for the independent review.

[Sections 4201.404-4201.450 reserved for expansion]

SUBCHAPTER J. SPECIALTY UTILIZATION REVIEW AGENTS

Revised Law

Sec. 4201.451. DEFINITION. For purposes of this subchapter, "specialty utilization review agent" means a utilization review agent who conducts utilization review for a

specialty health care service, including dentistry, chiropractic services, or physical therapy. (V.T.I.C. Art. 21.58A, Sec. 14(j) (part).)

Source Law

> (j) . . . For purposes of this subsection, a specialty utilization review agent means a utilization review agent that conducts utilization review for specialty health care services, including but not limited to dentistry, chiropractic, or physical therapy. . . .

Revisor's Note

Section 14(j), V.T.I.C. Article 21.58A, refers to "including but not limited to." The revised law omits "but not limited to" for the reason stated in Revisor's Note (5) to Section 4201.002.

Revised Law

Sec. 4201.452. INAPPLICABILITY OF CERTAIN OTHER LAW. A specialty utilization review agent is not subject to Section 4201.151, 4201.152, 4201.206, 4201.252, or 4201.356. (V.T.I.C. Art. 21.58A, Sec. 14(j) (part).)

Source Law

> (j) A specialty utilization review agent is not subject to Section 4(b), (c), (h), or (k) or Section 6(b)(3) of this article. . . .

Revised Law

Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty utilization review agent's utilization review plan, including reconsideration and appeal requirements, must be reviewed by a health care provider of the appropriate specialty and conducted in accordance with standards developed with input from a health care provider of the appropriate specialty. (V.T.I.C. Art. 21.58A, Sec. 14(j) (part).)

Source Law

> (j) . . . A specialty utilization review agent shall comply with the following requirements:
>
> (1) the utilization review plan, including reconsideration and appeal requirements, shall be reviewed by a health care provider of the appropriate specialty and conducted in accordance with standards developed with input from a health care provider of the appropriate specialty; . . . .

Revised Law

Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF PROVIDER OF SAME SPECIALTY. A specialty utilization review agent shall conduct utilization review under the direction of a health care provider who is of the same specialty as the agent and who is licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States. (V.T.I.C. Art. 21.58A, Sec. 14(j) (part).)

Source Law

> (j) . . . A specialty utilization review agent shall comply with the following requirements:
>
> . . .
>
> (3) utilization review conducted by a specialty utilization review agent shall be conducted under the direction of a health care provider of the same specialty and shall be licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States; . . . .

Revised Law

Sec. 4201.455. PERSONNEL. (a) Personnel who are employed by or under contract with a specialty utilization review agent to perform utilization review must be appropriately trained and qualified.

(b) Personnel who obtain oral or written information directly from a physician or other health care provider must be a nurse, physician assistant, or other health care provider of the same specialty as the agent and who are licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States.

(c) This section does not require personnel who perform only clerical or administrative tasks to have the qualifications prescribed by this section. (V.T.I.C. Art. 21.58A, Sec. 14(j) (part).)

Source Law

> (j) . . . A specialty utilization review agent shall comply with the following requirements:
>
> . . .
>
> (2) personnel employed by or under contract with a specialty utilization review agent to perform utilization review shall be appropriately

trained and qualified. Personnel who obtain information directly from the physician or health care provider, either orally or in writing, shall be nurses, physician assistants, or other health care providers of the same specialty as the utilization review agent and who are licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States, except that this provision does not require those qualifications for personnel who perform solely clerical or administrative tasks; . . . .

Revised Law

Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. Subject to the notice requirements of Subchapter G, before a specialty utilization review agent who questions the medical necessity or appropriateness of a health care service issues an adverse determination, the agent shall provide the health care provider who ordered the service a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the agent's determination with a health care provider who is of the same specialty as the agent. (V.T.I.C. Art. 21.58A, Sec. 14(j) (part).)

Source Law

(j) . . . A specialty utilization review agent shall comply with the following requirements:

. . .

(4) subject to the notice requirements of Section 5 of this article, in any instance where the specialty utilization review agent questions the medical necessity or appropriateness of health care services, the health care provider who ordered the services shall, prior to the issuance of an adverse determination, be afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis for the decision of the utilization review agent with a health care provider of the same specialty as the utilization review agent; and . . . .

Revised Law

Sec. 4201.457. APPEAL DECISIONS. A specialty utilization review agent shall comply with the requirement that a physician or other health care provider who makes the decision in an appeal of an adverse determination must be of the same or a similar specialty as the health care provider who would typically manage the specialty condition, procedure, or treatment under review in the appeal. (V.T.I.C. Art. 21.58A, Sec. 14(j) (part).)

Source Law

(j) . . . A specialty utilization review agent shall comply with the following requirements:

. . .

(5) appeal decisions shall be made by a physician or health care provider in the same or a similar specialty as typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review of the adverse determination.

Revisor's Note

Section 14(j)(5), V.T.I.C. Article 21.58A, refers to appeal decisions made by health care providers in the "same or a similar specialty as typically manages the medical, dental, or specialty condition, procedure, or treatment." The revised law omits the references to "medical" and "dental" because those terms are included within the meaning of specialty health care services subject to specialty utilization review as described by other provisions of Section 14(j), Article 21.58A, revised in this chapter as Section 4201.451.

[Sections 4201.458-4201.500 reserved for expansion]

SUBCHAPTER K. CLAIMS REVIEW OF MEDICAL NECESSITY AND APPROPRIATENESS

Revised Law

Sec. 4201.501. RETROSPECTIVE REVIEW OF MEDICAL NECESSITY AND APPROPRIATENESS. (a) A retrospective review of the medical necessity and appropriateness of a health care service made under a health insurance policy or health benefit plan shall be based on written screening criteria established and periodically updated with appropriate involvement from physicians, including practicing physicians, and other health care providers.

(b) A payor's system for retrospective review of medical necessity and appropriateness under this section must be under the direction of a physician. (V.T.I.C. Art. 21.58A, Sec. 11(a).)

Source Law

Sec. 11. (a) When a retrospective review of the

medical necessity and appropriateness of health care service is made under a health insurance policy or plan: (1) such retrospective review shall be based on written screening criteria established and periodically updated with appropriate involvement from physicians, including practicing physicians, and other health care providers; and (2) the payor's system for such retrospective review of medical necessity and appropriateness shall be under the direction of a physician.

Revisor's Note

Section 11(a), V.T.I.C. Article 21.58A, refers to a "health insurance policy or plan." The revised law substitutes "health benefit plan" for "plan" for the reason stated in Revisor's Note (7) to Section 4201.002.

Revised Law

Sec. 4201.502. APPEALS OF RETROSPECTIVE ADVERSE DETERMINATIONS. (a) When an adverse determination is made under a health insurance policy or health benefit plan based on a retrospective review of the medical necessity and appropriateness of the allocation of health care resources and services, the payor shall provide the health care provider with the opportunity to appeal the determination in the same manner as provided to the enrollee, with the enrollee's consent to act on the enrollee's behalf. In no event shall a health care provider be precluded from appeal if the enrollee is not reasonably available or competent to consent.

(b) The appeal does not imply or confer on a health care provider any contractual right with respect to the enrollee's health insurance policy or health benefit plan that the health care provider does not otherwise have. (V.T.I.C. Art. 21.58A, Sec. 11(b).)

Source Law

(b) When an adverse determination is made under a health insurance policy or plan based on a retrospective review of the medical necessity and appropriateness of the allocation of health care resources and services, the payor shall afford the health care providers the opportunity to appeal the determination in the same manner afforded the enrollee, with the enrollee's consent to act on his or her behalf, but in no event shall health care providers

be precluded from appeal if the enrollee is not reasonably available or competent to consent. Such appeal shall not be construed to imply or confer on such health care providers any contract rights with respect to the enrollee's health insurance policy or plan that the health care provider does not otherwise have.

Revisor's Note

Section 11(b), V.T.I.C. Article 21.58A, refers to a "health insurance policy or plan." The revised law substitutes a reference to a "health insurance policy or health benefit plan" for the reason stated in Revisor's Note (7) to Section 4201.002.

[Sections 4201.503-4201.550 reserved for expansion]

SUBCHAPTER L. CONFIDENTIALITY OF INFORMATION; ACCESS TO OTHER INFORMATION

Revised Law

Sec. 4201.551. GENERAL CONFIDENTIALITY REQUIREMENT. (a) A utilization review agent shall preserve the confidentiality of individual medical records to the extent required by law.

(b) This chapter does not authorize a utilization review agent to take any action that violates a state or federal law or regulation concerning confidentiality of patient records. (V.T.I.C. Art. 21.58A, Secs. 8(a), (h) (part).)

Source Law

Sec. 8. (a) A utilization review agent shall preserve the confidentiality of individual medical records to the extent required by law.

(h) . . . Nothing in this article shall be construed to allow a utilization review agent to take actions that violate a state or federal statute or regulation concerning confidentiality of patient records.

Revised Law

Sec. 4201.552. CONSENT REQUIREMENTS. (a) A utilization review agent may not disclose individual medical records, personal information, or other confidential information about a patient obtained in the performance of utilization review without the patient's prior written consent or except as otherwise required by law.

(b) If the prior written consent is submitted by anyone other than the patient who is the subject of the personal or confidential information requested, the consent must:

(1) be dated; and

(2) contain the patient's signature.

(c) The patient's signature for purposes of Subsection (b)(2) must have been obtained one year or less before the date the disclosure is sought or the consent is invalid. (V.T.I.C. Art. 21.58A, Sec. 8(b).)

Source Law

> (b) A utilization review agent may not disclose or publish individual medical records, personal information, or other confidential information about a patient obtained in the performance of utilization review without the prior written consent of the patient or as otherwise required by law. If such authorization is submitted by anyone other than the individual who is the subject of the personal or confidential information requested, such authorization must:
>
> (1) be dated; and
>
> (2) contain the signature of the individual who is the subject of the personal or confidential information requested. The signature must have been obtained one year or less prior to the date the disclosure is sought or the authorization is invalid.

Revisor's Note

Section 8(b), V.T.I.C. Article 21.58A, provides that a utilization review agent may not "disclose or publish" certain information. The revised law omits the reference to "publish" because, in this context, "publish" is included in the meaning of "disclose."

Revised Law

Sec. 4201.553. PROVIDING INFORMATION TO AFFILIATED ENTITIES. A utilization review agent may provide confidential information to a third party under contract with or affiliated with the agent solely to perform or assist with utilization review. Information provided to a third party under this section remains confidential. (V.T.I.C. Art. 21.58A, Sec. 8(c).)

Source Law

(c) A utilization review agent may provide

confidential information to a third party under contract or affiliated with the utilization review agent for the sole purpose of performing or assisting with utilization review. Information provided to third parties shall remain confidential.

