AN ACT

relating to a nonsubstantive revision of statutes relating to the Texas Department of Insurance, the business of insurance, and certain related businesses, including conforming amendments, repeals, and penalties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. TITLE 3, INSURANCE CODE. The Insurance Code is amended by adding Title 3 to read as follows:

TITLE 3. DEPARTMENT FUNDS, FEES, AND TAXES

SUBTITLE A. GENERAL PROVISIONS

CHAPTER 201. COLLECTION OF REVENUE AND ADMINISTRATION OF FUNDS

CHAPTER 202. FEES

CHAPTER 203. GENERAL PROVISIONS RELATING TO TAXES

[Chapters 204-220 reserved for expansion]

SUBTITLE B. INSURANCE PREMIUM TAXES

CHAPTER 221. PROPERTY AND CASUALTY INSURANCE PREMIUM TAX

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

CHAPTER 223. TITLE INSURANCE PREMIUM TAX

CHAPTER 224. RECIPROCAL AND INTERINSURANCE EXCHANGE PREMIUM TAX

CHAPTER 225. SURPLUS LINES INSURANCE PREMIUM TAX

CHAPTER 226. UNAUTHORIZED AND INDEPENDENTLY PROCURED

CHAPTER 201. COLLECTION OF REVENUE AND ADMINISTRATION OF FUNDS

SUBCHAPTER A. GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 201.002. ACCOUNTING PROCEDURE. The commissioner shall

maintain a procedure to account for the receipt, disbursement, and allocation of money deposited in the Texas Department of Insurance operating account, including recordkeeping procedures adequate for:

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

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

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

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

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

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

comptroller.

(b) The comptroller shall:

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

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

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

(B) a description of the security;

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

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

(c) To verify the correctness of records:

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

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

[Sections 201.006-201.050 reserved for expansion]

SUBCHAPTER B. ADMINISTRATION

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

law of this state, as specifically provided by this code.

(b) The comptroller may:

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

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

(c) A rule adopted by the comptroller that relates to the administration, collection, reporting, or enforcement of taxes imposed under this code prevails over a conflicting rule, policy, or procedure established by the department, the commissioner, or otherwise.

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

Sec. 201.052. REIMBURSEMENT. (a) The department shall

reimburse the appropriate portion of the general revenue fund for the amount of expenses incurred by the comptroller in administering taxes imposed under this code or another insurance law of this state.

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

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

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

(e) If the amount of maintenance taxes collected is not sufficient to reimburse the appropriate portion of the general revenue fund for the amount of expenses incurred by the comptroller, other money in the Texas Department of Insurance

operating account shall be used to reimburse the appropriate portion of the general revenue fund. (V.T.I.C. Art. 4.19.)

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

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

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

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

(1) the postal service postmark stamped on the cover

in which the report or payment is mailed; or

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

CHAPTER 202. FEES

SUBCHAPTER A. GENERAL PROVISIONS

SUBCHAPTER B. SPECIFIC MAXIMUM FEES

SUBCHAPTER C. DEPOSIT AND USE OF FEES

CHAPTER 202. FEES

SUBCHAPTER A. GENERAL PROVISIONS

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

(1) stock insurance companies;

(2) mutual insurance companies;

(3) local mutual aid associations;

(4) statewide mutual assessment companies;

(5) group hospital service corporations; and

(6) stipulated premium companies. (V.T.I.C. Art. 4.07, Sec. D.)

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

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

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

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

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

[Sections 202.005-202.050 reserved for expansion]

SUBCHAPTER B. SPECIFIC MAXIMUM FEES

Sec. 202.051. GENERAL FEES IMPOSED ON INSURERS. The

department shall impose and receive fees for the use of the state from each authorized insurer writing insurance in this state. The amount of the fees may not exceed:

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

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

(3) for reservation of name. $200;

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

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

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

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

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

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

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

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

(12) for accepting a security deposit $200;

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

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

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

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

(17) for filing a statement under Subchapters D and E, Chapter 823, if the amount of the consideration exceeds $9.9 million . . . . . an additional $500 for each additional $10 million of the consideration that exceeds $9.9 million, but not more than a total amount of $10,000 under this subdivision and Subdivision (16);

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

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

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

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

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

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

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

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

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

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

Sec. 202.052. FEES IMPOSED ON CERTAIN INSURERS. (a) The department shall impose and the comptroller shall collect fees for the use of the state from each authorized insurer writing a class of insurance that may be written by an insurer operating under Chapter 841. The amount of the fees may not exceed:

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

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

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

[Sections 202.053-202.100 reserved for expansion]

SUBCHAPTER C. DEPOSIT AND USE OF FEES

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

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

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

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

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

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

CHAPTER 203. GENERAL PROVISIONS RELATING TO TAXES

Sec. 203.001. LIMITATION ON CERTAIN ADDITIONAL TAXES

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

CHAPTER 203. GENERAL PROVISIONS RELATING TO TAXES

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

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

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

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

(c) Subsection (b) does not:

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

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

Sec. 203.002. TAX PAYMENT REQUIRED FOR CERTAIN CERTIFICATES; UNREPORTED GROSS PREMIUM RECEIPTS. (a) A life insurance company may not receive a certificate of authority to engage in the business of insurance in this state until all taxes imposed under this code or another insurance law of this state are paid.

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

[Chapters 204-220 reserved for expansion]

SUBTITLE B. INSURANCE PREMIUM TAXES

CHAPTER 221. PROPERTY AND CASUALTY INSURANCE PREMIUM TAX

Sec. 221.005. CHANGE IN DUE DATES

Sec. 221.006. CREDIT FOR FEES PAID

Sec. 221.007. FAILURE TO PAY TAXES

CHAPTER 221. PROPERTY AND CASUALTY INSURANCE PREMIUM TAX

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

(b) This chapter does not apply to:

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

(2) a group hospital service corporation operating under Chapter 842;

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

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

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

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

the insurer's taxable premium receipts for a calendar year.

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

(1) fire insurance;

(2) ocean marine insurance;

(3) inland marine insurance;

(4) accident insurance;

(5) credit insurance;

(6) livestock insurance;

(7) fidelity insurance;

(8) guaranty insurance;

(9) surety insurance;

(10) casualty insurance;

(11) workers' compensation insurance;

(12) employers' liability insurance; and

(13) crop insurance written by a farm mutual insurance company.

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

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

(2) premium receipts received from the business of life insurance, personal accident insurance, life and accident insurance, or health and accident insurance for profit, written by

a life insurance company, life and accident insurance company, health and accident insurance company, or for mutual benefit or protection in this state;

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

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

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

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

Sec. 221.003. TAX DUE DATES. (a) The total tax imposed by this chapter is due and payable not later than March 1 after the end of the calendar year for which the tax is due.

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

(c) The comptroller may refund any overpayment of taxes that results from the semiannual prepayment system prescribed by this section. (V.T.I.C. Art. 4.10, Secs. 6(a) (part), (b).)

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

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

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

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

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

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

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

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

Sec. 222.001. APPLICABILITY OF CHAPTER

Sec. 222.002. TAX IMPOSED

Sec. 222.003. TAX RATES

Sec. 222.004. TAX DUE DATES

Sec. 222.005. TAX REPORT

Sec. 222.006. CHANGE IN DUE DATES

Sec. 222.007. CREDIT FOR FEES PAID

Sec. 222.008. FAILURE TO PAY TAXES

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

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

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

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

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

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

(D) a statewide mutual assessment company operating under Chapter 881;

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

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

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

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

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

(J) a Mexican casualty insurance company

operating under Chapter 984; and

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

(b) This chapter does not apply to:

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

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

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

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

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

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

(b) Except as otherwise provided by this section, in determining an insurer's taxable gross premiums or a health maintenance organization's taxable gross revenues, the insurer or health maintenance organization shall include the total gross amounts of premiums, membership fees, assessments, dues, revenues, and other considerations received by the insurer or health maintenance organization in a calendar year from any kind of health maintenance organization certificate or contract or insurance policy or contract covering a person located in this state and

arising from the business of a health maintenance organization or the business of life insurance, accident insurance, health insurance, life and accident insurance, life and health insurance, health and accident insurance, life, health, and accident insurance, including variable life insurance, credit life insurance, and credit accident and health insurance for profit or otherwise or for mutual benefit or protection.

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

(1) returned premiums or revenues;

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

(3) premiums received from an insurer for reinsurance;

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

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

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

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

(A) a municipality, county, or hospital district

in this state; or

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

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

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

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

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

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

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

life insurance.

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

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

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

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

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

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

(3) another date prescribed by the comptroller.

(b) An insurer or health maintenance organization that had a net tax liability for the previous calendar year of more than $1,000 shall make semiannual prepayments of tax on March 1 and August 1. The tax paid on each date must be equal to 50 percent of the total amount of tax the insurer or health maintenance organization paid under this chapter for the previous calendar year. If the insurer or health maintenance organization did not pay a tax under this chapter during the previous calendar year, the tax paid on each date

must be equal to the tax that would be owed on the aggregate of the taxable gross premiums or taxable gross revenues for the two previous calendar quarters.

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

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

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

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

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

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

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

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

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

CHAPTER 223. TITLE INSURANCE PREMIUM TAX

CHAPTER 223. TITLE INSURANCE PREMIUM TAX

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

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

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

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

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

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

(2) returned premiums and dividends paid to policyholders.

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

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

to the company's or agent's gross premium receipts.

(b) This section does not:

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

(2) prohibit the imposition and collection of state, county, and municipal taxes on the property of title insurance companies or title insurance agents or state, county, and municipal taxes imposed by other laws of this state, unless a specific exemption for title insurance companies or title insurance agents is provided in those laws. (V.T.I.C. Art. 9.59, Sec. 8(a).)

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

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

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

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

(2) another date prescribed by the comptroller.

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

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

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

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

Sec. 223.008. RULES. (a) The commissioner or the comptroller, as appropriate, may adopt fair and reasonable rules, minimum standards, and limitations as appropriate to augment and implement this chapter.

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

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

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

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

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

CHAPTER 224. RECIPROCAL AND INTERINSURANCE EXCHANGE PREMIUM TAX

CHAPTER 224. RECIPROCAL AND INTERINSURANCE EXCHANGE PREMIUM TAX

Sec. 224.001. APPLICABILITY OF CHAPTER. This chapter applies to a reciprocal or interinsurance exchange that has a certificate of authority to engage in business in this state. (V.T.I.C. Arts. 4.11B, Sec. 1; 4.11C, Sec. 1.)

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

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

(2) withdraws that election.

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

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

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

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

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

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

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

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

CHAPTER 225. SURPLUS LINES INSURANCE PREMIUM TAX

CHAPTER 225. SURPLUS LINES INSURANCE PREMIUM TAX

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

(1) a premium;

(2) a membership fee;

(3) an assessment;

(4) dues; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 225.007. COLLECTED TAXES HELD IN TRUST. A surplus lines agent holds taxes collected under this chapter in trust.

(V.T.I.C. Art. 1.14-2, Sec. 12(b) (part).)

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

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

Sec. 225.009. PREPAYMENT OF TAX. (a) A surplus lines agent shall prepay the tax imposed by this chapter when the amount of the accrued taxes due is equal to at least $70,000.

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

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

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

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

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

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

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

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

CHAPTER 226. UNAUTHORIZED AND INDEPENDENTLY PROCURED INSURANCE PREMIUM TAX

SUBCHAPTER A. UNAUTHORIZED INSURANCE PREMIUM TAX

Sec. 226.001. DEFINITION

Sec. 226.002. APPLICABILITY OF SUBCHAPTER

Sec. 226.003. TAX IMPOSED; RATE

Sec. 226.004. TAX EXCLUSIVE

Sec. 226.005. TAX PAYMENT; DUE DATE

[Sections 226.006-226.050 reserved for expansion]

SUBCHAPTER B. INDEPENDENTLY PROCURED INSURANCE PREMIUM TAX

Sec. 226.051. DEFINITION

Sec. 226.052. APPLICABILITY OF SUBCHAPTER

Sec. 226.053. TAX IMPOSED; RATE

Sec. 226.054. TAX PAYMENT BY CERTAIN INSUREDS

Sec. 226.055. TAX PAYMENT BY CERTAIN CORPORATIONS

Sec. 226.056. EFFECT ON OTHER LAW

CHAPTER 226. UNAUTHORIZED AND INDEPENDENTLY PROCURED INSURANCE PREMIUM TAX

SUBCHAPTER A. UNAUTHORIZED INSURANCE PREMIUM TAX

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

(1) a premium;

(2) a membership fee;

(3) an assessment; or

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

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

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

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

(c) If a policy covers risks or exposures only partially located in this state, the tax is computed on the portion of the

premium that is properly allocated to a risk or exposure located in this state.