Revised Law

Sec. 4201.554. PROVIDING INFORMATION TO COMMISSIONER. Notwithstanding this subchapter, a utilization review agent shall provide to the commissioner on request individual medical records or other confidential information to enable the commissioner to determine compliance with this chapter. The information is confidential and privileged and is not subject to Chapter 552, Government Code, or to subpoena, except to the extent necessary to enable the commissioner to enforce this chapter. (V.T.I.C. Art. 21.58A, Sec. 8(i).)

Source Law

(i) Notwithstanding the provisions in Subsections (a) through (h) of this section, the utilization review agent shall provide to the commissioner on request individual medical records or other confidential information for determination of compliance with this article. The information is confidential and privileged and is not subject to the open records law, Chapter 552, Government Code, or to subpoena, except to the extent necessary to enable the commissioner to enforce this article.

Revisor's Note

Section 8(i), V.T.I.C. Article 21.58A, provides that, "[n]otwithstanding the provisions in Subsections (a) through (h)" of Section 8, a utilization review agent shall provide certain confidential information to the commissioner of insurance. The referenced provisions are revised as Subchapter L of this chapter, which includes this section, with the exception of Section 8(f), as added by Chapter 163, Acts of the 75th Legislature, Regular Session, 1997. That section is revised in Subchapter I of this chapter as Section 4201.402(b). The revised law substitutes "[n]otwithstanding this subchapter" for the quoted language and does not include a reference to Section 4201.402(b) because that

provision does not restrict or otherwise relate to a utilization review agent providing information to the commissioner.

Revised Law

Sec. 4201.555. ACCESS TO RECORDED PERSONAL INFORMATION. (a) If an individual submits a written request to a utilization review agent for access to recorded personal information concerning the individual, the agent shall, within 10 business days from the date the agent receives the request:

(1) inform the requesting individual in writing of the nature and substance of the recorded personal information; and

(2) allow the individual, at the individual's discretion, to:

(A) view and copy, in person, the recorded personal information concerning the individual; or

(B) obtain a copy of the information by mail.

(b) If the information requested under this section is in coded form, the utilization review agent shall provide in writing an accurate translation of the information in plain language.

(c) A utilization review agent's charges for providing a copy of information requested under this section shall be reasonable, as determined by rule adopted by the commissioner. The charges may not include any costs otherwise recouped as part of the charges for utilization review. (V.T.I.C. Art. 21.58A, Secs. 8(d), (e).)

Source Law

(d) If an individual submits a written request to the utilization review agent for access to recorded personal information about the individual, the utilization review agent shall within 10 business days from the date such request is received:

(1) inform the individual submitting the request of the nature and substance of the recorded personal information in writing; and

(2) permit the individual to see and copy, in person, the recorded personal information pertaining to the individual or to obtain a copy of the recorded personal information by mail, at the discretion of the individual, unless the recorded personal information is in coded form, in which case an accurate translation in plain language shall be

provided in writing.

(e) A utilization review agent's charges for providing a copy of recorded personal information to individuals shall be reasonable, as determined by rule of the commissioner, and may not include any costs that are otherwise recouped as part of the charge for utilization review.

Revised Law

Sec. 4201.556. PUBLISHING INFORMATION IDENTIFIABLE TO HEALTH CARE PROVIDER. (a) A utilization review agent may not publish data that identifies a particular physician or other health care provider, including data in a quality review study or performance tracking data, without providing prior written notice to the physician or other provider.

(b) The prohibition under this section does not apply to internal systems or reports used by the utilization review agent. (V.T.I.C. Art. 21.58A, Sec. 8(f), as added Acts 75th Leg., R.S., Ch. 1025.)

Source Law

(f) The utilization review agent may not publish data which identifies a particular physician or health care provider, including any quality review studies or performance tracking data, without prior written notice to the involved provider. This prohibition does not apply to internal systems or reports used by the utilization review agent.

Revised Law

Sec. 4201.557. REQUIREMENT TO MAINTAIN DATA IN CONFIDENTIAL MANNER. A utilization review agent shall maintain all data concerning a patient or physician or other health care provider in a confidential manner that prevents unauthorized disclosure to a third party. (V.T.I.C. Art. 21.58A, Sec. 8(h) (part).)

Source Law

(h) All patient, physician, and health care provider data shall be maintained by the utilization review agent in a confidential manner which prevents unauthorized disclosure to third parties. . . .

Revised Law

Sec. 4201.558. DESTRUCTION OF CERTAIN CONFIDENTIAL DOCUMENTS. When a utilization review agent determines a document in the custody of the agent that contains confidential patient information or confidential physician or other health care provider

financial data is no longer needed, the document shall be destroyed by a method that ensures the complete destruction of the information. (V.T.I.C. Art. 21.58A, Sec. 8(g).)

Source Law

> (g) Documents in the custody of the utilization review agent that contain confidential patient information or physician or health care provider financial data shall be destroyed by a method which induces complete destruction of the information when the agent determines the information is no longer needed.

[Sections 4201.559-4201.600 reserved for expansion]

SUBCHAPTER M. ENFORCEMENT

Revised Law

Sec. 4201.601. NOTICE OF SUSPECTED VIOLATION; COMPELLING PRODUCTION OF INFORMATION. If the commissioner believes that a person or entity conducting utilization review is in violation of this chapter or applicable rules, the commissioner:

(1) shall notify the utilization review agent, health maintenance organization, or insurer of the alleged violation; and

(2) may compel the production of documents or other information as necessary to determine whether a violation has occurred. (V.T.I.C. Art. 21.58A, Sec. 9(a).)

Source Law

> Sec. 9. (a) If the commissioner believes that any person or entity conducting utilization review pursuant to this article is in violation of this article or applicable regulations, the commissioner shall notify the utilization review agent, health maintenance organization, or insurer of the alleged violation and may compel the production of any and all documents or other information as necessary in order to determine whether or not such violation has taken place.

Revisor's Note

> Section 9(a), V.T.I.C. Article 21.58A, refers to "regulations" concerning utilization review. The revised law substitutes "rules" for "regulations" for the reason stated in Revisor's Note (3) to Section 4201.003.

Revised Law

Sec. 4201.602. ENFORCEMENT PROCEEDING. (a) The commissioner may initiate a proceeding under this subchapter.

(b) A proceeding under this chapter is a contested case for purposes of Chapter 2001, Government Code. (V.T.I.C. Art. 21.58A, Secs. 9(b), (c).)

Source Law

(b) The commissioner may initiate the proceedings under this section.

(c) Proceedings under this article are a contested case for the purposes of the administrative procedure act.

Revised Law

Sec. 4201.603. REMEDIES AND PENALTIES FOR VIOLATION. If the commissioner determines that a utilization review agent, health maintenance organization, insurer, or other person or entity conducting utilization review has violated or is violating this chapter, the commissioner may:

(1) impose a sanction under Chapter 82;

(2) issue a cease and desist order under Chapter 83; or

(3) assess an administrative penalty under Chapter 84. (V.T.I.C. Art. 21.58A, Sec. 9(d).)

Source Law

(d) If the commissioner determines that the utilization review agent, health maintenance organization, insurer, or other person or entity conducting utilization review pursuant to this article has violated or is violating any provision of this article, the commissioner may:

(1) impose sanctions under Section 7, Article 1.10 of this code;

(2) issue a cease and desist order under Article 1.10A of this code; or

(3) assess administrative penalties under Article 1.10E of this code.

CHAPTER 4202. INDEPENDENT REVIEW ORGANIZATIONS

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## CHAPTER 4202. INDEPENDENT REVIEW ORGANIZATIONS

Revised Law

Sec. 4202.001. DEFINITION. In this chapter, "payor" has the meaning assigned by Section 4201.002. (V.T.I.C. Art. 21.58C, Sec. 1(2).)

Source Law

(2) "Payor" has the meaning assigned by Section 2, Article 21.58A of this code.

Revised Law

Sec. 4202.002. ADOPTION OF STANDARDS FOR INDEPENDENT REVIEW ORGANIZATIONS. (a) The commissioner shall adopt standards and rules for:

(1) the certification, selection, and operation of independent review organizations to perform independent review described by Subchapter I, Chapter 4201; and

(2) the suspension and revocation of the certification.

(b) The standards adopted under this section must ensure:

(1) the timely response of an independent review organization selected under this chapter;

(2) the confidentiality of medical records transmitted to an independent review organization for use in conducting an independent review;

(3) the qualifications and independence of each physician or other health care provider making a review determination for an independent review organization;

(4) the fairness of the procedures used by an independent review organization in making review determinations; and

(5) the timely notice to an enrollee of the results of an independent review, including the clinical basis for the review determination. (V.T.I.C. Art. 21.58C, Secs. 2(a) (part), (b).)

Source Law

Sec. 2. (a) The commissioner shall:

(1) promulgate standards and rules for:

(A) the certification, selection, and operation of independent review organizations to perform independent review described by Section 6, Article 21.58A of this code; and

(B) the suspension and revocation of the certification;

. . . .

(b) The standards required by Subsection (a)(1) of this section must ensure:

(1) the timely response of an independent review organization selected under this article;

(2) the confidentiality of medical records transmitted to an independent review organization for use in independent reviews;

(3) the qualifications and independence of each health care provider or physician making review determinations for an independent review organization;

(4) the fairness of the procedures used by an independent review organization in making the determinations; and

(5) timely notice to enrollees of the results of the independent review, including the clinical basis for the determination.

Revisor's Note

Section 2(a)(1)(A), V.T.I.C. Article 21.58C, refers to independent review organizations that perform "independent review described by Section 6, Article 21.58A of this code." The reference to Section 6, V.T.I.C. Article 21.58A, appears to be a typographical error. Section 6, Article 21.58A, revised as Subchapter H, Chapter 4201, of this code, provides procedures for appealing an adverse determination made by a utilization review agent. The

review of an appeal under Section 6 is conducted by a physician or other health care provider under the direction of the utilization review agent. If the appeal of the adverse determination is denied under Section 6, the party whose appeal was denied may appeal to an independent review organization under Section 6A, V.T.I.C. Article 21.58A, revised as Subchapter I, Chapter 4201, of this code. It is clear from the context that the legislature intended to refer to independent review conducted by an independent review organization as provided by Section 6A. For that reason, the revised law substitutes a reference to Subchapter I, Chapter 4201, of this code.

Although the provision revised as Section 4201.402(b), which is contained in Subchapter I, Chapter 4201, is not derived from Section 6A, it is appropriate throughout this chapter to substitute references to Subchapter I in its entirety for references to Section 6A because the provision revised as Section 4201.402(b) applies certain rules and standards to a utilization review agent who provides confidential information to a utilization review organization, and that provision would apply by its own terms in an appeal to an independent review organization conducted under Section 6A.

Revised Law

Sec. 4202.003. REQUIREMENTS REGARDING TIMELINESS OF DETERMINATION. The standards adopted under Section 4202.002 must require each independent review organization to make the organization's determination:

(1) for a life-threatening condition as defined by Section 4201.002, not later than the earlier of:

(A) the fifth day after the date the organization receives the information necessary to make the determination; or

(B) the eighth day after the date the organization receives the request that the determination be made; and

(2) for a condition other than a life-threatening condition, not later than the earlier of:

(A) the 15th day after the date the organization receives the information necessary to make the determination; or

(B) the 20th day after the date the organization receives the request that the determination be made. (V.T.I.C. Art. 21.58C, Secs. 1(1), 2(c).)

Source Law

Art. 21.58C
Sec. 1. In this article:
(1) "Life-threatening condition" has the meaning assigned by Section 6, Article 21.58A of this code.

[Sec. 2]
(c) The standards adopted under Subsection (a)(1) of this section must include standards that require each independent review organization to make its determination:
(1) not later than the earlier of:
(A) the 15th day after the date the independent review organization receives the information necessary to make the determination; or
(B) the 20th day after the date the independent review organization receives the request that the determination be made; and
(2) in the case of a life-threatening condition, not later than the earlier of:
(A) the fifth day after the date the independent review organization receives the information necessary to make the determination; or
(B) the eighth day after the date the independent review organization receives the request that the determination be made.

Revisor's Note

Section 1(1), V.T.I.C. Article 21.58C, defines "life-threatening condition" to have the meaning assigned by Section 6, V.T.I.C. Article 21.58A. Section 6(c) of that article, as originally enacted by Chapter 163, Acts of the 75th Legislature, Regular Session, 1997, defined "life-threatening condition" for purposes of Section 6. During the same legislative session, the legislature enacted Chapter 1025, Acts of

the 75th Legislature, Regular Session, 1997, which added a definition of "life threatening" as Section 2(12), V.T.I.C. Article 21.58A, revised in Section 4201.002 of this code. That definition was substantively identical to the definition enacted in Section 6(c) and applied to the entire article, making the definition in Section 6(c) superfluous. The legislature subsequently enacted Chapter 1456, Acts of the 76th Legislature, Regular Session, 1999, which repealed the definition contained in Section 6(c). For that reason, the revised law substitutes a reference to Section 4201.002 of this code for the reference to Section 6, Article 21.58A.

In addition, the definition of "life-threatening condition" provided by Section 1(1), Article 21.58C, applies to the entire article, revised as this chapter. The revised law incorporates the substance of the definition in this section because the term only appears in Section 2(c), Article 21.58C, which is revised in this section.

Revised Law

Sec. 4202.004. CERTIFICATION. To be certified as an independent review organization under this chapter, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(1) for an applicant that is publicly held, the name of each shareholder or owner of more than five percent of any of the applicant's stock or options;

(2) the name of any holder of the applicant's bonds or notes that exceed $100,000;

(3) the name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the control or affiliation;

(4) the name and a biographical sketch of each

director, officer, and executive of the applicant and of any entity listed under Subdivision (3) and a description of any relationship the named individual has with:

(A) a health benefit plan;

(B) a health maintenance organization;

(C) an insurer;

(D) a utilization review agent;

(E) a nonprofit health corporation;

(F) a payor;

(G) a health care provider; or

(H) a group representing any of the entities described by Paragraphs (A) through (G);

(5) the percentage of the applicant's revenues that are anticipated to be derived from independent reviews conducted under Subchapter I, Chapter 4201;

(6) a description of the areas of expertise of the physicians or other health care providers making review determinations for the applicant; and

(7) the procedures to be used by the applicant in making independent review determinations under Subchapter I, Chapter 4201. (V.T.I.C. Art. 21.58C, Sec. 2(d).)

Source Law

(d) To be certified as an independent review organization under this article, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(1) for an applicant that is publicly held, the name of each stockholder or owner of more than five percent of any stock or options;

(2) the name of any holder of bonds or notes of the applicant that exceed $100,000;

(3) the name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the affiliation or control;

(4) the name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under Subdivision (3) of this subsection and a description of any relationship the named individual has with:

(A) a health benefit plan;

(B) a health maintenance organization;

(C) an insurer;

(D) a utilization review agent;
(E) a nonprofit health corporation;
(F) a payor;
(G) a health care provider; or
(H) a group representing any of the entities described by Paragraphs (A) through (G) of this subdivision;

(5) the percentage of the applicant's revenues that are anticipated to be derived from reviews conducted under Section 6A, Article 21.58A of this code;

(6) a description of the areas of expertise of the health care professionals making review determinations for the applicant; and

(7) the procedures to be used by the independent review organization in making review determinations with respect to reviews conducted under Section 6A, Article 21.58A of this code.

Revisor's Note

Section 2(d)(6), V.T.I.C. Article 21.58C, refers to "health care professionals" who make review determinations. The standards the commissioner of insurance is required to adopt under Section 2(b)(3), V.T.I.C. Article 21.58C, revised as Section 4202.002(b)(3), refer to a "health care provider or physician" making those determinations. The revised law substitutes "physicians or other health care providers" for "health care professionals" for consistency of terminology throughout this chapter.

Revised Law

Sec. 4202.005. PERIODIC REPORTING OF INFORMATION; ANNUAL DESIGNATION. (a) An independent review organization shall annually submit the information required in an application for certification under Section 4202.004. Anytime there is a material change in the information the organization included in the application, the organization shall submit updated information to the commissioner.

(b) The commissioner shall designate annually each organization that meets the standards for an independent review organization adopted under Section 4202.002. (V.T.I.C. Art. 21.58C, Secs. 2(a) (part), (e).)

Source Law

(a) The commissioner shall:

. . .

(2) designate annually each organization that meets the standards as an independent review organization;

. . . .

(e) The independent review organization shall annually submit the information required by Subsection (d) of this section. If at any time there is a material change in the information included in the application under Subsection (d) of this section, the independent review organization shall submit updated information to the commissioner.

Revised Law

Sec. 4202.006. PAYORS FEES. The commissioner shall charge payors fees in accordance with this chapter as necessary to fund the operations of independent review organizations. (V.T.I.C. Art. 21.58C, Sec. 2(a) (part).)

Source Law

(a) The commissioner shall:

. . .

(3) charge payors fees in accordance with this article as necessary to fund the operations of independent review organizations; and

. . . .

Revised Law

Sec. 4202.007. OVERSIGHT. The commissioner shall provide ongoing oversight of the independent review organizations to ensure continued compliance with this chapter and the standards and rules adopted under this chapter. (V.T.I.C. Art. 21.58C, Sec. 2(a) (part).)

Source Law

(a) The commissioner shall:

. . .

(4) provide ongoing oversight of the independent review organizations to ensure continued compliance with this article and the standards and rules adopted under this article.

Revised Law

Sec. 4202.008. PROHIBITED OWNERSHIP OR CONTROL OF INDEPENDENT REVIEW ORGANIZATION. An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a payor or a trade or professional association of payors. (V.T.I.C. Art. 21.58C, Sec. 2(f).)

Source Law

(f) An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a payor or a trade or professional association of payors.

Revised Law

Sec. 4202.009. CONFIDENTIAL INFORMATION. Information that reveals the identity of a physician or other individual health care provider who makes a review determination for an independent review organization is confidential. (V.T.I.C. Art. 21.58C, Sec. 2(h).)

Source Law

(h) Information that reveals the identity of a physician or individual health care provider who makes a review determination for an independent review organization is confidential.

Revised Law

Sec. 4202.010. IMMUNITY FROM LIABILITY. (a) An independent review organization conducting an independent review under Subchapter I, Chapter 4201, is not liable for damages arising from the review determination made by the organization.

(b) This section does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence. (V.T.I.C. Art. 21.58C, Sec. 2(g).)

Source Law

(g) An independent review organization conducting a review under Section 6A, Article 21.58A of this code is not liable for damages arising from the determination made by the organization. This subsection does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence.

CHAPTER 4203. PROHIBITED CONSULTANT ACTIVITIES

Sec. 4203.001. DEFINITION . . . . . 1726

Sec. 4203.002. PROHIBITED CONSULTANT ACTIVITIES . . . . . 1727

CHAPTER 4203. PROHIBITED CONSULTANT ACTIVITIES

Revised Law

Sec. 4203.001. DEFINITION. In this chapter, "consultant" means a person who, for compensation and at the request of an insurer, business, individual, or utilization review agent:

(1) reviews, assesses, or evaluates a claim, charge,

or service of another chiropractor to determine whether the claim, charge, or service is:

(A) medically necessary, reasonable, or appropriate; or

(B) recommended for payment or nonpayment; or

(2) advises an insurer or utilization review agent regarding a chiropractic charge or service or recommends to that insurer or agent guidelines for a chiropractic charge or service. (V.T.I.C. Art. 21.58B (part).)

Source Law

> . . . For the purposes of this section, the term "consultant" means a person who: (1) for compensation and at the request of an insurance company, business, individual or utilization review agent, reviews, assesses or evaluates any claim, charge, treatment or service of another chiropractor for the purposes of determining if said claims, charges, treatment or services are medically necessary, reasonable, appropriate or are recommended for payment or non-payment; or (2) for compensation and at the request of an insurance company, business, individual or utilization review agent, advises or recommends to any insurance company or utilization review agent, guidelines regarding chiropractic charges, treatment or services.

Revisor's Note

V.T.I.C. Article 21.58B refers to any "treatment or service" of a chiropractor and to chiropractic "treatment or services." The revised law omits as unnecessary the reference to "treatment" because in this context, "treatment" is included within the meaning of "service."

Revised Law

Sec. 4203.002. PROHIBITED CONSULTANT ACTIVITIES. A member or employee of the Texas Board of Chiropractic Examiners may not act as a consultant or perform any consultant activities for an insurer or business, individual, or utilization review agent that audits chiropractic claims, charges, or services. (V.T.I.C. Art. 21.58B (part).)

Source Law

Art. 21.58B. A member or employee of the Board

of Chiropractic Examiners shall be prohibited from acting as a consultant or performing any consultant activities for any insurance company or business, individual or utilization review agent that audits chiropractic claims, charges or services. . . .

Revisor's Note

V.T.I.C. Article 21.58B refers to the "Board of Chiropractic Examiners." The revised law substitutes "Texas Board of Chiropractic Examiners" because under Chapter 201, Occupations Code, that is the correct name of the board.