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

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

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

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

(1) the application is made;

(2) the negotiations are conducted; or

(3) the premiums are remitted.

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

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

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

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

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

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

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

(2) another date prescribed by the comptroller.

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

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

[Sections 226.006-226.050 reserved for expansion]

SUBCHAPTER B. INDEPENDENTLY PROCURED INSURANCE PREMIUM TAX

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

(1) a premium;

(2) a membership fee; or

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

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

(part).)

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

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

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

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

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

(2) another date prescribed by the comptroller.

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

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

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

Sec. 226.055. TAX PAYMENT BY CERTAIN CORPORATIONS. The amount of tax due and payable under this subchapter by a corporation

that files a franchise tax report shall be reported directly to the comptroller and is due:

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

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

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

CHAPTER 227. DISPOSITION OF PROCEEDS OF CERTAIN PREMIUM TAXES

Sec. 227.001. DISPOSITION OF TAX PROCEEDS

CHAPTER 227. DISPOSITION OF PROCEEDS OF CERTAIN PREMIUM TAXES

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

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

[Chapters 228-250 reserved for expansion]

SUBTITLE C. INSURANCE MAINTENANCE TAXES

CHAPTER 251. GENERAL PROVISIONS

Sec. 251.001. DETERMINING RATE OF ASSESSMENT

Sec. 251.002. DUTY TO ADVISE COMPTROLLER OF RATE

Sec. 251.003. EFFECT OF LATE ADVISEMENT OF RATE

Sec. 251.004. DEPOSIT OF MAINTENANCE TAXES

CHAPTER 251. GENERAL PROVISIONS

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

(b) In determining the rate of assessment, the commissioner shall consider the requirement to reimburse the appropriate portion of the general revenue fund under Section 201.052. (V.T.I.C. Art. 1.14-3, Secs. 8(a) (part), (b) (part); Art. 4.17, Secs. (a) (part), (c) (part); Art. 5.12, Secs. (a) (part), (c) (part); Art. 5.24, Secs. (a) (part), (c) (part); Art. 5.49, Secs. (a) (part), (c) (part); Art. 5.68, Secs. (a) (part), (d) (part); Art. 5.91, Secs. (a) (part), (c) (part); Art. 20A.33, Secs. (d) (part), (f) (part); Art. 21.07-6, Secs. 21(a) (part), (c) (part); Art. 23.08A, Secs. (a) (part), (c) (part).)

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

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

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

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

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

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

CHAPTER 252. FIRE AND ALLIED LINES INSURANCE

CHAPTER 252. FIRE AND ALLIED LINES INSURANCE

Sec. 252.001. MAINTENANCE TAX IMPOSED. A maintenance tax

is imposed on each authorized insurer with gross premiums subject to taxation under Section 252.003. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter. (V.T.I.C. Art. 5.49, Secs. (a) (part), (b).)

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

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

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

(1) bombardment;

(2) civil war or commotion;

(3) cyclone;

(4) earthquake;

(5) excess or deficiency of moisture;

(6) explosion as defined by Article 5.52;

(7) fire;

(8) flood;

(9) frost and freeze;

(10) hail;

(11) insurrection;

(12) invasion;

(13) lightning;

(14) military or usurped power;

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

(16) rain;

(17) riot;

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

(19) smoke or smudge;

(20) strike or lockout;

(21) tornado;

(22) vandalism or malicious mischief;

(23) volcanic eruption;

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

(25) weather or climatic conditions; or

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

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

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

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

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

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

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

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

5.24, Secs. (a) (part), (c) (part).)

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

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

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

CHAPTER 254. MOTOR VEHICLE INSURANCE

CHAPTER 254. MOTOR VEHICLE INSURANCE

Sec. 254.001. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each authorized insurer with gross premiums subject to taxation under Section 254.003. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter. (V.T.I.C. Art. 5.12, Secs. (a) (part), (b).)

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

254.003.

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

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

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

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

CHAPTER 255. WORKERS' COMPENSATION INSURANCE

CHAPTER 255. WORKERS' COMPENSATION INSURANCE

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

(1) stock insurance company;

(2) mutual insurance company;

(3) reciprocal or interinsurance exchange; and

(4) Lloyd's plan.

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

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

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

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

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

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

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

CHAPTER 256. AIRCRAFT INSURANCE

CHAPTER 256. AIRCRAFT INSURANCE

Sec. 256.001. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each authorized insurer with gross premiums subject to taxation under Section 256.003. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter. (V.T.I.C. Art. 5.91, Secs. (a) (part), (b).)

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

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating all classes of insurance specified under Subchapter K, Chapter 5. (V.T.I.C. Art.

5.91, Secs. (a) (part), (c) (part).)

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

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

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

CHAPTER 257. LIFE, HEALTH, AND ACCIDENT INSURANCE

Sec. 257.001. MAINTENANCE TAX IMPOSED

Sec. 257.002. MAXIMUM RATE; ANNUAL ADJUSTMENT

Sec. 257.003. PREMIUMS AND CONSIDERATIONS SUBJECT TO TAXATION; LIMIT

Sec. 257.004. MAINTENANCE TAX DUE DATES

CHAPTER 257. LIFE, HEALTH, AND ACCIDENT INSURANCE

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

addition to other taxes imposed that are not in conflict with this chapter. (V.T.I.C. Art. 4.17, Secs. (a) (part), (b), (f).)

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

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating life, health, and accident insurers. (V.T.I.C. Art. 4.17, Secs. (a) (part), (c) (part).)

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

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

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

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

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

301 et seq.); or

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

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

(b) The comptroller may require semiannual or other periodic payment only from an insurer whose maintenance tax liability under this chapter for the previous year was at least $2,000. (V.T.I.C. Art. 4.17, Secs. (a) (part), (e).)

CHAPTER 258. HEALTH MAINTENANCE ORGANIZATIONS

CHAPTER 258. HEALTH MAINTENANCE ORGANIZATIONS

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

Sec. 258.002. MAINTENANCE TAX IMPOSED. A per capita maintenance tax is imposed on each authorized health maintenance organization with gross revenues subject to taxation under Section 258.004. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter. (V.T.I.C. Art. 20A.33, Secs. (d) (part), (e).)

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

(b) The commissioner shall annually adjust the rate of assessment of the per capita maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating health maintenance organizations.

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

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

(b) The amount of maintenance tax assessed may not be computed based on enrollees who as individual certificate holders or their dependents are covered by a master group policy paid for by revenues received from this state or the United States for insurance contracted for by this state or the United States:

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

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

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

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

CHAPTER 259. THIRD-PARTY ADMINISTRATORS

CHAPTER 259. THIRD-PARTY ADMINISTRATORS

Sec. 259.001. DEFINITIONS. In this chapter:

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

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

Sec. 259.002. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each authorized administrator with administrative or

service fees subject to taxation under Section 259.004. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter. (V.T.I.C. Art. 21.07-6, Secs. 21(a) (part), (b).)

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

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses of regulating administrators. (V.T.I.C. Art. 21.07-6, Secs. 21(a) (part), (c) (part).)

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

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

CHAPTER 260. NONPROFIT LEGAL SERVICES CORPORATIONS

Sec. 260.005. APPLICABILITY OF OTHER LAW

CHAPTER 260. NONPROFIT LEGAL SERVICES CORPORATIONS

Sec. 260.001. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each nonprofit legal services corporation subject to Chapter 961 with gross revenues subject to taxation under Section 260.003. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter. (V.T.I.C. Art. 23.08A, Secs. (a) (part), (b).)

Sec. 260.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed one percent of the corporation's gross revenues subject to taxation under Section 260.003.

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating nonprofit legal services corporations. (V.T.I.C. Art. 23.08A, Secs. (a) (part), (c) (part).)

Sec. 260.003. REVENUES SUBJECT TO TAXATION. A corporation shall pay maintenance taxes under this chapter on the correctly reported gross revenues received from issuing prepaid legal services contracts in this state. (V.T.I.C. Art. 23.08A, Sec. (a) (part).)

Sec. 260.004. MAINTENANCE TAX DUE DATES; RULES. (a) The corporation shall pay the maintenance tax annually or semiannually.

(b) The comptroller may require semiannual payments only

from a corporation whose maintenance tax liability under this chapter for the previous tax year was at least $2,000.

(c) The comptroller may adopt reasonable rules to implement semiannual payments that the comptroller considers advisable. (V.T.I.C. Art. 23.08A, Secs. (a) (part), (f).)

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

CHAPTER 261. TEXAS INSURANCE EXCHANGE

CHAPTER 261. TEXAS INSURANCE EXCHANGE

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

Sec. 261.002. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on the gross premiums paid through the exchange and subject to taxation under Section 261.004. (V.T.I.C. Art. 1.14-3, Sec. 8(a) (part).)

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

(b) The commissioner shall annually adjust the rate of

assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating all classes of insurance specified under Article 1.14-3. (V.T.I.C. Art. 1.14-3, Secs. 8(a) (part), (b) (part).)

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

Sec. 261.005. MAINTENANCE TAX DUE DATES. The exchange shall pay the maintenance tax annually, semiannually, or on another periodic basis, as determined by the comptroller. (V.T.I.C. Art. 1.14-3, Sec. 8(a) (part).)

[Chapters 262-270 reserved for expansion]

SUBTITLE D. TITLE INSURANCE MAINTENANCE FEES

CHAPTER 271. TITLE INSURANCE MAINTENANCE FEES

Sec. 271.009. EFFECT OF LATE ADVISEMENT OF RATE

Sec. 271.010. DEPOSIT OF MAINTENANCE FEES

Sec. 271.011. MAINTENANCE FEE DUE DATES

Sec. 271.012. RULES

CHAPTER 271. TITLE INSURANCE MAINTENANCE FEES

Sec. 271.001. APPLICABILITY OF CERTAIN DEFINITIONS. In this chapter, a term defined by Chapter 2501 has the meaning assigned by that chapter. (New.)

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

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

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

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

(b) In determining the rate of assessment, the commissioner shall consider the requirement to reimburse the appropriate portion

of the general revenue fund under Section 201.052. (V.T.I.C. Art. 9.46, Secs. (a) (part), (b) (part), as amended Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18; V.T.I.C. Art. 9.46 (part), as amended Acts 73rd Leg., R.S., Ch. 486, Sec. 6.04.)

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

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

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

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

Sec. 271.008. DUTY TO ADVISE COMPTROLLER OF RATE. The commissioner shall advise the comptroller of the applicable rate of

assessment of the maintenance fee not later than the 45th day before the due date of the maintenance fee return for the period for which that fee is due. (V.T.I.C. Art. 9.46, Sec. (e) (part), as amended Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18.)

Sec. 271.009. EFFECT OF LATE ADVISEMENT OF RATE. (a) Except as provided by Subsection (b), if the commissioner does not advise the comptroller of the applicable rate of assessment of the maintenance fee by the date required by Section 271.008, the rate of assessment is the rate imposed in the preceding period.

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

(1) advise each insurer in writing of the amount of any additional fees due; or

(2) refund any excess fees paid. (V.T.I.C. Art. 9.46, Sec. (e) (part), as amended Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18.)

Sec. 271.010. DEPOSIT OF MAINTENANCE FEES. (a) The comptroller shall deposit maintenance fees collected under this chapter in the general revenue fund to be reallocated to the Texas Department of Insurance operating account.

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

Sec. 271.011. MAINTENANCE FEE DUE DATES. (a) The insurer shall pay the maintenance fee on an annual, semiannual, or other periodic basis, as determined by the comptroller.

(b) The comptroller may require semiannual or other periodic payment only from an insurer whose maintenance fee liability under this chapter for the preceding year was at least $2,000. (V.T.I.C. Art. 9.46, Secs. (a) (part), (d), as amended Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18.)

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

[Chapters 272-280 reserved for expansion]

SUBTITLE E. OTHER TAXES

CHAPTER 281. RETALIATORY PROVISIONS

SUBCHAPTER A. RETALIATORY TAXES AND OTHER CHARGES

[Sections 281.008-281.050 reserved for expansion]

SUBCHAPTER B. RETALIATORY PENALTIES OR OTHER OBLIGATIONS

Sec. 281.051. DEFINITIONS

Sec. 281.052. IMPOSITION OF PENALTY OR OTHER OBLIGATION

CHAPTER 281. RETALIATORY PROVISIONS

SUBCHAPTER A. RETALIATORY TAXES AND OTHER CHARGES

Sec. 281.001. DEFINITIONS. In this subchapter:

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

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

(3) "Tax or other charge" includes:

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

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

(C) a license;

(D) a fine;

(E) a penalty;

(F) a deposit requirement; and

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

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

(1) has established its principal office or agency in

the United States;

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

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

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

(1) at least 15 percent of the voting stock of the person, company, firm, association, group, corporation, or insurance organization is owned by a corporation organized under the laws of and domiciled in this state; and

(2) the person, company, firm, association, group, corporation, or insurance organization met the requirements of Subdivision (1) before January 30, 1957. (V.T.I.C. Art. 21.46, Sec. (f).)