APPENDIX A

CONFORMING AMENDMENTS

SECTION 5. CONFORMING AMENDMENT. Article 5.25, Insurance Code, is amended to read as follows:

Art. 5.25. BOARD SHALL FIX RATES. (a) The State Board of Insurance shall have the sole and exclusive power and authority and it shall be its duty to prescribe, fix, determine and promulgate the rates of premiums to be charged and collected by fire insurance companies transacting business in this State. Said Board shall also have authority to alter or amend any and all such rates of premiums so fixed and determined and adopted by it, and to raise or lower the same, or any part thereof, as herein provided. [~~Said Board shall have authority to employ clerical help, inspectors, experts and other assistants, and to incur such other expenses as may be necessary in carrying out the provisions of this law. Said Board shall ascertain as soon as practicable the annual fire loss in this State; obtain, make and maintain a record thereof and collect such data with respect thereto as will enable said Board to classify the fire losses of this State, the causes thereof, and the amount of premiums collected therefor for each class of risks and the amount paid thereon, in such manner as will aid in determining equitable insurance rates, methods of reducing such fire losses and reducing the insurance rates of the State, or subdivisions of the State. The Board may designate one or more advisory organizations or other agencies to gather, audit, and compile such experience of insurers, and the cost thereof shall be borne by such insurers.~~]

(b) Notwithstanding Subsection (a) of this article, on and after the effective date of S.B. No. 14, Acts of the 78th Legislature, Regular Session, 2003, rates for homeowners and residential fire and residential allied lines insurance coverage under this subchapter are determined as provided by Subchapter Q of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code, except that on and after December 1, 2004, rates for all lines

of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. [~~This subsection does not affect the requirement for the commissioner to conduct inspections of commercial property and prescribe a manual of rules and rating schedules for commercial property under this subchapter.~~]

SECTION 6. CONFORMING AMENDMENT. Article 5.25-3, Insurance Code, is amended to read as follows:

Art. 5.25-3. FIRE INSURANCE RATES AND FIRE SUPPRESSION RATINGS FOR BORDER MUNICIPALITY. The commissioner, in adopting fire insurance rates [~~or in assigning or evaluating a fire suppression rating~~] for a municipality at or near the border between this state and another state or the United Mexican States, shall take into account the existence and capabilities of a fire department or volunteer fire department that serves an adjoining or nearby municipality in the other state or the United Mexican States and that by agreement or by long-standing practice provides fire suppression services to the Texas municipality.

SECTION 7. CONFORMING AMENDMENT. Article 5.28(a), Insurance Code, is amended to read as follows:

(a) Said Board is authorized and empowered to require sworn statements for any period of time from any insurance company affected by this law and from any of its directors, officers, representatives, general agents, state agents, special agents, and local agents of the rates and premiums collected for fire insurance on each class of risks, on all property in this State and of the causes of fire, if such be known, if they are in possession of such data, and information, or can obtain it at a reasonable expense; and said Board is empowered to require such statements showing all necessary facts and information to enable said Board to make, amend and maintain the general basis schedules provided for in this law and the rules and regulations for applying same and to determine reasonable and proper maximum specific rates [~~and to determine and assist in the enforcement of the provisions of this law~~].

SECTION 8. CONFORMING AMENDMENT. Article 5.30(a),

Insurance Code, is amended to read as follows:

(a) [~~When a policy of fire insurance shall be issued by any company transacting the business of fire insurance in this State, such company shall furnish the policyholder with a written or printed analysis of the rate or premium charged for such policy, showing the items of charge and credit which determine the rate, unless such policyholder has theretofore been furnished with such analysis of such rate.~~] All schedules of rates promulgated by said Board shall be open to the public, and every local agent of any company engaging in the business of fire insurance in this state [~~such fire insurance company~~] shall have and exhibit to the public copies of such schedules covering all risks upon which he is authorized to write insurance.

SECTION 9. CONFORMING AMENDMENT. Article 5.41(a), Insurance Code, is amended to read as follows:

(a) A [~~No~~] company engaging or participating [~~shall engage or participate~~] in the insuring or reinsuring of any property in this state [~~State~~] against loss or damage by fire may not [~~except in compliance with the terms and provisions of this law; nor shall any such company~~] knowingly write insurance at any lesser rate than the rates herein provided for, and it shall be unlawful for any company so to do, unless it shall thereafter file an analysis of same with the Board[~~, and it shall be unlawful for any company, or its officers, directors, general agents, state agents, special agents, local agents, or its representatives, to grant or contract for any special favor or advantages in the dividends or other profits to come thereon, or in commissions in the dividends or other profits to accrue thereon, or in commissions or division of commission, or any position or any valuable consideration or any inducement not specified in the policy contract of insurance; nor shall such company give, sell or purchase, offer to give, sell or purchase, directly or indirectly, as an inducement to insure or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, partnership or individual, or any~~

~~dividends or profits accrued or to accrue thereon, or anything of value whatsoever, not specified in the policy. Nothing in this law shall be construed to prohibit a company from sharing its profits with its policyholders, if such agreement as to profit sharing shall be placed on or in the face of the policy, and such profit sharing shall be uniform and shall not discriminate between individuals or between classes. No part of the profit shall be paid until the expiration of the policy. Any company, or any of its officers, directors, general agents, state agents, special agents, local agents or its representatives, doing any of the acts in this article prohibited, shall be deemed guilty of unjust discrimination. If any agent or company shall issue a policy without authority, and any policyholder holding such policy shall sustain a loss or damage thereunder, said company or companies shall be liable to the policyholder thereunder, in the same manner and to the same extent as if said company had been authorized to issue said policies, although the company issued said policy in violation of the provisions of this subchapter. But this shall not be construed to give any company the right to issue any contract or policy of insurance other than as provided in this subchapter~~].

SECTION 10. CONFORMING AMENDMENT. Chapter 30, Insurance Code, is amended to read as follows:

CHAPTER 30. GENERAL PROVISIONS

Sec. 30.001. PURPOSE OF TITLES 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, [~~AND~~] 13, AND 14. (a) This title and Titles 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, [~~and~~] 13, and 14 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 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, [~~and~~] 13, and 14 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, 4, 5, 6, 7, 8, 9, 10, 11, 12, [~~and~~] 13, and 14.

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, 4, 5, 6, 7, 8, 9, 10, 11, 12, [~~or~~] 13, or 14.

Sec. 30.004. REFERENCE IN LAW TO STATUTE REVISED BY TITLE 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, [~~OR~~] 13, OR 14. A reference in a law to a statute or a part of a statute revised by this title or by Title 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, [~~or~~] 13, or 14 is considered to be a reference to the part of this code that revises that statute or part of that statute.

SECTION 11. CONFORMING AMENDMENT. Subchapter A, Chapter 36, Insurance Code, is amended by adding Section 36.002 to read as follows:

Sec. 36.002. ADDITIONAL RULEMAKING AUTHORITY. The commissioner may adopt reasonable rules that are:

(1) necessary to effect the purposes of a provision of:

(A) Subchapter B, Chapter 5;

(B) Subchapter C, Chapter 1806;

(C) Subchapter A, Chapter 2301;

(D) Chapter 251, as that chapter relates to casualty insurance and fidelity, guaranty, and surety bond insurance;

(E) Chapter 253;

(F) Chapter 2251 or 2252; or

(G) Subtitle B, Title 10; or

(2) appropriate to accomplish the purposes of a provision of:

(A) Section 37.051(a), 403.002, 492.051(b) or (c), 501.159, 941.003(b)(3) or (c), or 942.003(b)(3) or (c);

(B) Subchapter H, Chapter 544;

(C) Chapter 251, as that chapter relates to:

(i) automobile insurance;

(ii) casualty insurance and fidelity, guaranty, and surety bond insurance;

(iii) fire insurance and allied lines;

(iv) workers' compensation insurance; or

(v) aircraft insurance;

(D) Chapter 5, 252, 253, 254, 255, 256, 426, 493, 494, 1804, 1805, 1806, or 2171;

(E) Subtitle B, C, D, E, F, H, or I, Title 10;

(F) Section 417.008, Government Code;

(G) Chapter 406A, Labor Code; or

(H) Chapter 2154, Occupations Code. (V.T.I.C. Art. 5.19, Sec. (d); Art. 5.98.)

Source Law

[Art. 5.19]

(d) Rules and Regulations.--The Board may make reasonable rules and regulations necessary to effect the purposes of this subchapter.

Art. 5.98. The State Board of Insurance may adopt reasonable rules that are appropriate to accomplish the purposes of this chapter.

Revisor's Note

(1) Section (d), V.T.I.C. Article 5.19, refers to the "Board," meaning the Board of Insurance Commissioners, and V.T.I.C. Article 5.98 refers to the "State Board of Insurance." 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. For that reason, the revised law substitutes a reference to the commissioner for the references to the Board of Insurance Commissioners and the State Board of Insurance.

(2) Section (d), V.T.I.C. Article 5.19, 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.

(3) Section (d), V.T.I.C. Article 5.19, and V.T.I.C. Article 5.98 authorize the State Board of Insurance, meaning the commissioner of insurance for the reason stated in Revisor's Note (1) to this section, to adopt "rules . . . to effect the purposes of this subchapter," meaning Subchapter B, V.T.I.C. Chapter 5, and "reasonable rules that are appropriate to accomplish the purposes of this chapter," meaning V.T.I.C. Chapter 5. Those provisions are, to a great extent, duplicative of Section 36.001(a) of this code. Except as described by Revisor's Note (4) to this

section, the revised law continues the specific references to all of the provisions previously contained in Subchapter B, Chapter 5, or in Chapter 5, as applicable. However, the revision of those provisions does not affect the applicability of Section 36.001.

(4) V.T.I.C. Article 5.98 provides that the State Board of Insurance, meaning the commissioner of insurance for the reason stated in Revisor's Note (1) to this section, may "adopt reasonable rules that are appropriate to accomplish the purposes of this chapter," meaning V.T.I.C. Chapter 5. V.T.I.C. Article 5.53, contained in Chapter 5, is revised in pertinent part as Chapter 1807 of this code, and provides that "[t]he provisions of Chapter 5 of this code, other than [Article 5.53], shall not apply to marine insurance as defined by [Article 5.53]." Because Article 5.53 makes clear that Article 5.98 does not apply to marine insurance and Chapter 1807 applies only to marine insurance, the revised law omits the reference to Chapter 1807. Other provisions of Article 5.53 are revised as part of Section 2002.006; those provisions merely state the inapplicability of specific laws to the kinds of insurance governed by marine insurance, and it is appropriate to include those provisions in the reference in the revised law to Subtitle D, Title 10, which includes Chapter 2002.

SECTION 12. CONFORMING AMENDMENT. Subtitle B, Title 2, Insurance Code, is amended by adding Chapter 86 to read as follows:

CHAPTER 86. REVOCATION OR MODIFICATION OF CERTIFICATE OF AUTHORITY; AUTHORITY TO BRING CERTAIN ACTIONS

SUBCHAPTER A. REVOCATION OR MODIFICATION OF CERTIFICATE OF AUTHORITY

Sec. 86.001. AUTHORITY TO REVOKE OR MODIFY CERTIFICATE OF AUTHORITY. The commissioner may revoke or modify a certificate of authority if a condition or requirement prescribed by law for granting the certificate is no longer satisfied. (V.T.I.C. Art. 1.15, Sec. 1 (part); Art. 1.19 (part).)

Source Law

[Art. 1.15]

Sec. 1. . . . Such [State] Board [of Insurance] may revoke or modify any certificate of authority issued by such Board or by any predecessor in office when any condition or requirement prescribed by law for granting it no longer exists. . . .

Art. 1.19. . . . The Board [of Insurance Commissioners] may revoke or modify any certificate of authority issued by it when any conditions prescribed by law for granting it no longer exist.

. . .

Revisor's Note

Section 1, V.T.I.C. Article 1.15, refers to the State Board of Insurance, and V.T.I.C. Article 1.19 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 board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the Board of Insurance Commissioners and the State Board of Insurance have been changed appropriately.

Sec. 86.002. NOTICE OF INTENT TO REVOKE OR MODIFY CERTIFICATE OF AUTHORITY. (a) The commissioner must notify an insurance carrier in writing of the commissioner's intent to revoke or modify the carrier's certificate of authority.

(b) The commissioner must provide the notice not later than the 10th day before the date the revocation or modification is to

occur.

(c) The commissioner must specifically state in the notice the reason for the action. (V.T.I.C. Art. 1.15, Sec. 1 (part).)

Source Law

> Sec. 1. . . . Such Board shall give such company at least ten (10) days written notice of its intention to revoke or modify such certificate of authority stating specifically the reason for the action it proposes to take.

Revisor's Note

The portion of Section 1, V.T.I.C. Article 1.15, revised in this section requires certain notice to be given to "such company." For consistency with the remaining portion of Section 1, V.T.I.C. Article 1.15, revised in this code in Sections 401.051, 401.052, 401.054, and 86.001, the revised law substitutes "insurance carrier" for "such company."

[Sections 86.003-86.050 reserved for expansion]

SUBCHAPTER B. AUTHORITY TO BRING CERTAIN ACTIONS

Sec. 86.051. AUTHORITY TO BRING ACTION FOR OR PROSECUTE VIOLATION OF LAW. The department, through the attorney general or an attorney designated by the attorney general, may institute an action relating to or initiate a prosecution for a violation of a law of this state relating to insurance. (V.T.I.C. Art. 1.19 (part).)

Source Law

> Art. 1.19. . . . The Board shall also have power to institute suits and prosecutions, either by the Attorney General or such other attorneys as the Attorney General may designate, for any violation of the law of this State relating to insurance. . . .

Sec. 86.052. AUTHORITY TO BRING ACTION TO CLOSE AFFAIRS OR RESTRAIN BUSINESS OF DOMESTIC INSURANCE COMPANY. Only the department may bring an action to:

(1) close the affairs of an insurance company organized under the laws of this state; or

(2) enjoin, restrain, or interfere with the prosecution of the business of an insurance company organized under

the laws of this state. (V.T.I.C. Art. 1.19 (part).)

Source Law

> Art. 1.19. . . . No action shall be brought or maintained by any person other than the Board for closing up the affairs or to enjoin, restrain or interfere with the prosecution of the business of any such insurance company organized under the laws of this State.

SECTION 13. CONFORMING AMENDMENT. Chapter 252, Insurance Code, is amended by adding Section 252.005 to read as follows:

Sec. 252.005. EXCEPTION. This chapter does not apply to:

(1) a farm mutual insurance company operating under Chapter 911; or

(2) a mutual insurance company engaged in business under Chapter 12, Title 78, Revised Statutes, before that chapter's repeal by Section 18, Chapter 40, Acts of the 41st Legislature, 1st Called Session, 1929, as amended by Section 1, Chapter 60, General Laws, Acts of the 41st Legislature, 2nd Called Session, 1929, that retains the rights and privileges under the repealed law to the extent provided by those sections. (V.T.I.C. Art. 5.54 (part).)

Source Law

> Art. 5.54. Nothing in Articles 5.49, . . . of this subchapter shall ever be construed to apply to any farm mutual insurance company operating under Chapter 16 of this Code or to any company now operating under Chapter 12, of Title 78, which has heretofore been repealed. . . .

SECTION 14. CONFORMING AMENDMENT. Subchapter D, Chapter 501, Insurance Code, is amended by adding Section 501.159 to read as follows:

Sec. 501.159. COMMENTS ON CERTAIN INSURER FILINGS. (a) Notwithstanding this chapter, the office may submit written comments to the commissioner and otherwise participate regarding individual insurer filings made under Chapters 2251 and 2301 relating to insurance described by Subchapter B, Chapter 2301.

(b) The commissioner may adopt reasonable and necessary rules to implement this section. (V.T.I.C. Art. 5.145, Secs. 5, 6.)

Source Law

> Sec. 5. Notwithstanding Article 1.35A of this

code, the office of public insurance counsel may submit written comments to the commissioner and otherwise participate regarding individual company filings made under Article 5.13-2 of this code.

Sec. 6. The commissioner may adopt reasonable and necessary rules to implement this article.

Revisor's Note

(1) Section 5, V.T.I.C. Article 5.145, refers to "filings made under Article 5.13-2 of this code." V.T.I.C. Article 5.13-2 is revised in part in Chapters 2251 and 2301 of this code. Chapter 2251 includes provisions derived from V.T.I.C. Article 5.13-2C, and Chapter 2301 includes provisions derived from V.T.I.C. Article 5.145. The revised law appropriately substitutes references to Chapters 2251 and 2301 in their entirety for the reference to Article 5.13-2 because filings are not made under the provisions of those chapters that are derived from Articles 5.13-2C and 5.145. In addition, the revised law does not refer to the provisions of Article 5.13-2 that are not revised because filings are not made under those provisions.

(2) Section 6, V.T.I.C. Article 5.145, authorizes the commissioner of insurance to adopt reasonable and necessary rules to implement Article 5.145. In addition to Section 6, Section 5 of that article is revised as this section, and Sections 1, 2, 3, and 4 are revised in this code as Subchapter B, Chapter 2301. The revised law in Section 501.159(b) substitutes "this section" for "this article" and does not refer to Subchapter B, Chapter 2301, because the substance of Section 6 is repeated in that subchapter.

SECTION 15. CONFORMING AMENDMENT. Subchapter O, Chapter 841, Insurance Code, is amended by adding Section 841.705 to read as follows:

Sec. 841.705. PENALTY FOR FAILURE TO INVEST OR REPORT. (a) In addition to the penalty provided by this subchapter, an

insurance company is subject to a penalty as prescribed by Subsection (b) if, while holding a certificate of authority to engage in the business of insurance in this state, or after the company ceases to write new business or ceases to hold a certificate of authority, the company intentionally fails or refuses to:

(1) make the investments required by Chapter 425;

(2) make a report required by a law described by Section 841.002;

(3) make any special report requested by the commissioner under a law described by Section 841.002; or

(4) comply with another provision of a law described by Section 841.002.

(b) A penalty under this section is in the amount of $25 per day for each day the company remains in default after the commissioner notifies the company of the default in the manner provided by this subchapter.

(c) A penalty under this section may be recovered in a suit brought by the attorney general on behalf of the state in a district court of Travis County.

(d) In a suit brought to recover a penalty under this section:

(1) there are rebuttable presumptions that:

(A) any default that may have occurred was intentional; and

(B) the notice required by Subsection (b) was given; and

(2) if the question of whether the investments required by Chapter 425 were made is at issue, the defendant insurance company has the burden of proving that the investments were made as required by that chapter. (V.T.I.C. Art. 3.56.)

Source Law

Art. 3.56. If any such company shall intentionally fail or refuse to make the investments required by this chapter, or make any report required by this chapter, or to make any special report requested by the Board of Insurance Commissioners

under authority of this chapter, or generally to comply with any provision or requirements of this chapter, while holding a certificate of authority to transact business in this State, or after it shall cease to write new business or cease to hold such certificate, such failure or refusal shall subject such company, in addition to the penalty provided in the preceding article, in cases to which said article may be applicable, to the payment of a penalty of Twenty-five ($25.00) Dollars per day for each day that such company shall remain in default after the Board shall notify such company of such default, in the manner provided in the preceding article, to be recovered in a suit that may be brought by the Attorney General in behalf of the State in the District Court of Travis County. In any suit brought to recover such penalty, there shall be a prima facie presumption subject to rebuttal, that any default that may have occurred was intentional; that the notice required by this chapter was given, and the burden of proof shall be on the defendant company to prove that the investments required by this chapter were made as herein required whenever the question of whether or not such investments were thus made is in issue.

Revisor's Note

(1) V.T.I.C. Article 3.56 refers to investments and reports required or requested under V.T.I.C. Chapter 3. Chapter 425 of this code, which is derived from portions of Chapter 3, includes the revision of the provisions of Chapter 3 relating to investments for those companies. The provisions of Chapter 3 regarding reports required or potentially requested of those companies are revised as various provisions of this code. Section 841.002 of this code refers to Chapter 3 and describes laws derived from Chapter 3 that may require, or under which a request may be made of, a domestic life, accident, or health insurance company to make a report. The revised law is drafted accordingly.

(2) V.T.I.C. Article 3.56 refers to a failure to comply with "any provision or requirements" of V.T.I.C. Chapter 3. The revised law omits the reference to "requirements" because, in the context of Article 3.56, the meaning of that term is included in the meaning of "any provision."

(3) V.T.I.C. Article 3.56 refers to a "prima

facie presumption subject to rebuttal." The revised law omits "prima facie" as unnecessary because a presumption necessarily involves a "prima facie" presumption of a fact. Consequently, the term does not add to the clear meaning of the law.

SECTION 16. CONFORMING AMENDMENT. Subtitle H, Title 6, Insurance Code, is amended by adding Chapter 962 to read as follows:

CHAPTER 962. JOB PROTECTION INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 962.001. GENERAL DEFINITIONS. In this chapter:

(1) "Insured" means an individual whose indemnification against income loss is provided because of the individual's membership in a company or association that offers a job protection insurance plan.

(2) "Insurer" has the meaning assigned by Section 801.001.

(3) "Person" means an individual, corporation, association, or other legal entity. (V.T.I.C. Art. 25.01, Secs. (3), (4), (5).)

Source Law

Art. 25.01. In this chapter:

(3) "Carrier" has the meaning provided by Article 1.14 of this code.

(4) "Insured" means one whose indemnification against income loss is provided by virtue of his membership in a company or association that offers a job protection insurance plan.

(5) "Person" means an individual, corporation, association, or any other legal entity.

Revisor's Note

(1) Section (2), V.T.I.C. Article 25.01, defines "board" as the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred the board's functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the

board have been changed to "commissioner" or "department" as appropriate. For this reason, the revised law omits the definition of "board." The omitted law reads:

(2) "Board" means the State Board of Insurance.

(2) Section (3), V.T.I.C. Article 25.01, defines "carrier" to have the meaning provided by V.T.I.C. Article 1.14, revised in pertinent part as Section 801.001 of this code. Section 801.001 defines "insurer" instead of "carrier." For that reason the term "insurer" is substituted for "carrier" in this section and throughout this chapter.

Sec. 962.002. JOB PROTECTION INSURANCE DEFINED. (a) In this chapter, "job protection insurance" means insurance providing indemnity that is:

(1) paid for loss of position arising from discharge or suspension;

(2) payable in installments that do not exceed the average monthly wage of the insured; and

(3) provided to:

(A) conductors, engineers, motormen, brakemen, switchmen, firemen, dispatchers, clerks, operators, trackmen, signalmen, and maintenance-of-way personnel of steam and electric railways; and

(B) bus drivers and truck drivers employed by common carriers.