Sec. 281.004. RETALIATORY TAXES OR OTHER CHARGES, PROHIBITIONS, AND RESTRICTIONS. (a) The comptroller shall impose and collect a tax or other charge or a prohibition or restriction on a foreign insurer authorized to engage in business in this state if:

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

(2) the sum of the taxes or other charges,

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

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

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

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

(1) an ad valorem tax on property;

(2) a personal income tax;

(3) a sales tax;

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

(5) an assessment for a special purpose, such as an assessment for a guaranty association, high risk health pool, joint underwriting association, or windstorm association, under the law of this or another state. (V.T.I.C. Art. 21.46, Secs. 1(e), (g) (part).)

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

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

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

[Sections 281.008-281.050 reserved for expansion]

SUBCHAPTER B. RETALIATORY PENALTIES OR OTHER OBLIGATIONS

Sec. 281.051. DEFINITIONS. In this subchapter:

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

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

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

business of insurance in this state if:

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

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

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

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

(b) A penalty or other obligation imposed by the Texas Department of Insurance on a foreign insurer under this section must be the same as the penalty or other obligation imposed on the domestic insurer by the insurance department or regulatory official of the foreign insurer's state of organization. (V.T.I.C. Art. 21.46, Sec. 2.)

SECTION 2. TITLE 5, INSURANCE CODE. The Insurance Code is amended by adding Title 5 to read as follows:

TITLE 5. PROTECTION OF CONSUMER INTERESTS

SUBTITLE A. PUBLIC INSURANCE COUNSEL

CHAPTER 501. OFFICE OF PUBLIC INSURANCE COUNSEL

[Chapters 502-520 reserved for expansion]

SUBTITLE B. CONSUMER SERVICE PROVISIONS

CHAPTER 521. CONSUMER INFORMATION AND COMPLAINTS

CHAPTER 522. CONSUMER INFORMATION IN SPANISH

CHAPTER 523. MARKET ASSISTANCE PROGRAM FOR RESIDENTIAL PROPERTY INSURANCE

[Chapters 524-540 reserved for expansion]

SUBTITLE C. DECEPTIVE, UNFAIR, AND PROHIBITED PRACTICES

CHAPTER 541. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES

CHAPTER 542. PROCESSING AND SETTLEMENT OF CLAIMS

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CHAPTER 501. OFFICE OF PUBLIC INSURANCE COUNSEL

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 501.001. DEFINITION. In this chapter, "office" means

the office of public insurance counsel. (New.)

Sec. 501.002. OFFICE OF PUBLIC INSURANCE COUNSEL. The independent office of public insurance counsel represents the interests of insurance consumers in this state. (V.T.I.C. Art. 1.35A, Sec. 1.)

Sec. 501.003. SUNSET PROVISION. The office is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the office is abolished September 1, 2005. (V.T.I.C. Art. 1.35A, Sec. 7.)

Sec. 501.004. PUBLIC INTEREST INFORMATION. (a) The office shall prepare information of public interest describing the functions of the office.

(b) The office shall make the information available to the public and appropriate state agencies. (V.T.I.C. Art. 1.35A, Sec. 6(a).)

Sec. 501.005. ACCESS TO PROGRAMS AND FACILITIES. (a) The office shall prepare and maintain a written plan that describes how a person who does not speak English can be provided reasonable access to the office's programs.

(b) The office shall comply with federal and state laws for program and facility accessibility. (V.T.I.C. Art. 1.35A, Sec. 6(b).)

[Sections 501.006-501.050 reserved for expansion]

SUBCHAPTER B. PUBLIC COUNSEL

Sec. 501.051. APPOINTMENT; TERM. (a) The governor, with the advice and consent of the senate, shall appoint a public counsel to serve as the executive director of the office. The public

counsel serves a two-year term that expires on February 1 of each odd-numbered year.

(b) The governor shall appoint the public counsel without regard to the race, color, disability, sex, religion, age, or national origin of the appointee. (V.T.I.C. Art. 1.35A, Secs. 2(a), (d), (e), 3(a) (part).)

Sec. 501.052. QUALIFICATIONS. To be eligible to serve as public counsel, a person must:

(1) be licensed to practice law in this state;

(2) have demonstrated a strong commitment to and involvement in efforts to safeguard the rights of the public; and

(3) possess the knowledge and experience necessary to practice effectively in insurance proceedings. (V.T.I.C. Art. 1.35A, Sec. 2(b).)

Sec. 501.053. BUSINESS INTEREST; SERVICE AS PUBLIC COUNSEL. A person is not eligible for appointment as public counsel if the person or the person's spouse:

(1) is employed by or participates in the management of a business entity or other organization regulated by or receiving funds from the department;

(2) owns or controls, directly or indirectly, more than a 10 percent interest in a business entity or other organization regulated by or receiving funds from the department or the office; or

(3) uses or receives a substantial amount of tangible goods, services, or funds from the department or the office, other than compensation or reimbursement authorized by law for department

or office membership, attendance, or expenses. (V.T.I.C. Art. 1.35A, Sec. 2(c).)

Sec. 501.054. LOBBYING ACTIVITIES. A person may not serve as public counsel or act as general counsel to the office if the person is required to register as a lobbyist under Chapter 305, Government Code, because of the person's activities for compensation related to the operation of the department or the office. (V.T.I.C. Art. 1.35A, Sec. 4(a).)

Sec. 501.055. GROUNDS FOR REMOVAL. (a) It is a ground for removal from office if the public counsel:

(1) does not have at the time of appointment or maintain during service as public counsel the qualifications required by Section 501.052;

(2) violates a prohibition established by Section 501.053, 501.054, 501.056, or 501.102; or

(3) cannot, because of illness or disability, discharge the public counsel's duties for a substantial part of the public counsel's term.

(b) The validity of an action of the office is not affected by the fact that the action is taken when a ground for removal of the public counsel exists. (V.T.I.C. Art. 1.35A, Secs. 2(f), (g).)

Sec. 501.056. PROHIBITED REPRESENTATION OR EMPLOYMENT. A former public counsel may not represent any person or receive compensation for services rendered on behalf of any person regarding a case pending before the commissioner or department before the second anniversary of the date the person ceases to serve as public counsel. (V.T.I.C. Art. 1.35A, Sec. 4(b).)

[Sections 501.057-501.100 reserved for expansion]

SUBCHAPTER C. PERSONNEL

Sec. 501.101. OFFICE PERSONNEL. (a) The public counsel shall employ professional, technical, and other employees necessary to implement this chapter.

(b) Compensation for an employee shall be set under the General Appropriations Act as provided by the legislature. (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

Sec. 501.102. TRADE ASSOCIATIONS. (a) In this section, "trade association" means a nonprofit, cooperative, and voluntarily joined association of business or professional competitors designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

(b) A person may not serve as public counsel or be an employee of the office who is exempt from the state's position classification plan or is compensated at or above the amount prescribed by the General Appropriations Act for step 1, salary group A17, of the position classification salary schedule if the person is:

(1) an officer, employee, or paid consultant of a trade association in the field of insurance; or

(2) the spouse of an officer, manager, or paid consultant of a trade association in the field of insurance. (V.T.I.C. Art. 1.35A, Secs. 4(c), (d), (e).)

Sec. 501.103. CAREER LADDER PROGRAM; PERFORMANCE EVALUATIONS. (a) The public counsel or the public counsel's

designee shall develop an intra-agency career ladder program. The program must require intra-agency posting of all nonentry level positions concurrently with any public posting.

(b) The public counsel or the public counsel's designee shall develop a system of annual performance evaluations. All merit pay for office employees must be based on the system established under this subsection. (V.T.I.C. Art. 1.35A, Secs. 3(g), (h).)

Sec. 501.104. EQUAL EMPLOYMENT OPPORTUNITY POLICY; REPORT. (a) The public counsel or the public counsel's designee shall prepare and maintain a written policy statement to ensure implementation of an equal employment opportunity program under which all personnel transactions are made without regard to race, color, disability, sex, religion, age, or national origin. The policy statement must include:

(1) personnel policies, including policies relating to recruitment, evaluation, selection, appointment, training, and promotion of personnel that are in compliance with the requirements of Chapter 21, Labor Code;

(2) a comprehensive analysis of the office workforce that meets federal and state guidelines;

(3) procedures by which a determination can be made about areas of significant underuse in the office workforce of all persons for whom federal or state guidelines encourage a more equitable balance; and

(4) reasonable methods to appropriately address those areas of significant underuse.

(b) A policy statement prepared under Subsection (a) must:

(1) cover an annual period;

(2) be updated at least annually;

(3) be reviewed by the Commission on Human Rights for compliance with Subsection (a)(1); and

(4) be filed with the governor.

(c) The governor shall deliver a biennial report to the legislature based on the information received under Subsection (b). The report may be made separately or as a part of other biennial reports to the legislature. (V.T.I.C. Art. 1.35A, Secs. 3(d), (e), (f).)

Sec. 501.105. QUALIFICATIONS AND STANDARDS OF CONDUCT. The office shall provide to the public counsel and office employees, as often as necessary, information regarding their:

(1) qualifications for office or employment under this chapter; and

(2) responsibilities under applicable laws relating to standards of conduct for state officers or employees. (V.T.I.C. Art. 1.35A, Sec. 3(i).)

[Sections 501.106-501.150 reserved for expansion]

SUBCHAPTER D. POWERS AND DUTIES

Sec. 501.151. POWERS AND DUTIES OF OFFICE. The office:

(1) may assess the impact of insurance rates, rules, and forms on insurance consumers in this state; and

(2) shall advocate in the office's own name positions determined by the public counsel to be most advantageous to a substantial number of insurance consumers. (V.T.I.C. Art. 1.35A,

Sec. 5(a).)

Sec. 501.152. ADMINISTRATION OF OFFICE. The public counsel shall administer and enforce this chapter, including preparing and submitting to the legislature a budget for the office and approving expenditures for professional services, travel, per diem, and other actual and necessary expenses incurred in administering the office. (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

Sec. 501.153. AUTHORITY TO APPEAR, INTERVENE, OR INITIATE. The public counsel:

(1) may appear or intervene, as a party or otherwise, as a matter of right before the commissioner or department on behalf of insurance consumers, as a class, in matters involving:

(A) rates, rules, and forms affecting:

(i) property and casualty insurance;

(ii) title insurance;

(iii) credit life insurance;

(iv) credit accident and health insurance; or

(v) any other line of insurance for which the commissioner or department promulgates, sets, adopts, or approves rates, rules, or forms;

(B) rules affecting life, health, or accident insurance; or

(C) withdrawal of approval of policy forms:

(i) in proceedings initiated by the department under Sections 1701.055 and 1701.057; or

(ii) if the public counsel presents

persuasive evidence to the department that the forms do not comply with this code, a rule adopted under this code, or any other law;

(2) may initiate or intervene as a matter of right or otherwise appear in a judicial proceeding involving or arising from an action taken by an administrative agency in a proceeding in which the public counsel previously appeared under the authority granted by this chapter;

(3) may appear or intervene, as a party or otherwise, as a matter of right on behalf of insurance consumers as a class in any proceeding in which the public counsel determines that insurance consumers are in need of representation, except that the public counsel may not intervene in an enforcement or parens patriae proceeding brought by the attorney general; and

(4) may appear or intervene before the commissioner or department as a party or otherwise on behalf of small commercial insurance consumers, as a class, in a matter involving rates, rules, or forms affecting commercial insurance consumers, as a class, in any proceeding in which the public counsel determines that small commercial consumers are in need of representation. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

Sec. 501.154. ACCESS TO INFORMATION. The public counsel:

(1) is entitled to the same access as a party, other than department staff, to department records available in a proceeding before the commissioner or department under the authority granted to the public counsel by this chapter; and

(2) is entitled to obtain discovery under Chapter 2001, Government Code, of any nonprivileged matter that is relevant

to the subject matter involved in a proceeding or submission before the commissioner or department as authorized by this chapter. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

Sec. 501.155. RECOMMENDATION OF LEGISLATION. The public counsel may recommend legislation to the legislature that the public counsel determines would positively affect the interests of insurance consumers. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

Sec. 501.156. CONSUMER BILL OF RIGHTS. The public counsel shall submit to the department for adoption a consumer bill of rights appropriate to each personal line of insurance regulated by the department to be distributed on issuance of a policy by an insurer to each policyholder under department rules. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

Sec. 501.157. PROHIBITED INTERVENTIONS OR APPEARANCES. The public counsel may not intervene or appear in:

(1) any proceeding or hearing before the commissioner or department, or any other proceeding, that relates to approval or consideration of an individual charter, license, certificate of authority, acquisition, merger, or examination; or

(2) any proceeding concerning the solvency of an individual insurer, a financial issue, a policy form, advertising, or another regulatory issue affecting an individual insurer or agent. (V.T.I.C. Art. 1.35A, Sec. 5(c) (part).)

Sec. 501.158. CONFIDENTIALITY REQUIREMENTS. Confidentiality requirements applicable to examination reports under Article 1.18 and to the commissioner under Section 3A, Article 21.28-A, apply to the public counsel. (V.T.I.C. Art.

1.35A, Sec. 5(c) (part).)

[Sections 501.159-501.200 reserved for expansion]

SUBCHAPTER E. ASSESSMENTS

Sec. 501.201. OFFICE EXPENSES. Expenses of the office shall be paid from the assessments collected under this subchapter. (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

Sec. 501.202. ASSESSMENT. To defray the costs of operating the office, the comptroller shall collect assessments under this subchapter annually in connection with the collection of other taxes imposed on an insurer. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

Sec. 501.203. ASSESSMENT ON PROPERTY AND CASUALTY INSURERS. Each property and casualty insurer authorized to engage in business in this state shall pay an annual assessment of 5.7 cents for each property and casualty insurance policy in force in this state at the end of the year. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

Sec. 501.204. ASSESSMENT ON LIFE, HEALTH, AND ACCIDENT INSURERS AND RELATED ENTITIES. (a) This section applies to each insurer authorized to engage in business in this state under:

(1) Chapter 25;

(2) Chapter 841;

(3) Chapter 842;

(4) Chapter 843;

(5) Chapter 882;

(6) Chapter 884;

(7) Chapter 885;

(8) Chapter 887;

(9) Chapter 888;

(10) Chapter 961;

(11) Chapter 982;

(12) Subchapter B, Chapter 1103;

(13) Subchapter A, Chapter 1104;

(14) Chapter 1201, or a provision listed in Section 1201.005;

(15) Chapter 1551;

(16) Chapter 1578; or

(17) Chapter 1601.

(b) Each insurer subject to this section shall pay an annual assessment of 5.7 cents for each individual policy, and for each certificate of insurance evidencing coverage under a group policy, of life, health, or accident insurance that is written for delivery and placed in force in this state during each calendar year and for which the initial premium is paid in full. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

Sec. 501.205. ASSESSMENT ON TITLE INSURANCE COMPANIES. Each title insurance company authorized to engage in business in this state shall pay an annual assessment of 5.7 cents for each owner and mortgage policy that is written for delivery in this state during each calendar year and for which the full basic premium is charged. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

[Sections 501.206-501.250 reserved for expansion]

SUBCHAPTER F. DUTIES RELATING TO HEALTH MAINTENANCE ORGANIZATIONS

Sec. 501.251. COMPARISON OF HEALTH MAINTENANCE

ORGANIZATIONS. (a) The office shall develop and implement a system to compare and evaluate, on an objective basis, the quality of care provided by and the performance of health maintenance organizations established under Chapter 843.

(b) In developing the system, the office may use information or data from a person, agency, organization, or governmental unit that the office considers reliable. (V.T.I.C. Art. 1.35A, Sec. 5(e) (part).)

Sec. 501.252. ANNUAL CONSUMER REPORT CARDS. (a) The office shall develop and issue annual consumer report cards that identify and compare, on an objective basis, health maintenance organizations in this state. The consumer report cards may be based on information or data from any person, agency, organization, or governmental unit that the office considers reliable.

(b) The office may not endorse or recommend a specific health maintenance organization or plan, or subjectively rate or rank health maintenance organizations or plans, other than through comparison and evaluation of objective criteria.

(c) The office shall provide a copy of any consumer report card on request on payment of a reasonable fee. (V.T.I.C. Art. 1.35A, Secs. 5(e)(2), (10), (11).)

Sec. 501.253. ACCESS TO INFORMATION. (a) The office is entitled to information that is confidential under a law of this state, including Section 843.006 of this code, Chapter 108, Health and Safety Code, and Chapter 552, Government Code.

(b) The department and the Texas Health Care Information Council shall provide any information or data as requested by the

office in furtherance of the duties under this subchapter.

(c) The office shall use information collected or received under this subchapter for the benefit of the public. (V.T.I.C. Art. 1.35A, Secs. 5(e)(3), (4) (part), (5).)

Sec. 501.254. CONFIDENTIALITY AND USE OF INFORMATION. (a) Except as provided by this section, information collected under this subchapter is subject to Chapter 552, Government Code, and the office shall make determinations on requests for information in favor of access.

(b) The office may not make public any confidential information provided to the office under this subchapter but may disclose a summary of the information that does not directly or indirectly identify the health maintenance organization that is the subject of the information. The office may not release, and a person or entity may not gain access to, any information that:

(1) could reasonably be expected to reveal the identity of a patient or physician;

(2) reveals the zip code of a patient's primary residence;

(3) discloses a provider discount or a differential between a payment and a billed charge; or

(4) relates to an actual payment made by a payer to an identified provider.

(c) Information collected or used by the office under this subchapter is subject to the confidentiality provisions and criminal penalties of:

(1) Section 81.103, Health and Safety Code;

(2) Section 311.037, Health and Safety Code; and

(3) Chapter 159, Occupations Code.

(d) Information on patients and physicians that is in the possession of the office and any compilation, report, or analysis produced from the information that identifies patients and physicians is not:

(1) subject to discovery, subpoena, or other means of legal compulsion for release to any person or entity; or

(2) admissible in any civil, administrative, or criminal proceeding.

(e) Notwithstanding Subsection (b)(2), the office may use zip code information to analyze information on a geographical basis. (V.T.I.C. Art. 1.35A, Secs. 5(e)(4) (part), (6), (7), (8), (9).)

[Chapters 502-520 reserved for expansion]

SUBTITLE B. CONSUMER SERVICE PROVISIONS

CHAPTER 521. CONSUMER INFORMATION AND COMPLAINTS

SUBCHAPTER A. PUBLIC INTEREST INFORMATION AND COMPLAINT PROCEDURES

Sec. 521.001. PUBLIC INTEREST INFORMATION

Sec. 521.002. COMPLAINT RESOLUTION PROGRAM

Sec. 521.003. NOTIFICATION OF COMPLAINT STATUS

Sec. 521.004. RECORDS OF COMPLAINTS

Sec. 521.005. NOTICE TO ACCOMPANY POLICY

[Sections 521.006-521.050 reserved for expansion]

SUBCHAPTER B. DEPARTMENT TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS

CHAPTER 521. CONSUMER INFORMATION AND COMPLAINTS

SUBCHAPTER A. PUBLIC INTEREST INFORMATION AND COMPLAINT PROCEDURES

Sec. 521.001. PUBLIC INTEREST INFORMATION. (a) The department shall prepare information of public interest describing the department's functions and the procedures by which complaints are filed with and resolved by the department.

(b) The department shall make the information available to the public and appropriate state agencies. (V.T.I.C. Art. 1.37.)

Sec. 521.002. COMPLAINT RESOLUTION PROGRAM. The department shall establish a program to facilitate resolution of policyholder

complaints. (V.T.I.C. Art. 1.04B.)

Sec. 521.003. NOTIFICATION OF COMPLAINT STATUS. If a written complaint is filed with the department, the department, at least quarterly and until final disposition of the complaint, shall notify each party to the complaint of the complaint's status unless the notice would jeopardize an undercover investigation. (V.T.I.C. Art. 1.10, Sec. 19.)

Sec. 521.004. RECORDS OF COMPLAINTS. The department shall keep an information file about each complaint filed with the department that concerns an activity regulated by the department or the commissioner. (V.T.I.C. Art. 1.10, Sec. 18.)

Sec. 521.005. NOTICE TO ACCOMPANY POLICY. (a) Each insurance policy delivered or issued for delivery in this state shall include with the policy a brief written notice that includes:

(1) a suggested procedure to be followed by a policyholder with a dispute concerning the policyholder's claim or premium;

(2) the department's name and address; and

(3) the department's toll-free telephone number maintained under Subchapter B.

(b) The commissioner shall adopt appropriate wording for the notice. (V.T.I.C. Art. 1.35.)

[Sections 521.006-521.050 reserved for expansion]

SUBCHAPTER B. DEPARTMENT TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS

Sec. 521.051. DEPARTMENT TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS. The department shall maintain a toll-free

telephone number to:

(1) provide the information described by Section 521.052; and

(2) receive and aid in resolving complaints against insurers. (V.T.I.C. Art. 1.35D, Sec. (a).)

Sec. 521.052. INFORMATION PROVIDED. The department shall provide to the public through the department's toll-free telephone number only the following information:

(1) information collected or maintained by the department relating to the number and disposition of complaints received against an insurer that are justified, verified as accurate, and documented as valid, expressed as a percentage of the total number of insurance policies written by the insurer and in force on December 31 of the preceding year;

(2) the rating of an insurer, if any, as published by a nationally recognized rating organization;

(3) the kinds of coverage available to a consumer through any insurer writing insurance in this state;

(4) an insurer's admitted assets-to-liabilities ratio; and

(5) other appropriate information collected and maintained by the department. (V.T.I.C. Art. 1.35D, Sec. (b).)

Sec. 521.053. PUBLICITY REQUIREMENTS. The department shall publicize the department's toll-free telephone number in public service announcements and publish that number in telephone books throughout the state, as the department finds appropriate. (V.T.I.C. Art. 1.35D, Sec. (e).)

Sec. 521.054. RECORD OF INQUIRY OR COMPLAINT REQUIRED. The department shall maintain a written record of each inquiry and complaint received through the department's toll-free telephone number. (V.T.I.C. Art. 1.35D, Sec. (c).)

Sec. 521.055. COMPLAINT NOTIFICATION SYSTEM. The department shall establish a system to notify insurers by electronic transmission to a facsimile machine or other appropriate system of complaints received by the department through the department's toll-free telephone number. (V.T.I.C. Art. 1.35D, Sec. (d).)

Sec. 521.056. INFORMATION BULLETIN TO ACCOMPANY POLICY. Each insurer that delivers, issues for delivery, or renews an insurance policy in this state shall include with the policy an information bulletin that includes:

(1) the department's toll-free telephone number; and

(2) a description of the services available through the department's toll-free telephone number. (V.T.I.C. Art. 1.35D, Sec. (f).)

[Sections 521.057-521.100 reserved for expansion]

SUBCHAPTER C. HEALTH MAINTENANCE ORGANIZATION OR INSURER TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS

Sec. 521.101. APPLICABILITY OF SUBCHAPTER. (a) Except as provided by Subsection (b), this subchapter applies to a health maintenance organization authorized to engage in the business of a health maintenance organization in this state or an insurer authorized to engage in the business of insurance in this state, including:

(1) a capital stock insurance company;

(2) a mutual insurance company;

(3) a title insurance company;

(4) a fraternal benefit society;

(5) a local mutual aid association;

(6) a statewide mutual assessment company;

(7) a county mutual insurance company;

(8) a Lloyd's plan;

(9) a reciprocal or interinsurance exchange;

(10) a stipulated premium company;

(11) a group hospital service corporation; and

(12) a risk retention group.

(b) This subchapter does not apply to a health maintenance organization or insurer:

(1) that has gross initial premium receipts collected in this state of less than $2 million each year; or

(2) with regard to fidelity, surety, or guaranty bonds. (V.T.I.C. Art. 21.71, Secs. (a), (b).)

Sec. 521.102. HEALTH MAINTENANCE ORGANIZATION OR INSURER TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS. A health maintenance organization or insurer shall maintain a toll-free telephone number to:

(1) provide information concerning evidences of coverage or policies issued by the health maintenance organization or insurer; and

(2) receive complaints from enrollees or policyholders. (V.T.I.C. Art. 21.71, Sec. (c).)

Sec. 521.103. INFORMATION INCLUDED IN EVIDENCE OF COVERAGE OR POLICY. (a) Each health maintenance organization or insurer that delivers, issues for delivery, or renews an evidence of coverage or insurance policy in this state shall print on the evidence of coverage or policy the health maintenance organization's or insurer's toll-free telephone number.

(b) The commissioner may adopt rules governing the manner in which the toll-free telephone number appears on the evidence of coverage or insurance policy. (V.T.I.C. Art. 21.71, Sec. (d).)