(b) The term "job protection insurance" does not include a job benefit fund administered by and through a labor union only for the union's members. (V.T.I.C. Art. 25.01, Sec. (1).)

Source Law

Art. 25.01. In this chapter:

(1) "Job protection insurance" means the business of providing indemnity to conductors, engineers, motormen, brakemen, switchmen, firemen, dispatchers, clerks, operators, trackmen, signalmen, and maintenance of way personnel of steam and electric

railways and to bus drivers and truck drivers employed by common carriers for loss of position arising from discharge or suspension, which indemnity is payable in installments that do not exceed the average monthly wage of the insured; but shall not apply to job benefit funds administered by and through labor unions for their members only.

Revisor's Note

Section (1), V.T.I.C. Article 25.01, defines "job protection insurance" to mean "the business of providing" certain indemnity. The revised law substitutes "insurance providing indemnity" for "the business of providing indemnity" because as the term is used in Article 25.01, revised as this chapter, "job protection insurance" refers to the kind of insurance provided and not to the business of providing that kind of insurance.

Sec. 962.003. COMPLIANCE WITH CHAPTER REQUIRED. An insurer must comply with this chapter to write the insurance coverages authorized by Section 962.101. (V.T.I.C. Art. 25.02, Sec. (c).)

Source Law

(c) On or after the effective date of this chapter, an insurance carrier may not write the coverages specified in Subdivisions (1) and (2) of Section (a) of this article except by complying with this chapter.

Revisor's Note

Section (c), V.T.I.C. Article 25.02, states that "[o]n or after the effective date of this chapter," meaning V.T.I.C. Chapter 25, compliance with the chapter is required to write certain coverages. The revised law omits the quoted language as executed and because Section 311.022, Government Code (Code Construction Act), which applies to the revised law, provides that a statute is presumed to operate prospectively unless expressly made retrospective.

Sec. 962.004. APPLICABILITY OF OTHER LAW. An insurer operating under this chapter is subject to the following provisions, if not in conflict with this chapter:

(1) the other chapters of this code, including:

(A) Chapter 221;

(B) Chapter 281, other than any minimum capital and surplus requirements specified in that chapter;

(C) Chapter 822, including Sections 822.203, 822.205, 822.210, and 822.212;

(D) Chapter 861; and

(E) Chapter 402; and

(2) Section 171.0525, Tax Code. (V.T.I.C. Arts. 25.05, 25.07.)

Source Law

Art. 25.05. Chapter 2, including Article 2.20, Chapter 8, and Article 4.10 of this code, and all other provisions of the Insurance Code, if not in conflict with this chapter, shall apply to and govern any insurance carrier operating under this chapter. In addition, Article 21.49-8 of this code applies to each insurance carrier operating under this chapter.

Art. 25.07. Article 21.46 of this code, with the exception of the minimum capital and surplus requirements specified in that article, applies to any carrier operating under this chapter.

Revisor's Note

V.T.I.C. Article 25.05 states that "all . . . provisions of the Insurance Code, if not in conflict with this chapter," meaning V.T.I.C. Chapter 25, revised as this chapter, apply to an insurer operating under this chapter and specifically lists certain provisions that apply. The revised law retains the specific references for the convenience of the reader. Among the specific references is V.T.I.C. Chapter 8, revised in this code as Chapters 861 and 984. The revised law references only Chapter 861 because Chapter 984 is applicable only to Mexican casualty insurance companies that provide certain automobile coverage or accident or other casualty coverage.

In addition, V.T.I.C. Articles 25.05 and 25.07 provide that V.T.I.C. Article 21.49-8, revised as

Chapter 402 of this code, and certain provisions of V.T.I.C. Article 21.46, revised as Chapter 281 of this code, apply to an insurer operating under this chapter. While it is not explicitly stated, it is clear from the portion of Article 25.05 quoted above that Articles 21.49-8 and 21.46 apply only to the extent that those articles do not conflict with the law revised as this chapter. Also, general rules of statutory construction provide that a more specific provision supersedes a general statement of law. Because the law revised as this chapter is specific to job protection insurance, it is clear that Articles 21.49-8 and 21.46 apply only to the extent that there is no conflict with that law. The revised law is drafted accordingly.

Sec. 962.005. AGENTS. Title 13 applies to the licensing and regulation of an agent authorized to solicit job protection insurance for an insurer operating under this chapter. (V.T.I.C. Art. 25.06.)

Source Law

Art. 25.06. Subchapter A, Chapter 21, of this code applies to the licensing and regulation of an agent authorized to solicit job protection insurance for an insurance carrier under this chapter.

Revisor's Note

V.T.I.C. Article 25.06 states that Subchapter A, V.T.I.C. Chapter 21, applies to the licensing and regulation of certain agents. The pertinent portions of that subchapter were revised as part of Title 13 of this code. Title 13 contains some provisions that were not derived from Subchapter A, Chapter 21. Those provisions either are inapplicable by their own terms or apply to the licensing and regulation of the agents in accordance with V.T.I.C. Article 25.05, revised as Section 962.004 of this chapter. The revised law is

drafted accordingly.

[Sections 962.006-962.050 reserved for expansion]

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 962.051. QUALIFICATIONS FOR CERTIFICATE OF AUTHORITY. An insurer may not be issued a certificate of authority to operate under this chapter unless:

(1) it or a predecessor was writing the insurance coverages authorized by Section 962.101 on or before January 1, 1920, in at least one state; and

(2) it had policyholders in this state on August 29, 1983, and provides proof of that fact to the department. (V.T.I.C. Art. 25.04, Sec. (a).)

Source Law

Art. 25.04. (a) An insurance carrier may not be granted a certificate of authority to operate under this chapter unless:

(1) it or a predecessor carrier was writing the insurance coverages authorized by Subdivisions (1) and (2) of Section (a), Article 25.02, of this chapter on or before January 1, 1920, in at least one state; and

(2) it has policyholders in this state on the effective date of this chapter and provides proof of that fact to the board.

Revisor's Note

V.T.I.C. Article 25.04 refers to the effective date of "this chapter," meaning V.T.I.C. Chapter 25. That chapter became effective on August 29, 1983. The revised law is drafted accordingly.

Sec. 962.052. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) The commissioner shall issue a certificate of authority to a domestic or foreign insurer that applies for a certificate if:

(1) the applicant has:

(A) complied with the requirements of this chapter and all other requirements imposed on the applicant by law; and

(B) paid any deposit imposed by law; and

(2) the operational history of the applicant indicates a condition such that the expanded operation of the applicant in

this state or the applicant's operations outside this state will not create a condition that might be hazardous to the applicant's policyholders or creditors or to the public, when that operational history is reviewed in conjunction with:

(A) the applicant's loss experience;

(B) the kinds and nature of risks insured;

(C) the financial condition of the applicant and the applicant's ownership;

(D) the applicant's proposed method of operation;

(E) the applicant's affiliations;

(F) the applicant's investments;

(G) any contracts leading to contingent liability or agreements relating to guaranty and surety, other than insurance; and

(H) the ratio of the applicant's total annual premium and net investment income to commission expenses, general insurance expenses, policy benefits paid, and required policy reserve increases.

(b) The commissioner shall file in the department's offices any documents delivered to the commissioner under this section.

(c) The certificate of authority authorizes the insurer to engage in the kind or kinds of business in this state specified in the certificate. (V.T.I.C. Art. 25.04, Sec. (b) (part).)

Source Law

(b) If a domestic or foreign carrier has complied with the requirements of this chapter and all other requirements imposed on the company by law; has paid any deposit imposed by law; and the operational history of the company when reviewed in conjunction with its loss experience, the kinds and nature of risks insured, the financial condition of the company and its ownership, its proposed method of operation, its affiliations, its investments, any contracts leading to contingent liability or agreements in respect to guaranty and surety, other than insurance, and the ratio of total annual premium and net investment income to commission expenses, general insurance expenses, policy benefits paid and required policy reserve increases, indicates a condition such that the expanded operation of the company in this state or its operations outside this state will not create a

condition that might be hazardous to its policyholders, creditors, or the general public, the commissioner shall file in the office the documents delivered to him and shall issue to the company a certificate of authority to transact the kind or kinds of business in this state specified in the certificate. . . .

Sec. 962.053. COMPLIANCE WITH STATE LAW REQUIRED. A certificate of authority issued under this chapter continues in effect on the condition that the insurer continue to comply with the laws of this state. (V.T.I.C. Art. 25.04, Sec. (b) (part).)

Source Law

(b) . . . The certificate shall continue in full force and effect on the condition that the company continue to comply with the laws of this state.

Revisor's Note

Section (b), V.T.I.C. Article 25.04, provides that a certificate of authority continues "in full force and effect" on certain conditions. The revised law omits the reference to "in full force" because "in full force" is included within the meaning of "in effect."

Sec. 962.054. INSURERS NOT MEETING CERTAIN REQUIREMENTS. To write the insurance coverages authorized by Section 962.101, a domestic or foreign insurer that does not meet the requirements of Sections 962.051 and 962.052 must comply with Chapters 822 and 861. (V.T.I.C. Art. 25.04, Sec. (c).)

Source Law

(c) Domestic and foreign insurance carriers not meeting the requirements of this article must comply with the requirements of Chapters 2 and 8 of this code in order for those carriers to be permitted to write the insurance coverages authorized by Article 25.02 of this code.

Revisor's Note

Section (c), V.T.I.C. Article 25.04, references former V.T.I.C. Chapter 8, revised in this code as Chapters 861 and 984. The revised law references only Chapter 861 for the reason stated in the revisor's note to Section 962.004.

Sec. 962.055. CAPITAL AND SURPLUS REQUIREMENTS. A domestic

or foreign insurer operating under this chapter shall maintain the minimum capital and surplus required by Sections 822.054, 822.210, and 822.211. (V.T.I.C. Art. 25.03.)

Source Law

Art. 25.03. Domestic and foreign insurance carriers operating under this chapter shall maintain the minimum capital and surplus required by Article 2.02 of this code.

Revisor's Note

V.T.I.C. Article 25.03 refers to the minimum capital and surplus required by V.T.I.C. Article 2.02, revised in this code as Sections 822.052, 822.053, 822.054, 822.202, 822.210, and 822.211. The revised law does not reference Sections 822.052 and 822.053 because those sections do not relate to capital and surplus requirements. The revised law does not reference Section 822.202 because that section relates to the determination of capital and surplus in relation to full coverage automobile insurance. The revised law references Section 822.210, derived from both V.T.I.C. Article 2.02 and V.T.I.C. Article 2.20. Under V.T.I.C. Article 25.05, revised in this chapter as Section 962.004, an insurer under this chapter is subject to both Articles 2.02 and 2.20.