CHAPTER 522. CONSUMER INFORMATION IN SPANISH

Sec. 522.001. INFORMATIONAL SHEET FOR TEXAS PERSONAL AUTOMOBILE POLICIES

CHAPTER 522. CONSUMER INFORMATION IN SPANISH

Sec. 522.001. INFORMATIONAL SHEET FOR TEXAS PERSONAL AUTOMOBILE POLICIES. (a) The commissioner shall develop or adopt an informational sheet in the Spanish language to provide a general explanation of the terms most commonly used in the Texas personal automobile insurance policy. The department shall make the informational sheet available to the public.

(b) The informational sheet is intended to provide only a general explanation of insurance terms used in the Texas personal automobile insurance policy and is not intended to alter any rights, obligations, or responsibilities of the contracting parties. All other applicable laws, including provisions of this code, apply regardless of whether an informational sheet is used.

(c) The informational sheet must include a disclaimer in the Spanish language, prominently printed in 10-point boldfaced type at

the top of the informational sheet, that contains the following:

"This document is for informational purposes only and is not intended to alter or replace the insurance policy. Additionally, this informational sheet is not intended to fully set out your rights and obligations or the rights and obligations of the insurer. If you have questions about your insurance, you should consult your insurance agent, the insurer, or the language of the insurance policy." (V.T.I.C. Art. 1.35E.)

CHAPTER 523. MARKET ASSISTANCE PROGRAM FOR RESIDENTIAL PROPERTY INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 523.001. DEFINITION

Sec. 523.002. RULES

Sec. 523.003. IMMUNITY

[Sections 523.004-523.050 reserved for expansion]

SUBCHAPTER B. OPERATION OF MARKET ASSISTANCE PROGRAM

Sec. 523.051. MARKET ASSISTANCE PROGRAM

Sec. 523.052. MARKET ASSISTANCE PROGRAM DIVISION

Sec. 523.053. EXECUTIVE COMMITTEE

Sec. 523.054. PLAN OF OPERATION

Sec. 522.055. AMENDMENT OF PLAN OF OPERATION

[Sections 523.056-523.100 reserved for expansion]

SUBCHAPTER C. PARTICIPATION IN MARKET ASSISTANCE PROGRAM

Sec. 523.101. PARTICIPATION BY INSURERS

CHAPTER 523. MARKET ASSISTANCE PROGRAM FOR RESIDENTIAL PROPERTY INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 523.001. DEFINITION. In this chapter, "residential property insurance" means insurance provided by a homeowners policy or residential fire and allied lines policy against loss incurred at a fixed location to real or tangible personal property. The term does not include insurance against loss provided by a farm and ranch owners policy. (V.T.I.C. Art. 21.49-12, Sec. 1(a) (part).)

Sec. 523.002. RULES. In addition to the plan of operation adopted under Subchapter B, the commissioner may adopt appropriate rules to accomplish the purposes of this chapter. (V.T.I.C. Art.

21.49-12, Sec. 8.)

Sec. 523.003. IMMUNITY. The market assistance program, the members of the executive committee, and participating insurers and agents are not personally liable for:

(1) an act performed in good faith in the scope of the person's authority as determined under this chapter; or

(2) damages arising from the person's official acts or omissions, other than a corrupt or malicious act or omission. (V.T.I.C. Art. 21.49-12, Sec. 7.)

[Sections 523.004-523.050 reserved for expansion]

SUBCHAPTER B. OPERATION OF MARKET ASSISTANCE PROGRAM

Sec. 523.051. MARKET ASSISTANCE PROGRAM. (a) The market assistance program is a voluntary program designed to assist applicants for insurance and insureds in this state in obtaining residential property insurance coverage in underserved areas. The commissioner by rule shall designate underserved areas using the standards described by Section 1, Article 5.35-3.

(b) The commissioner shall establish the types of risks for which the market assistance program will provide assistance.

(c) The market assistance program may not provide assistance regarding windstorm and hail insurance coverage for a risk eligible for that coverage under Article 21.49. (V.T.I.C. Art. 21.49-12, Secs. 1(a) (part), (b).)

Sec. 523.052. MARKET ASSISTANCE PROGRAM DIVISION. The department shall operate a market assistance program division. (V.T.I.C. Art. 21.49-12, Sec. 1(a) (part).)

Sec. 523.053. EXECUTIVE COMMITTEE. (a) The market

assistance program is administered by an executive committee.

(b) The executive committee consists 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) Each member of the executive committee who represents the interests of insurers must be a full-time employee of an authorized insurer.

(d) The commissioner or the commissioner's designated representative serves as an ex officio member of the executive committee and must be present at each executive committee meeting.

(e) The executive committee shall be available to advise and consult with the commissioner regarding the administration of the market assistance program. (V.T.I.C. Art. 21.49-12, Secs. 2(a) (part), 3.)

Sec. 523.054. PLAN OF OPERATION. (a) The operation and management of the market assistance program is governed by a plan of operation adopted by rule by the commissioner.

(b) In addition to the other requirements specified by this chapter, the plan of operation must include provisions regarding types of coverage, policy forms and terms, application forms, eligibility, and the overall operation of the market assistance program.

(c) The plan of operation may provide for subcommittees

necessary to administer the market assistance program. (V.T.I.C. Art. 21.49-12, Secs. 2(a) (part), (b) (part), (c).)

Sec. 523.055. AMENDMENT OF PLAN OF OPERATION. (a) The executive committee may develop amendments to the plan of operation and submit the amendments to the commissioner for adoption by rule.

(b) If the executive committee fails to submit suitable amendments to the plan of operation, the department shall develop and submit to the commissioner suitable amendments and the commissioner shall, after notice and hearing, adopt the amendments by rule. (V.T.I.C. Art. 21.49-12, Sec. 2(a) (part).)

[Sections 523.056-523.100 reserved for expansion]

SUBCHAPTER C. PARTICIPATION IN MARKET ASSISTANCE PROGRAM

Sec. 523.101. PARTICIPATION BY INSURERS. (a) An insurer authorized to engage in the business of property or casualty insurance that writes residential property insurance in this state, including a Lloyd's plan or a reciprocal or interinsurance exchange, may voluntarily participate in the market assistance program. The commissioner may not permit an insurer to condition its participation in the program in a manner that is inequitable to the participants.

(b) Notwithstanding Subsection (a), the commissioner may make insurer participation in the market assistance program mandatory. The plan of operation must contain the criteria under which the commissioner may make insurer participation in the market assistance program mandatory.

(c) Each participating insurer is entitled to individually evaluate a risk and apply rates under the market assistance program

in accordance with the provisions of this code applicable to the insurer. (V.T.I.C. Art. 21.49-12, Secs. 2(a) (part), (b) (part).)

Sec. 523.102. APPLICATION ASSISTANCE AND REFERRALS. The department may:

(1) assist an applicant for coverage through the market assistance program in completing an initial application; and

(2) refer the applicant to one or more participating insurers. (V.T.I.C. Art. 21.49-12, Sec. 4(a).)

Sec. 523.103. APPLICATION FOR ASSISTANCE. (a) An application for assistance must be addressed to the market assistance program at the department.

(b) An application must be accompanied by a copy of a current notice of nonrenewal or cancellation of coverage and a current declination letter from at least one other insurer that writes the coverage sought, except that an applicant who does not have previous residential property insurance coverage must provide copies of current declination letters from at least two unaffiliated insurers that write the coverage sought. (V.T.I.C. Art. 21.49-12, Sec. 2(b) (part).)

Sec. 523.104. INSURER ACTION ON APPLICATION. (a) Not later than the 30th day after the date an insurer receives an application, the insurer shall:

(1) quote a premium;

(2) indicate its refusal to quote a premium; or

(3) request additional time to consider a premium quote.

(b) If the insurer quotes a premium, the insurer shall

notify the applicant or the applicant's agent, if an agent is used, so that the placement of the insurance may be completed if the applicant accepts the coverage at the quoted premium.

(c) The insurer may provide a premium quote on the same coverage basis for which the insurer normally provides insurance in this state using the insurer's underwriting guidelines and applying rates determined in accordance with the provisions of this code applicable to the insurer. (V.T.I.C. Art. 21.49-12, Sec. 2(b) (part).)

Sec. 523.105. NONPAYMENT OF PREMIUM OR SUBMISSION OF FRAUDULENT CLAIM. If an insurer cancels or does not renew coverage for nonpayment of premium or submission of a fraudulent claim, an applicant is ineligible to subsequently apply to the market assistance program for the same coverage for the same risk. (V.T.I.C. Art. 21.49-12, Sec. 2(b) (part).)

[Sections 523.106-523.150 reserved for expansion]

SUBCHAPTER D. PROGRAM AGENTS

Sec. 523.151. TYPES OF AGENTS. (a) Notwithstanding other law, the market assistance program may have both originating agents and issuing agents.

(b) An originating agent may complete on behalf of an applicant an application for insurance to submit to the market assistance program. An applicant is not required to submit the application through an originating agent. If an originating agent is used, the originating agent is not required to be appointed to represent the ultimate insurer.

(c) An issuing agent must be appointed to represent the

ultimate insurer. The issuing agent shall perform the customary duties of a general property and casualty agent, including:

(1) signing, executing, and delivering insurance policies;

(2) maintaining a record of the business;

(3) examining and inspecting the risk; and

(4) receiving and collecting premiums.

(d) A person may act as both the originating agent and the issuing agent. If the originating agent and the issuing agent are not the same person, the originating agent may not be held to be the agent of the insurer unless the agent is appointed as provided by Chapter 4051. (V.T.I.C. Art. 21.49-12, Secs. 4(b), (c), (d), (f).)

Sec. 523.152. SHARING OF AGENT COMMISSIONS. (a) An originating agent shall share commissions with an issuing agent as required by the market assistance program plan of operation if the originating agent holds a license as:

(1) a general property and casualty agent; or

(2) a salaried representative for one or more insurers whose plan of operation does not contemplate the use of general property and casualty agents.

(b) The market assistance program may not share in commissions. (V.T.I.C. Art. 21.49-12, Secs. 4(e), (g).)

[Sections 523.153-523.200 reserved for expansion]

SUBCHAPTER E. MARKET ASSISTANCE PROGRAM REVIEW; PROGRAM TERMINATION

Sec. 523.201. COLLECTION OF PROGRAM INFORMATION. Information concerning the number and type of applications received

and placed by the market assistance program and other information about the program the executive committee or the commissioner considers appropriate shall be collected. (V.T.I.C. Art. 21.49-12, Sec. 6(a).)

Sec. 523.202. PERIODIC REVIEW OF PROGRAM. (a) The executive committee shall review the demand for and performance of the market assistance program at least annually, as necessary.

(b) After each review, the executive committee shall report to the commissioner regarding:

(1) the need to continue operating the voluntary market assistance program;

(2) the need to establish a mandatory market assistance program;

(3) the need to establish a FAIR (Fair Access to Insurance Requirements) Plan under Article 21.49A; or

(4) other recommendations the executive committee considers appropriate. (V.T.I.C. Art. 21.49-12, Sec. 6(b) (part).)

Sec. 523.203. TERMINATION OF PROGRAM. The department may terminate the market assistance program only on the commissioner's approval. (V.T.I.C. Art. 21.49-12, Sec. 6(b) (part).)

[Chapters 524-540 reserved for expansion]

SUBTITLE C. DECEPTIVE, UNFAIR, AND PROHIBITED PRACTICES

CHAPTER 541. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES

SUBCHAPTER A. GENERAL PROVISIONS

CHAPTER 541. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 541.001. PURPOSE. The purpose of this chapter is to regulate trade practices in the business of insurance by:

(1) defining or providing for the determination of trade practices in this state that are unfair methods of competition or unfair or deceptive acts or practices; and

(2) prohibiting those trade practices. (V.T.I.C. Art. 21.21, Sec. 1(a).)

Sec. 541.002. DEFINITIONS. In this chapter:

(1) "Knowingly" means actual awareness of the falsity, unfairness, or deceptiveness of the act or practice on which a claim for damages under Subchapter D is based. Actual awareness may be inferred if objective manifestations indicate that a person acted with actual awareness.

(2) "Person" means an individual, corporation,

association, partnership, reciprocal or interinsurance exchange, Lloyd's plan, fraternal benefit society, or other legal entity engaged in the business of insurance, including an agent, broker, adjuster, or life and health insurance counselor. (V.T.I.C. Art. 21.21, Secs. 2(a), (c).)

Sec. 541.003. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES PROHIBITED. A person may not engage in this state in a trade practice that is defined in this chapter as or determined under this chapter to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance. (V.T.I.C. Art. 21.21, Sec. 3.)

Sec. 541.004. VENUE FOR ACTIONS INVOLVING DEPARTMENT OR COMMISSIONER. An action under this chapter in which the department or commissioner is a party must be brought in a district court in Travis County. (V.T.I.C. Art. 21.21, Sec. 21.)

Sec. 541.005. APPLICABILITY TO RISK RETENTION OR PURCHASING GROUP. (a) A risk retention group or purchasing group, as those terms are defined by Section 2, Article 21.54, not chartered in this state may not engage in a trade practice in this state that is defined as unlawful under this chapter.

(b) A risk retention group or purchasing group is subject to this chapter and rules adopted under this chapter. (V.T.I.C. Art. 21.21B.)

Sec. 541.006. PROHIBITED CONTENT OF CERTAIN INSURANCE POLICIES. Notwithstanding any other provision of this code, it is unlawful for an insurer engaged in the business of life, accident, or health insurance to issue or deliver in this state a policy

containing the words "Approved by the Texas Department of Insurance" or words of a similar meaning. (V.T.I.C. Art. 21.21, Sec. 9(a).)

Sec. 541.007. IMMUNITY FROM PROSECUTION. (a) This section applies to a person who requests to be excused from attending and testifying at a hearing or from producing books, papers, records, correspondence, or other documents at the hearing on the ground that the testimony or evidence may:

(1) tend to incriminate the person; or

(2) subject the person to a penalty or forfeiture.

(b) A person who, notwithstanding a request described by Subsection (a), is directed to provide the testimony or produce the documents shall comply with that direction. Except as provided by Subsection (c), the person may not be prosecuted or subjected to a penalty or forfeiture for or on account of a transaction, matter, or thing about which the person testifies or produces documents, and the testimony or documents produced may not be received against the person in a criminal action, investigation, or proceeding.

(c) A person who complies with a direction to testify or produce documents is not exempt from prosecution or punishment for perjury committed while testifying and the testimony or evidence given or produced is admissible against the person in a criminal action, investigation, or proceeding concerning the perjury, and the person is not exempt from the denial, revocation, or suspension of any license, permission, or authority conferred or to be conferred under this code.

(d) A person may waive the immunity or privilege granted by

this section by executing, acknowledging, and filing with the department a statement expressly waiving the immunity or privilege for a specified transaction, matter, or thing. On filing the statement:

(1) the testimony or documents produced by the person in relation to the transaction, matter, or thing may be received by or produced before a judge or justice or a court, grand jury, or other tribunal; and

(2) the person is not entitled to immunity or privilege for the testimony or documents received or produced under Subdivision (1). (V.T.I.C. Art. 21.21, Sec. 12.)

Sec. 541.008. LIBERAL CONSTRUCTION. This chapter shall be liberally construed and applied to promote the underlying purposes as provided by Section 541.001. (V.T.I.C. Art. 21.21, Sec. 1(b).)

[Sections 541.009-541.050 reserved for expansion]

SUBCHAPTER B. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES DEFINED

Sec. 541.051. MISREPRESENTATION REGARDING POLICY OR INSURER. It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to:

(1) make, issue, or circulate or cause to be made, issued, or circulated an estimate, illustration, circular, or statement misrepresenting with respect to a policy issued or to be issued:

(A) the terms of the policy;

(B) the benefits or advantages promised by the policy; or

(C) the dividends or share of surplus to be received on the policy;

(2) make a false or misleading statement regarding the dividends or share of surplus previously paid on a similar policy;

(3) make a misleading representation or misrepresentation regarding:

(A) the financial condition of an insurer; or

(B) the legal reserve system on which a life insurer operates;

(4) use a name or title of a policy or class of policies that misrepresents the true nature of the policy or class of policies; or

(5) make a misrepresentation to a policyholder insured by any insurer for the purpose of inducing or that tends to induce the policyholder to allow an existing policy to lapse or to forfeit or surrender the policy. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Sec. 541.052. FALSE INFORMATION AND ADVERTISING. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to 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 an advertisement, announcement, or statement containing an untrue, deceptive, or misleading assertion, representation, or statement regarding the business of insurance or a person in the conduct of the person's insurance business.

(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. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Sec. 541.053. DEFAMATION OF INSURER. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to directly or indirectly make, publish, disseminate, or circulate or to aid, abet, or encourage the making, publication, dissemination, or circulation of a statement that:

(1) is false, maliciously critical of, or derogatory to the financial condition of an insurer; and

(2) is calculated to injure a person engaged in the business of insurance.

(b) This section applies to any oral or written statement, including a statement in any pamphlet, circular, article, or literature. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Sec. 541.054. BOYCOTT, COERCION, OR INTIMIDATION. It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to commit through concerted action or to enter into an agreement to commit an act of boycott, coercion, or intimidation that results in or tends to result in the unreasonable restraint of or a monopoly in the business of insurance. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Sec. 541.055. FALSE FINANCIAL STATEMENT. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to, with intent to deceive:

(1) file with a supervisory or other public official a false statement of financial condition of an insurer; or

(2) make, publish, disseminate, circulate, deliver to any person, or place before the public or directly or indirectly cause to be made, published, disseminated, circulated, delivered to any person, or placed before the public a false statement of financial condition of an insurer.

(b) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to make a false entry in an insurer's book, report, or statement or wilfully omit to make a true entry of a material fact relating to the insurer's business in the insurer's book, report, or statement with intent to deceive:

(1) an agent or examiner lawfully appointed to examine the insurer's condition or affairs; or

(2) a public official to whom the insurer is required by law to report or who has authority by law to examine the insurer's condition or affairs. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Sec. 541.056. PROHIBITED REBATES AND INDUCEMENTS. (a) Subject to Section 541.058 and except as otherwise expressly provided by law, it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to knowingly permit the making of, offer to make, or make a life

insurance contract, life annuity contract, or accident and health insurance contract or an agreement regarding the contract, other than as plainly expressed in the issued contract, or directly or indirectly pay, give, or allow or offer to pay, give, or allow as inducement to enter into a life insurance contract, life annuity contract, or accident and health insurance contract a rebate of premiums payable on the contract, a special favor or advantage in the dividends or other benefits of the contract, or a valuable consideration or inducement not specified in the contract, or give, sell, or purchase or offer to give, sell, or purchase in connection with a life insurance, life annuity, or accident and health insurance contract or as inducement to enter into the contract stocks, bonds, or other securities of an insurer or other corporation, association, or partnership, dividends or profits accrued from the stocks, bonds, or securities, or anything of value not specified in the contract.

(b) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to issue or deliver or to permit an agent, officer, or employee to issue or deliver as an inducement to insurance:

(1) company stock or other capital stock;

(2) a benefit certificate or share in a corporation;

(3) securities; or

(4) a special or advisory board contract or any other contract promising returns or profits.

(c) Subsection (b) does not prohibit issuing or delivering a participating insurance policy otherwise authorized by law.

(V.T.I.C. Art. 21.21, Sec. 4 (part).)

Sec. 541.057. UNFAIR DISCRIMINATION IN LIFE INSURANCE AND ANNUITY CONTRACTS. Subject to Section 541.058, it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to make or permit with respect to a life insurance or life annuity contract an unfair discrimination between individuals of the same class and equal life expectancy regarding:

(1) the rates charged;

(2) the dividends or other benefits payable; or

(3) any of the other terms and conditions of the contract. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Sec. 541.058. CERTAIN PRACTICES NOT CONSIDERED DISCRIMINATION OR INDUCEMENT. It is not a rebate or discrimination prohibited by Section 541.056(a) or 541.057:

(1) for a life insurance or life annuity contract, to pay a bonus to a policyholder or otherwise abate the policyholder's premiums in whole or in part out of surplus accumulated from nonparticipating insurance policies if the bonus or abatement:

(A) is fair and equitable to policyholders; and

(B) is in the best interests of the insurer and its policyholders;

(2) for a life insurance policy issued on the industrial debit plan, to make to a policyholder who has continuously for a specified period made premium payments directly to the insurer's office an allowance in an amount that fairly represents the saving in collection expenses;

(3) for a group insurance policy, to readjust the rate

of premium based on the loss or expense experience under the policy at the end of a policy year if the adjustment is retroactive for only that policy year; or

(4) for a life annuity contract, to waive surrender charges under the contract when the contract holder exchanges that contract for another annuity contract issued by the same insurer if the waiver and the exchange are fully, fairly, and accurately explained to the contract holder in a manner that is not deceptive or misleading. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Sec. 541.059. DECEPTIVE NAME, WORD, SYMBOL, DEVICE, OR SLOGAN. (a) Except as provided by Subsection (b), it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media:

(1) a name as the corporate or business name of a person or entity engaged in the business of insurance or in an insurance-related business in this state that is the same as or deceptively similar to the name adopted and used by an insurance entity, health maintenance organization, third-party administrator, or group hospital service corporation authorized to engage in business under the laws of this state; or

(2) a word, symbol, device, or slogan, either alone or in combination and regardless of whether registered, and including the titles, designations, character names, and distinctive

features of broadcast or other advertising, that is the same as or deceptively similar to a word, symbol, device, or slogan adopted and used by an insurance entity, health maintenance organization, third-party administrator, or group hospital service corporation to distinguish the entity or the entity's products or services from another entity.

(b) If more than one person or entity uses names, words, symbols, devices, or slogans, either alone or in combination, that are the same or deceptively similar and are likely to cause confusion or mistake, the person or entity that demonstrates the first continuous actual use of the name, word, symbol, device, slogan, or combination has not engaged in an unfair method of competition or deceptive act or practice under this section. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Sec. 541.060. UNFAIR SETTLEMENT PRACTICES. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to engage in the following unfair settlement practices with respect to a claim by an insured or beneficiary:

(1) misrepresenting to a claimant a material fact or policy provision relating to coverage at issue;

(2) failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of:

(A) a claim with respect to which the insurer's liability has become reasonably clear; or

(B) a claim under one portion of a policy with respect to which the insurer's liability has become reasonably

clear to influence the claimant to settle another claim under another portion of the coverage unless payment under one portion of the coverage constitutes evidence of liability under another portion;

(3) failing to promptly provide to a policyholder a reasonable explanation of the basis in the policy, in relation to the facts or applicable law, for the insurer's denial of a claim or offer of a compromise settlement of a claim;

(4) failing within a reasonable time to:

(A) affirm or deny coverage of a claim to a policyholder; or

(B) submit a reservation of rights to a policyholder;

(5) refusing, failing, or unreasonably delaying a settlement offer under applicable first-party coverage on the basis that other coverage may be available or that third parties are responsible for the damages suffered, except as may be specifically provided in the policy;

(6) undertaking to enforce a full and final release of a claim from a policyholder when only a partial payment has been made, unless the payment is a compromise settlement of a doubtful or disputed claim;

(7) refusing to pay a claim without conducting a reasonable investigation with respect to the claim;

(8) with respect to a Texas personal automobile insurance policy, delaying or refusing settlement of a claim solely because there is other insurance of a different kind available to

satisfy all or part of the loss forming the basis of that claim; or

(9) requiring a claimant as a condition of settling a claim to produce the claimant's federal income tax returns for examination or investigation by the person unless:

(A) a court orders the claimant to produce those tax returns;

(B) the claim involves a fire loss; or

(C) the claim involves lost profits or income.

(b) Subsection (a) does not provide a cause of action to a third party asserting one or more claims against an insured covered under a liability insurance policy. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Sec. 541.061. MISREPRESENTATION OF INSURANCE POLICY. It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to misrepresent an insurance policy by:

(1) making an untrue statement of material fact;

(2) failing to state a material fact necessary to make other statements made not misleading, considering the circumstances under which the statements were made;

(3) making a statement in a manner that would mislead a reasonably prudent person to a false conclusion of a material fact;

(4) making a material misstatement of law; or

(5) failing to disclose a matter required by law to be disclosed, including failing to make a disclosure in accordance with another provision of this code. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

[Sections 541.062-541.100 reserved for expansion]

SUBCHAPTER C. DETERMINATION OF UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES; SANCTIONS AND PENALTIES

Sec. 541.101. EXAMINATION AND INVESTIGATION. The department may examine and investigate the affairs of a person engaged in the business of insurance in this state to determine whether the person has or is engaged in an unfair method of competition or unfair or deceptive act or practice prohibited by Section 541.003. (V.T.I.C. Art. 21.21, Sec. 5.)

Sec. 541.102. STATEMENT OF CHARGES; NOTICE OF HEARING. (a) When the department has reason to believe that a person engaged in the business of insurance in this state has engaged or is engaging in this state in an unfair method of competition or unfair or deceptive act or practice defined by Subchapter B and that a proceeding by the department regarding the charges is in the interest of the public, the department shall issue and serve on the person:

(1) a statement of the charges; and

(2) a notice of the hearing on the charges, including the time and place for the hearing.