[Sections 962.056-962.100 reserved for expansion]

SUBCHAPTER C. COVERAGE

Sec. 962.101. AUTHORIZED COVERAGES. A domestic or foreign insurer operating under this chapter may write:

(1) job protection insurance; and

(2) insurance that:

(A) insures an individual described by Section 962.002(a) against bodily injury or death by accident or against disability on account of sickness or accident;

(B) grants specific hospital benefits and medical, surgical, and sick-care benefits to an individual and the

individual's family; and

(C) provides reimbursement of funeral expenses in an amount not to exceed $200 to any person in connection with the coverage. (V.T.I.C. Art. 25.02, Sec. (a).)

Source Law

Art. 25.02. (a) The kinds of insurance to be written by domestic and foreign insurance carriers operating under this chapter are as follows:

(1) to provide indemnity to conductors, engineers, motormen, brakemen, switchmen, firemen, dispatchers, clerks, operators, trackmen, signalmen, and maintenance of way personnel of steam and electric railways and to bus drivers and truck drivers employed by common carriers for loss of position arising from discharge or suspension, which indemnity is payable in installments that do not exceed the average monthly wage of the insured; and

(2) to insure such persons against bodily injury or death by accident or against disability on account of sickness or accident, to grant specific hospital benefits and medical, surgical, and sick-care benefits to persons and their families, and to provide reimbursement of funeral expenses in an amount not to exceed $200 to any person in conjunction with this coverage.

Revisor's Note

Section (a), V.T.I.C. Article 25.02, describes the kinds of insurance that may be written by an insurer operating under this chapter. Section (a)(1) of that article is substantively identical to the definition of "job protection insurance" contained in V.T.I.C. Article 25.01, revised in this chapter as Section 962.002. For clarity and conciseness, the revised law substitutes the defined term for the substance of Section (a)(1).

Sec. 962.102. OTHER COVERAGES PROHIBITED. A domestic or foreign insurer operating under this chapter may not write coverage that is not authorized by Section 962.101. (V.T.I.C. Art. 25.02, Sec. (b).)

Source Law

[(a) The kinds of insurance to be written by domestic and foreign insurance carriers operating under this chapter are as follows . . . .]

(b) Any coverage that is not authorized by Subdivisions (1) and (2) of Section (a) of this article is specifically prohibited.

Sec. 962.103. APPLICABILITY OF GUARANTY FUND LAW. A guaranty fund established under this code does not provide coverage for insurance written under this chapter except as specifically provided by a law governing the fund. (V.T.I.C. Art. 25.08.)

Source Law

Art. 25.08. Coverages provided under this chapter are not subject to the guaranty funds provided in this code unless specifically indicated in the laws governing those funds.

[Sections 962.104-962.700 reserved for expansion]

SUBCHAPTER O. ENFORCEMENT PROVISIONS

Sec. 962.701. PROHIBITED ACTS; OFFENSE. (a) A person may not:

(1) provide coverage described by Section 962.101 unless the person holds a certificate of authority to provide that coverage; or

(2) solicit insurance for an insurer authorized to provide insurance coverage under this chapter unless the person holds an insurance agent's license.

(b) A person commits an offense if the person knowingly violates Subsection (a). An offense under this subsection is a Class B misdemeanor.

(c) Venue for prosecution of an offense under this section is in Travis County. (V.T.I.C. Art. 25.09; Art. 25.10, Secs. (b), (c).)

Source Law

Art. 25.09. A person may not engage in any of the following acts:

(1) providing any of the coverages indicated in Article 25.02 of this code without initially having obtained a certificate of authority to provide those coverages from the board; or

(2) soliciting insurance for a carrier authorized to provide insurance coverage under this chapter without initially having obtained an insurance agent's license.

[Art. 25.10]

(b) A person commits an offense if the person knowingly or intentionally violates Article 25.09 of this chapter.

(c) An offense under Section (b) of this article is a Class B misdemeanor. Venue for the offense is in Travis County.

Revisor's Note

Section (b), V.T.I.C. Article 25.09, refers to a person who "knowingly or intentionally" engages in certain conduct. The revised law omits the reference to the higher degree of culpability as unnecessary. Under Section 6.02, Penal Code, applicable to the revised law, culpable mental states are classified according to relative degrees from highest to lowest. An intentional mental state is a more culpable mental state than a knowing mental state. Proof of a higher degree of culpability than that charged constitutes proof of the culpability charged.

Sec. 962.702. REFUSAL TO ISSUE OR RENEW CERTIFICATE OF AUTHORITY OR LICENSE; SUSPENSION OR REVOCATION. If, after notice and hearing, the commissioner finds that the applicant, certificate holder, or license holder has violated this chapter or another provision of this code, the commissioner may refuse to issue or renew a certificate of authority or a license, or may suspend or revoke a certificate of authority or a license. (V.T.I.C. Art. 25.10, Sec. (a).)

Source Law

Art. 25.10. (a) The board may refuse to issue or renew a certificate of authority or a license, or may suspend or revoke a certificate of authority or a license if, after notice and hearing, the board finds that the applicant or licensee has violated this chapter or any other provision of this code.

SECTION 17. CONFORMING AMENDMENT. Subtitle A, Title 5, Labor Code, is amended by adding Chapter 406A to read as follows:

CHAPTER 406A. GROUP PURCHASE OF WORKERS' COMPENSATION INSURANCE COVERAGE

Sec. 406A.001. DEFINITIONS. In this chapter:

(1) "Business entity" means a business enterprise owned by a single person or a corporation, organization, business trust, trust, partnership, joint venture, association, or other business entity.

(2) "Commissioner" means the commissioner of insurance.

(3) "Department" means the Texas Department of Insurance. (V.T.I.C. Art. 5.57A, Sec. (a).)

Source Law

Art. 5.57A. (a) In this article:

(1) "Board" means the State Board of Insurance.

(2) "Business entity" means a business enterprise owned by a single person or a corporation, organization, business trust, trust, partnership, joint venture, association, or other business entity.

Revisor's Note

Section (a)(1), V.T.I.C. Article 5.57A, defines "board" as 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 board have been changed appropriately. For this reason, the revised law substitutes definitions of "commissioner" and "department" for the definition of "board."

Sec. 406A.002. CERTIFICATION PROGRAM. (a) The department shall:

(1) maintain a certification program for groups organized under this chapter; and

(2) issue certificates of approval to eligible business entities authorizing formation and maintenance of a group.

(b) The commissioner by rule shall adopt forms, criteria, and procedures for issuing certificates of approval to groups under this chapter. (V.T.I.C. Art. 5.57A, Secs. (d), (e).)

Source Law

(d) The Board shall establish a certification program for groups organized under this article and shall issue certificates of approval to eligible business entities authorizing formation and maintenance of a group.

(e) The Board by rule shall adopt forms, criteria, and procedures for the issuance of

certificates of approval to groups under this article.

Revisor's Note

Section (d), V.T.I.C. Article 5.57A, requires the Texas Department of Insurance to "establish" a certification program. The revised law omits the requirement to "establish" the certification program as executed and substitutes a requirement to "maintain" the certification program.

Sec. 406A.003. FORMATION OF GROUP. (a) On receipt of a certificate of approval issued by the department under this chapter, two or more business entities or two or more members of a trade association may join together to form a group to purchase individual workers' compensation insurance policies covering each member of the group.

(b) To be eligible to join a group, a business entity must:

(1) be engaged in a business pursuit that is the same as or similar to the other business entities participating in the group as determined by the department; or

(2) be a member of the same trade association as the other business entities participating in the group. (V.T.I.C. Art. 5.57A, Secs. (a)(3), (b), (c), as amended Acts 78th Leg., R.S., Chs. 275, 607.)

Source Law

[as amended Acts 78th Leg., R.S., Ch. 607]

(3) "Group" means:

(A) two or more business entities that join together with the approval of the Board to purchase individual workers' compensation insurance policies covering each business entity that is a part of the group; or

(B) two or more members of a trade association of business entities that join together with the approval of the commissioner to purchase individual workers' compensation insurance policies covering each participating trade association member.

[as amended Acts 78th Leg., R.S., Ch. 275]

(3) "Group" means:

(A) two or more business entities that join together with the approval of the Board to purchase individual workers' compensation insurance policies covering each business entity that is a part of the group; or

(B) two or more members of a trade association of business entities that join together to

purchase individual workers' compensation insurance policies covering each participating trade association member.

[as amended Acts 78th Leg., R.S., Ch. 607]

(b) On receiving approval of the Board as provided by this article, two or more business entities or members of a trade association may join together to form a group to purchase individual workers' compensation insurance policies covering each member of the group.

[as amended Acts 78th Leg., R.S., Ch. 275]

(b) On receiving approval of the Board as provided by this article, two or more business entities or two or more members of a trade association may join together to form a group to purchase individual workers' compensation insurance policies covering each member of the group.

(c) To be eligible to join a group, a business entity must be:

(1) engaged in a business pursuit that is the same as or similar to the other business entities participating in the group as determined by the Board; or

(2) a member of the same trade association as the other business entities participating in the group.

Revisor's Note

Section (b), V.T.I.C. Article 5.57A, refers to a group receiving "approval" as provided by that article. For consistency of terminology throughout this chapter, the revised law substitutes "certificate of approval" for "approval."

Sec. 406A.004. PLAN OF OPERATION. (a) A group shall:

(1) adopt a plan of operation; and

(2) file a copy of the plan of operation with the department.

(b) The plan of operation must include:

(1) provisions governing the composition and selection of a governing board;

(2) the methods for administering the group; and

(3) guidelines governing the workers' compensation insurance coverage obtained by the group that include provisions governing:

(A) the payment of premiums;

(B) the distribution of discounts; and

(C) the methods for providing risk management.

(V.T.I.C. Art. 5.57A, Sec. (i).)

Source Law

> (i) A group shall adopt a plan of operation that shall include the composition and selection of a governing board, the methods for administering the group, and guidelines for the workers' compensation insurance coverage obtained by the group including the payment of premiums, the distribution of discounts, and the methods for providing risk management. A group shall file a copy of its plan of operation with the Board.

Sec. 406A.005. GROUP PURCHASE AUTHORIZED. A group certified under this chapter may purchase individual workers' compensation insurance policies covering each member of the group from any insurer authorized to write workers' compensation insurance in this state. (V.T.I.C. Art. 5.57A, Sec. (f) (part).)

Source Law

> (f) A group certified under this article may purchase individual workers' compensation insurance policies covering each member of the group from any insurer authorized to write workers' compensation insurance in this state. . . .

Sec. 406A.006. POLICY RATES. Rates for policies purchased under this chapter must be computed using manual rules and rates. The department shall determine any experience rating factor that must be applied to those policies as provided by the commissioner by rule. (V.T.I.C. Art. 5.57A, Sec. (h).)

Source Law

> (h) Manual rules and rates shall be used in computing the rates for policies under this article, and the Board shall determine any experience rating factor that shall be applied to those group policies as provided by the Board's rules.

Sec. 406A.007. GROUP DISCOUNT. (a) A group that purchases a policy under this chapter is entitled to any premium or volume discount that would be applicable to a policy of the combined premium amount.

(b) A group shall apportion any discount or policyholder dividend received on workers' compensation insurance coverage among the members of the group according to a formula adopted in the plan of operation for the group. (V.T.I.C. Art. 5.57A, Secs. (f) (part), (g).)

Source Law

(f) . . . Under such a policy, the group is entitled to any premium or volume discount that would be applicable to a policy of the combined premium amount.

(g) A group shall apportion any discount or policyholder dividend received on workers' compensation insurance coverage among the members of the group according to a formula adopted in the plan of operation for the group.

Sec. 406A.008. APPLICABILITY OF OTHER LAW. (a) A group established under this chapter is entitled to any deviation applicable under Section 2052.004, 2053.051, or 2053.052(a) or (b), Insurance Code.

(b) A member of a group is not subject to the discounts and surcharges established under Subchapter F, Chapter 2053, Insurance Code. (V.T.I.C. Art. 5.57A, Sec. (j).)

Source Law

(j) A group established under this article is entitled to any deviation applicable under Article 5.60 of this code. A member of a group is not subject to the discounts and surcharges established under Article 5.55B of this code.

SECTION 18. REPEALER. (a) The following Acts and articles as compiled in Vernon's Texas Insurance Code are repealed:

(1) 1.04A, 1.14-3, 1.15, 1.15A, 1.15B, 1.16, 1.17, 1.17A, 1.18, 1.19, 1.32, and 1.39;

(2) 2.10, 2.10-1, 2.10-2, 2.10-3A, 2.10-4, and 2.10-5;

(3) 3.10, 3.16, 3.17, 3.18, 3.28, 3.29, 3.31, 3.32, 3.33, 3.39, 3.39a, 3.40, 3.40-1, 3.41, 3.41a, and 3.56;

(4) 5.01C, 5.01-3, 5.06-1, 5.06-2, 5.06-3, 5.06-4, 5.06-5, 5.06-6, 5.07, 5.07-1, 5.08, 5.09, 5.12-1, 5.13-2C, 5.15-2, 5.15-3, 5.15-4, 5.18, 5.19, 5.20, 5.21, 5.25-1, 5.25-2, 5.33, 5.33B, 5.33E, 5.35-1, 5.35-2, 5.35-3, 5.36, 5.37, 5.38, 5.41-1, 5.41-2, 5.41-3, 5.42, 5.43, 5.45, 5.46, 5.47, 5.48, 5.48-1, 5.48-2, 5.51, 5.52, 5.53, 5.53-A, 5.54, 5.55, 5.55B, 5.55C, 5.56, 5.57, 5.57A, 5.58, 5.59, 5.60, 5.60A, 5.61, 5.62, 5.63, 5.64, 5.65A, 5.65B, 5.65C, 5.67, 5.68-1, 5.69, 5.70, 5.71, 5.72, 5.73, 5.74, 5.75, 5.75-1, 5.75-3, 5.76-3, 5.76-4, 5.76-5, 5.90, 5.92, 5.98, 5.102, 5.131, 5.144, 5.145, 5.171, and 5.172;

(5) 7.01, 7.02, 7.19-1, 7.20, and 7.20-1;

(6) 21.11-2, 21.28, 21.28-A, 21.28-C, 21.28-D, 21.28-E, 21.31, 21.32, 21.32A, 21.39, 21.39-A, 21.39-B, 21.40, 21.49, 21.49-3b, 21.49-3d, 21.49-4, 21.49-4a, 21.49-6, 21.49-7, 21.49-8, 21.49-11, 21.49-13, 21.49-14, 21.49-15A, 21.49-17, 21.49-18, 21.49-20, 21.49A, 21.49A-1, 21.49B, 21.50, 21.54, 21.58A, 21.58B, 21.58C, 21.61, 21.72, 21.77, 21.79, 21.79E, and 21.81; and

(7) 25.01, 25.02, 25.03, 25.04, 25.05, 25.06, 25.07, 25.08, 25.09, and 25.10.

(b) Sections 3, 4, 5, and 17, Article 1.10, Insurance Code, are repealed.

(c) Subsections (5), (6), (9), (10), (11), and (12)(b), Article 5.06, Insurance Code, are repealed.

(d) Sections 2-8 and 10-16, Article 5.13-2, Insurance Code, are repealed.

(e) Sections 1-9 and 11, Article 5.15-1, Insurance Code, are repealed.

(f) Subsections (b) and (c), Article 5.28, Insurance Code, are repealed.

(g) Subsection (k), Article 5.35, Insurance Code, as added by Chapter 206, Acts of the 78th Legislature, Regular Session, 2003, is repealed.

(h) Sections 1, 3-4B, and 5-10, Article 21.49-3, Insurance Code, are repealed.

SECTION 19. 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 20. EFFECTIVE DATE. This Act takes effect April 1, 2007.

APPENDIX B

CHAPTER 311. CODE CONSTRUCTION ACT

(current as of end of 79th Legislature, 2nd Called Session, 2005)

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

entity.

(3) "Population" means the population shown by the most recent federal decennial census.

(4) "Property" means real and personal property.

(5) "Rule" includes regulation.

(6) "Signed" includes any symbol executed or adopted by a person with present intention to authenticate a writing.

(7) "State," when referring to a part of the United States, includes any state, district, commonwealth, territory, and insular possession of the United States and any area subject to the legislative authority of the United States of America.

(8) "Swear" includes affirm.

(9) "United States" includes a department, bureau, or other agency of the United States of America.

(10) "Week" means seven consecutive days.

(11) "Written" includes any representation of words, letters, symbols, or figures.

(12) "Year" means 12 consecutive months.

(13) "Includes" and "including" are terms of enlargement and not of limitation or exclusive enumeration, and use of the terms does not create a presumption that components not expressed are excluded.

Sec. 311.006. INTERNAL REFERENCES. In a code:

(1) a reference to a title, chapter, or section without further identification is a reference to a title, chapter, or section of the code; and

(2) a reference to a subtitle, subchapter, subsection, subdivision, paragraph, or other numbered or lettered unit without further identification is a reference to a unit of the next larger unit of the code in which the reference appears.

SUBCHAPTER B. CONSTRUCTION OF WORDS AND PHRASES

Sec. 311.011. COMMON AND TECHNICAL USAGE OF WORDS. (a) Words and phrases shall be read in context and construed according 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

permission or a power.

(2) "Shall" imposes a duty.

(3) "Must" creates or recognizes a condition precedent.

(4) "Is entitled to" creates or recognizes a right.

(5) "May not" imposes a prohibition and is synonymous with "shall not."

(6) "Is not entitled to" negates a right.

(7) "Is not required to" negates a duty or condition precedent.

SUBCHAPTER C. CONSTRUCTION OF STATUTES

Sec. 311.021. INTENTION IN ENACTMENT OF STATUTES. In enacting a statute, it is presumed that:

(1) compliance with the constitutions of this state and the United States is intended;

(2) the entire statute is intended to be effective;

(3) a just and reasonable result is intended;

(4) a result feasible of execution is intended; and

(5) public interest is favored over any private interest.

Sec. 311.022. PROSPECTIVE OPERATION OF STATUTES. A statute is presumed to be prospective in its operation unless expressly made retrospective.

Sec. 311.023. STATUTE CONSTRUCTION AIDS. In construing a statute, whether or not the statute is considered ambiguous on its face, a court may consider among other matters the:

(1) object sought to be attained;

(2) circumstances under which the statute was enacted;

(3) legislative history;

(4) common law or former statutory provisions, including laws on the same or similar subjects;

(5) consequences of a particular construction;

(6) administrative construction of the statute; and

(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

of law.

Sec. 311.026. SPECIAL OR LOCAL PROVISION PREVAILS OVER GENERAL. (a) If a general provision conflicts with a special or local provision, the provisions shall be construed, if possible, so that effect is given to both.

(b) If the conflict between the general provision and the special or local provision is irreconcilable, the special or local provision prevails as an exception to the general provision, unless the general provision is the later enactment and the manifest intent is that the general provision prevail.

Sec. 311.027. STATUTORY REFERENCES. Unless expressly provided otherwise, a reference to any portion of a statute or rule applies to all reenactments, revisions, or amendments of the statute or rule.

Sec. 311.028. UNIFORM CONSTRUCTION OF UNIFORM ACTS. A uniform act included in a code shall be construed to effect its general purpose to make uniform the law of those states that enact it.

Sec. 311.029. ENROLLED BILL CONTROLS. If the language of the enrolled bill version of a statute conflicts with the language of any subsequent printing or reprinting of the statute, the language of the enrolled bill version controls.

Sec. 311.030. REPEAL OF REPEALING STATUTE. The repeal of a repealing statute does not revive the statute originally repealed nor impair the effect of any saving provision in it.

Sec. 311.031. SAVING PROVISIONS. (a) Except as provided by Subsection (b), the reenactment, revision, amendment, or repeal of a statute does not affect:

(1) the prior operation of the statute or any prior action taken under it;

(2) any validation, cure, right, privilege, obligation, or liability previously acquired, accrued, accorded, or incurred under it;

(3) any violation of the statute or any penalty,

forfeiture, or punishment incurred under the statute before its amendment or repeal; or

(4) any investigation, proceeding, or remedy concerning any privilege, obligation, liability, penalty, forfeiture, or punishment; and the investigation, proceeding, or remedy may be instituted, continued, or enforced, and the penalty, forfeiture, or punishment imposed, as if the statute had not been repealed or amended.

(b) If the penalty, forfeiture, or punishment for any offense is reduced by a reenactment, revision, or amendment of a statute, the penalty, forfeiture, or punishment, if not already imposed, shall be imposed according to the statute as amended.

(c) The repeal of a statute by a code does not affect an amendment, revision, or reenactment of the statute by the same legislature that enacted the code. The amendment, revision, or reenactment is preserved and given effect as part of the code provision that revised the statute so amended, revised, or reenacted.

(d) If any provision of a code conflicts with a statute enacted by the same legislature that enacted the code, the statute controls.

Sec. 311.032. SEVERABILITY OF STATUTES. (a) If any statute contains a provision for severability, that provision prevails in interpreting that statute.

(b) If any statute contains a provision for nonseverability, that provision prevails in interpreting that statute.

(c) In a statute that does not contain a provision for severability or nonseverability, if any provision of the statute or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the statute that can be given effect without the invalid provision or application, and to this end the provisions of the statute are severable.

Sec. 311.034. WAIVER OF SOVEREIGN IMMUNITY. In order to preserve the legislature's interest in managing state fiscal matters through the appropriations process, a statute shall not be construed as a waiver of sovereign immunity unless the waiver is effected by clear and unambiguous language. In a statute, the use of "person," as defined by Section 311.005 to include governmental entities, does not indicate legislative intent to waive sovereign immunity unless the context of the statute indicates no other reasonable construction. Statutory prerequisites to a suit, including the provision of notice, are jurisdictional requirements in all suits against a governmental entity.

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