(b) The department may not hold the hearing before the sixth day after the date the notice is served. (V.T.I.C. Art. 21.21, Sec. 6(a).)

Sec. 541.103. HEARING. A person against whom charges are made under Section 541.102 is entitled at the hearing on the charges to have an opportunity to be heard and show cause why the department

should not issue an order requiring the person to cease and desist from the unfair method of competition or unfair or deceptive act or practice described in the charges. (V.T.I.C. Art. 21.21, Sec. 6(b) (part).)

Sec. 541.104. HEARING PROCEDURES. (a) Nothing in this chapter requires the observance of formal rules of pleading or evidence at a hearing under this subchapter.

(b) At a hearing under this subchapter, the department, on a showing of good cause, shall permit any person to intervene, appear, and be heard by counsel or in person. (V.T.I.C. Art. 21.21, Secs. 6(b) (part), (c).)

Sec. 541.105. RECORD OF HEARING. (a) At a hearing under this subchapter, the department may, and at the request of a party to the hearing shall, make a stenographic record of the proceedings and the evidence presented at the hearing.

(b) If the department does not make a stenographic record and a person seeks judicial review of the decision made at the hearing, the department shall prepare a statement of the evidence and proceeding for use on review. (V.T.I.C. Art. 21.21, Sec. 6(d) (part).)

Sec. 541.106. COMPLIANCE WITH SUBPOENA. (a) If a person refuses to comply with a subpoena issued in connection with a hearing under this subchapter or refuses to testify with respect to a matter about which the person may be lawfully interrogated, on application of the department, a district court in Travis County or in the county in which the person resides may order the person to comply with the subpoena or testify.

(b) A court may punish as contempt a person's failure to obey an order under this section. (V.T.I.C. Art. 21.21, Sec. 6(d) (part).)

Sec. 541.107. DETERMINATION OF VIOLATION. After a hearing under this subchapter, the department shall determine whether:

(1) the method of competition or the act or practice considered in the hearing is defined as:

(A) an unfair method of competition or deceptive act or practice under Subchapter B or a rule adopted under this chapter; or

(B) a false, misleading, or deceptive act or practice under Section 17.46, Business & Commerce Code; and

(2) the person against whom the charges were made engaged in the method of competition or act or practice in violation of:

(A) this chapter or a rule adopted under this chapter; or

(B) Subchapter E, Chapter 17, Business & Commerce Code, as specified in Section 17.46, Business & Commerce Code. (V.T.I.C. Art. 21.21, Sec. 7(a) (part).)

Sec. 541.108. CEASE AND DESIST ORDER. On determining that a person committed a violation described by Section 541.107, the department shall:

(1) make written findings; and

(2) issue and serve on the person an order requiring the person to cease and desist from engaging in the method of competition or act or practice determined to be a violation.

(V.T.I.C. Art. 21.21, Sec. 7(a) (part).)

Sec. 541.109. MODIFICATION OR SETTING ASIDE OF ORDER. On the notice and in the manner the department determines proper, the department may modify or set aside in whole or in part a cease and desist order issued under Section 541.108 at any time before a petition appealing the order is filed in accordance with Subchapter D, Chapter 36. (V.T.I.C. Art. 21.21, Sec. 7(b).)

Sec. 541.110. ADMINISTRATIVE PENALTY. (a) A person who violates a cease and desist order issued under Section 541.108 is subject to an administrative penalty under Chapter 84.

(b) In determining whether a person has violated a cease and desist order, the department shall consider the maintenance of procedures reasonably adapted to ensure compliance with the order.

(c) An administrative penalty imposed under this section may not exceed:

(1) $1,000 for each violation; or

(2) $5,000 for all violations.

(d) An order of the department imposing an administrative penalty under this section applies only to a violation of the cease and desist order committed before the date the order imposing the penalty is issued. (V.T.I.C. Art. 21.21, Secs. 7(c), (d).)

Sec. 541.111. CIVIL PENALTY FOR VIOLATION OF CEASE AND DESIST ORDER. (a) A person who is found by a court to have violated a cease and desist order issued under Section 541.108 is liable to the state for a penalty. The state may recover the penalty in a civil action.

(b) The penalty may not exceed $50 unless the court finds

the violation to be wilful, in which case the penalty may not exceed $500. (V.T.I.C. Art. 21.21, Sec. 10.)

[Sections 541.112-541.150 reserved for expansion]

SUBCHAPTER D. PRIVATE ACTION FOR DAMAGES

Sec. 541.151. PRIVATE ACTION FOR DAMAGES AUTHORIZED. A person who sustains actual damages may bring an action against another person for those damages caused by the other person engaging in an act or practice:

(1) defined by Subchapter B to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance; or

(2) specifically enumerated in Section 17.46(b), Business & Commerce Code, as an unlawful deceptive trade practice if the person bringing the action shows that the person relied on the act or practice to the person's detriment. (V.T.I.C. Art. 21.21, Sec. 16(a).)

Sec. 541.152. DAMAGES, ATTORNEY'S FEES, AND OTHER RELIEF. (a) A plaintiff who prevails in an action under this subchapter may obtain:

(1) the amount of actual damages, plus court costs and reasonable and necessary attorney's fees;

(2) an order enjoining the act or failure to act complained of; or

(3) any other relief the court determines is proper.

(b) On a finding by the trier of fact that the defendant knowingly committed the act complained of, the trier of fact may award an amount not to exceed three times the amount of actual

damages. (V.T.I.C. Art. 21.21, Sec. 16(b).)

Sec. 541.153. FRIVOLOUS ACTION. A court shall award to the defendant court costs and reasonable and necessary attorney's fees if the court finds that an action under this subchapter is groundless and brought in bad faith or brought for the purpose of harassment. (V.T.I.C. Art. 21.21, Sec. 16(c).)

Sec. 541.154. PRIOR NOTICE OF ACTION. (a) A person seeking damages in an action against another person under this subchapter must provide written notice to the other person not later than the 61st day before the date the action is filed.

(b) The notice must advise the other person of:

(1) the specific complaint; and

(2) the amount of actual damages and expenses, including attorney's fees reasonably incurred in asserting the claim against the other person.

(c) The notice is not required if giving notice is impracticable because the action:

(1) must be filed to prevent the statute of limitations from expiring; or

(2) is asserted as a counterclaim. (V.T.I.C. Art. 21.21, Secs. 16(e), (f).)

Sec. 541.155. ABATEMENT. (a) A person against whom an action under this subchapter is pending who does not receive the notice as required by Section 541.154 may file a plea in abatement not later than the 30th day after the date the person files an original answer in the court in which the action is pending.

(b) The court shall abate the action if, after a hearing,

the court finds that the person is entitled to an abatement because the claimant did not provide the notice as required by Section 541.154.

(c) An action is automatically abated without a court order beginning on the 11th day after the date a plea in abatement is filed if the plea:

(1) is verified and alleges that the person against whom the action is pending did not receive the notice as required by Section 541.154; and

(2) is not controverted by an affidavit filed by the claimant before the 11th day after the date the plea in abatement is filed.

(d) An abatement under this section continues until the 60th day after the date notice is provided in compliance with Section 541.154.

(e) This section does not apply if Section 541.154(c) applies. (V.T.I.C. Art. 21.21, Secs. 16(g), (h), (i).)

Sec. 541.156. SETTLEMENT OFFER. (a) A person who receives notice provided under Section 541.154 may make a settlement offer during a period beginning on the date notice under Section 541.154 is received and ending on the 60th day after that date.

(b) In addition to the period described by Subsection (a), the person may make a settlement offer during a period:

(1) if mediation is not conducted under Section 541.161, beginning on the date an original answer is filed in the action and ending on the 90th day after that date; or

(2) if mediation is conducted under Section 541.161,

beginning on the day after the date the mediation ends and ending on the 20th day after that date. (V.T.I.C. Art. 21.21, Secs. 16A(a), (b), (c).)

Sec. 541.157. CONTENTS OF SETTLEMENT OFFER. A settlement offer made by a person against whom a claim under this subchapter is pending must include an offer to pay the following amounts, separately stated:

(1) an amount of money or other consideration, reduced to its cash value, as settlement of the claim for damages; and

(2) an amount of money to compensate the claimant for the claimant's reasonable and necessary attorney's fees incurred as of the date of the offer. (V.T.I.C. Art. 21.21, Sec. 16A(d).)

Sec. 541.158. REJECTION OF SETTLEMENT OFFER. (a) A settlement offer is rejected unless both parts of the offer required under Section 541.157 are accepted by the claimant not later than the 30th day after the date the offer is made.

(b) A settlement offer made by a person against whom a claim under this subchapter is pending that complies with this subchapter and is rejected by the claimant may be filed with the court accompanied by an affidavit certifying the offer's rejection. (V.T.I.C. Art. 21.21, Secs. 16A(e), (f).)

Sec. 541.159. LIMIT ON RECOVERY AFTER SETTLEMENT OFFER. (a) If the court finds that the amount stated in the settlement offer for damages under Section 541.157(1) is the same as, substantially the same as, or more than the amount of damages found by the trier of fact, the claimant may not recover as damages any amount in excess of the lesser of:

(1) the amount of damages stated in the offer; or

(2) the amount of damages found by the trier of fact.

(b) If the court makes the finding described by Subsection (a), the court shall determine reasonable and necessary attorney's fees to compensate the claimant for attorney's fees incurred before the date and time the rejected settlement offer was made. If the court finds that the amount stated in the offer for attorney's fees under Section 541.157(2) is the same as, substantially the same as, or more than the amount of reasonable and necessary attorney's fees incurred by the claimant as of the date of the offer, the claimant may not recover any amount of attorney's fees in excess of the amount of fees stated in the offer.

(c) This section does not apply if the court finds that the offering party:

(1) could not perform the offer at the time the offer was made; or

(2) substantially misrepresented the cash value of the offer.

(d) The court shall award:

(1) damages as required by Section 541.152 if Subsection (a) does not apply; and

(2) attorney's fees as required by Section 541.152 if Subsection (b) does not apply. (V.T.I.C. Art. 21.21, Secs. 16A(g), (h), (i), (j).)

Sec. 541.160. EFFECT OF SETTLEMENT OFFER. A settlement offer is not an admission of engaging in an act or practice defined by Subchapter B to be an unfair method of competition or an unfair

or deceptive act or practice in the business of insurance. (V.T.I.C. Art. 21.21, Sec. 16A(k).)

Sec. 541.161. MEDIATION. (a) A party may, not later than the 90th day after the date a pleading seeking relief under this subchapter is served, file a motion to compel mediation of the dispute in the manner provided by this section.

(b) The court shall, not later than the 30th day after the date a motion under this section is filed, sign an order setting the time and place of the mediation.

(c) The court shall appoint a mediator if the parties do not agree on a mediator.

(d) The mediation must be held not later than the 30th day after the date the order is signed, unless:

(1) the parties agree otherwise; or

(2) the court determines that additional time not to exceed 30 days is warranted.

(e) Each party who has appeared in the action, except as agreed to by all parties who have appeared, shall:

(1) participate in the mediation; and

(2) except as provided by Subsection (f), share the mediation fee.

(f) A party may not compel mediation under this section if the amount of actual damages claimed is less than $15,000 unless the party seeking to compel mediation agrees to pay the costs of the mediation.

(g) Except as provided by this section, the following apply to the appointment of a mediator and the mediation process provided

by this section:

(1) Section 154.023, Civil Practice and Remedies Code; and

(2) Subchapters C and D, Chapter 154, Civil Practice and Remedies Code. (V.T.I.C. Art. 21.21, Sec. 16B.)

Sec. 541.162. LIMITATIONS PERIOD. (a) A person must bring an action under this chapter before the second anniversary of the following:

(1) the date the unfair method of competition or unfair or deceptive act or practice occurred; or

(2) the date the person discovered or, by the exercise of reasonable diligence, should have discovered that the unfair method of competition or unfair or deceptive act or practice occurred.

(b) The limitations period provided by Subsection (a) may be extended for 180 days if the person bringing the action proves that the person's failure to bring the action within that period was caused by the defendant's engaging in conduct solely calculated to induce the person to refrain from or postpone bringing the action. (V.T.I.C. Art. 21.21, Sec. 16(d).)

[Sections 541.163-541.200 reserved for expansion]

SUBCHAPTER E. ENFORCEMENT BY ATTORNEY GENERAL

Sec. 541.201. INJUNCTIVE RELIEF. (a) The attorney general may bring an action under this section if the attorney general has reason to believe that:

(1) a person engaged in the business of insurance in this state is engaging in, has engaged in, or is about to engage in

an act or practice defined as unlawful under:

(A) this chapter or a rule adopted under this chapter; or

(B) Section 17.46, Business & Commerce Code; and

(2) the action is in the public interest.

(b) The attorney general may bring the action in the name of the state to restrain by temporary or permanent injunction the person's use of the method, act, or practice. (V.T.I.C. Art. 21.21, Sec. 15(a).)

Sec. 541.202. VENUE FOR INJUNCTIVE ACTION. An action for an injunction under this subchapter may be commenced in a district court in:

(1) the county in which the person against whom the action is brought:

(A) resides;

(B) has the person's principal place of business; or

(C) is engaging in business;

(2) the county in which the transaction or a substantial portion of the transaction occurred; or

(3) Travis County. (V.T.I.C. Art. 21.21, Sec. 15(b) (part).)

Sec. 541.203. ISSUANCE OF INJUNCTION. (a) The court may issue an appropriate temporary or permanent injunction.

(b) The court shall issue the injunction without bond. (V.T.I.C. Art. 21.21, Sec. 15(b) (part).)

Sec. 541.204. CIVIL PENALTY. In addition to requesting a

temporary or permanent injunction under Section 541.201, the attorney general may request a civil penalty of not more than $10,000 for each violation on a finding by the court that the defendant has engaged in or is engaging in an act or practice defined as unlawful under:

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

(2) Section 17.46, Business & Commerce Code. (V.T.I.C. Art. 21.21, Sec. 15(c).)

Sec. 541.205. COMPENSATION OR RESTORATION. The court may make an additional order or judgment as necessary to compensate an identifiable person for actual damages or for restoration of money or property that may have been acquired by means of an enjoined act or practice. (V.T.I.C. Art. 21.21, Sec. 15(d).)

Sec. 541.206. CIVIL PENALTY FOR VIOLATION OF INJUNCTION. (a) A person who violates an injunction issued under this subchapter is liable for and shall pay to the state a civil penalty of not more than $10,000 for each violation.

(b) The attorney general may, in the name of the state, petition the court for recovery of the civil penalty against the person who violates the injunction.

(c) The court shall consider the maintenance of procedures reasonably adapted to ensure compliance with the injunction in determining whether a person has violated an injunction.

(d) The court issuing the injunction retains jurisdiction and the cause is continued for the purpose of assessing a civil penalty under this section. (V.T.I.C. Art. 21.21, Sec. 15(e).)

Sec. 541.207. REMEDIES NOT EXCLUSIVE. The remedies provided by this subchapter are:

(1) not exclusive; and

(2) in addition to any other remedy or procedure provided by another law or at common law. (V.T.I.C. Art. 21.21, Sec. 15(f).)

[Sections 541.208-541.250 reserved for expansion]

SUBCHAPTER F. CLASS ACTIONS BY ATTORNEY GENERAL OR PRIVATE INDIVIDUAL

Sec. 541.251. CLASS ACTION AUTHORIZED. (a) If a member of the insurance buying public has been damaged by an unlawful method, act, or practice defined in Subchapter B as an unlawful deceptive trade practice, the department may request the attorney general to bring a class action or the individual damaged may bring an action on the individual's own behalf and on behalf of others similarly situated to recover damages and obtain relief as provided by this subchapter.

(b) A class action may not be maintained under this subchapter if the department and attorney general have initiated an action under Subchapter G or an action under that subchapter has resulted in a final determination regarding the same act or practice and the same defendant in the action under this subchapter. (V.T.I.C. Art. 21.21, Secs. 17(a), (e).)

Sec. 541.252. RECOVERY. A plaintiff who prevails in a class action under this subchapter may recover:

(1) court costs and attorney's fees reasonable in relation to the amount of work expended in addition to actual

damages;

(2) an order enjoining the act or failure to act; and

(3) any other relief the court determines is proper. (V.T.I.C. Art. 21.21, Sec. 17(b).)

Sec. 541.253. FRIVOLOUS ACTION. The court may award to the defendant court costs and reasonable attorney's fees in relation to the work expended on a finding by the court that a class action under this subchapter was brought by an individual plaintiff in bad faith or for the purpose of harassment. (V.T.I.C. Art. 21.21, Sec. 17(c).)

Sec. 541.254. STATUTE OF LIMITATIONS TOLLED. The filing of a class action under this subchapter tolls the statute of limitations for bringing an action by an individual under Section 541.162. (V.T.I.C. Art. 21.21, Sec. 18(k) (part).)

Sec. 541.255. PRIOR NOTICE. (a) Not later than the 31st day before the date a class action for damages is commenced under this subchapter, the prospective plaintiff must:

(1) notify the intended defendant of the complaint; and

(2) demand that the defendant provide relief to the prospective plaintiff and others similarly situated.

(b) The notice must be in writing and be sent by certified or registered mail, return receipt requested, to:

(1) the place where the transaction occurred;

(2) the intended defendant's principal place of business in this state; or

(3) if notice to the place described by Subdivision

(1) or (2) does not effect notice, the office of the secretary of state.

(c) A copy of the notice must also be sent to the commissioner.

(d) A class action for injunctive relief may be commenced under this subchapter without complying with Subsection (a).

(e) A plaintiff in a class action for injunctive relief under this subchapter may, on or after the 31st day after the date the action is commenced and after complying with Subsection (a), amend the complaint without leave of court to include a request for damages. (V.T.I.C. Art. 21.21, Secs. 19(a), (b), (c).)

Sec. 541.256. PREREQUISITES TO CLASS ACTION. The court shall permit one or more members of a class to sue or be sued as representative parties on behalf of the class only if:

(1) the class is so numerous that joinder of all members is impracticable;

(2) there are questions of law or fact common to the class;

(3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and

(4) the representative parties will fairly and adequately protect the interests of the class. (V.T.I.C. Art. 21.21, Sec. 18(a).)

Sec. 541.257. CLASS ACTIONS MAINTAINABLE. (a) An action may be maintained as a class action under this subchapter if the prerequisites of Section 541.256 are satisfied and, in addition:

(1) the prosecution of separate actions by or against

individual members of the class would create a risk of:

(A) inconsistent or varying adjudications with respect to individual members of the class that would establish incompatible standards of conduct for the party opposing the class; or

(B) adjudication with respect to individual members of the class that would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests;

(2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole; or

(3) the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy.

(b) Matters pertinent to a finding under Subsection (a)(3) include:

(1) the interest of members of the class in individually controlling the prosecution or defense of separate actions;

(2) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class;

(3) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; and

(4) the difficulties likely to be encountered in the management of a class action.

(c) In construing this section, the courts of this state shall be guided by the decisions of the federal courts interpreting Rule 23, Federal Rules of Civil Procedure, as amended. (V.T.I.C. Art. 21.21, Secs. 18(b), (c).)

Sec. 541.258. CLASS ACTIONS: ISSUES AND SUBCLASSES AUTHORIZED. When appropriate, an action may be brought or maintained as a class action under this subchapter with respect to particular issues or a class may be divided into subclasses and each subclass treated as a class, and the provisions of this subchapter shall be construed and applied accordingly. (V.T.I.C. Art. 21.21, Sec. 18(h).)

Sec. 541.259. DETERMINATION REGARDING WHETHER CLASS ACTION MAY BE MAINTAINED. (a) As soon as practicable after the commencement of an action brought as a class action, the court shall determine by order whether it is to be maintained as a class action under this subchapter.

(b) An order under this section may be altered or amended before a decision on the merits.

(c) An order determining whether the action may be maintained as a class action under this subchapter is an interlocutory order that is appealable. The procedures applicable to accelerated appeals in the Texas Rules of Appellate Procedure

apply to the appeal. (V.T.I.C. Art. 21.21, Sec. 18(d).)

Sec. 541.260. EFFECT OF DENIAL OF CLASS ACTION. A court order denying that an action under this subchapter may be brought as a class action does not affect whether an individual may bring the same or a similar action under Subchapter D. (V.T.I.C. Art. 21.21, Sec. 18(k) (part).)

Sec. 541.261. NOTICE OF CLASS ACTION. (a) If an action is permitted as a class action under this subchapter, the court shall direct to the members of the class the best notice practicable under the circumstances, including individual notice to all members who can be identified through reasonable effort.

(b) The notice must contain a statement that:

(1) the court will exclude from the class a notified member if the member requests exclusion by a specified date;

(2) the judgment, whether favorable or not, includes all members who do not request exclusion; and

(3) a member who does not request exclusion may enter an appearance through counsel. (V.T.I.C. Art. 21.21, Secs. 18(e), (f).)

Sec. 541.262. PROCEDURES IN CLASS ACTION. In a class action under this subchapter, the court may make appropriate orders:

(1) determining the course of proceedings or prescribing measures to prevent undue repetition or complication in the presentation of evidence or argument;

(2) requiring, for the protection of the members of the class or otherwise for the fair conduct of the action, that notice be given in a manner the court directs to some or all of the

members or the attorney general of:

(A) any step in the action;

(B) the proposed extent of the judgment; or

(C) the opportunity for members to:

(i) signify whether the members consider the representation to be fair and adequate;

(ii) intervene and present claims or defenses; or

(iii) otherwise come into the action;

(3) imposing conditions on the representative parties or intervenors;

(4) requiring that the pleadings be amended to eliminate allegations relating to representation of absent persons, and that the action proceed accordingly; or

(5) dealing with similar procedural matters. (V.T.I.C. Art. 21.21, Sec. 18(j).)

Sec. 541.263. EFFECT OF SETTLEMENT OFFER. (a) Damages may not be awarded to a class under this subchapter if, not later than the 30th day after the date the intended defendant receives notice under Section 541.255, the intended defendant provides to the plaintiff by certified or registered mail, return receipt requested, a written settlement offer.

(b) The settlement offer must include:

(1) a statement that all persons similarly situated have been adequately identified or a reasonable effort to identify those persons has been made;

(2) a description of the class identified and the

method used to identify that class;

(3) a statement that all persons identified have been notified that, on request, the intended defendant will provide relief to those persons and all others similarly situated;

(4) a complete explanation of the relief being afforded;

(5) a copy of the notice or communication the intended defendant is providing to the members of the class;

(6) a statement that the relief being afforded the consumer has been or, if the offer is accepted by the consumer, will be given within a stated reasonable time; and

(7) a statement that the practice complained of has ceased.

(c) Except as provided by Subsection (d), an attempt to comply with this section by a person receiving a demand is:

(1) an offer to compromise;

(2) not admissible as evidence; and

(3) not an admission of engaging in an unlawful act or practice.

(d) A defendant may introduce evidence of compliance or an attempt to comply with this section for the purpose of:

(1) establishing good faith; or

(2) showing compliance with this section. (V.T.I.C. Art. 21.21, Secs. 19(d), (e).)

Sec. 541.264. DEFENSES. Damages may not be awarded in a class action under this subchapter if the defendant:

(1) proves that the action complained of resulted from

a bona fide error, notwithstanding the use of reasonable procedures adopted to avoid an error; and

(2) made restitution of any consideration received from any member of the class. (V.T.I.C. Art. 21.21, Sec. 20.)

Sec. 541.265. LIMITATIONS PERIOD FOR DAMAGES. In a class action under this subchapter, damages may not include any damages incurred more than two years before the date the action is commenced. (V.T.I.C. Art. 21.21, Sec. 17(d).)

Sec. 541.266. DISPOSITION. (a) A class action under this subchapter may not be dismissed, settled, or compromised without the approval of the court.

(b) Notice of the proposed dismissal, settlement, or compromise shall be given to all members of the class in the manner the court directs. (V.T.I.C. Art. 21.21, Sec. 18(g).)

Sec. 541.267. CONTENTS OF JUDGMENT; NOTICE. (a) The judgment in a class action under this subchapter must describe those to whom the notice under Section 541.261 was directed and who have not requested exclusion and those the court finds to be members of the class.

(b) The court shall direct to the members of the class the best notice of the judgment practicable under the circumstances, including individual notice to each member who can be identified through reasonable effort. (V.T.I.C. Art. 21.21, Sec. 18(i).)

[Sections 541.268-541.300 reserved for expansion]

SUBCHAPTER G. DEPARTMENT ACTION FOR REFUND OF PREMIUMS

Sec. 541.301. REFUND OF PREMIUMS. (a) After notice and hearing as provided in Subchapter C, the department may require a

person to make an accounting under Subsection (b):

(1) in connection with a method of competition or act or practice that is the basis of a cease and desist order issued under Section 541.108; or

(2) on application of an aggrieved person, in connection with a determination by the department that the aggrieved person and other persons similarly situated were induced to purchase an insurance policy as a result of the person engaging in a method of competition or act or practice in violation of:

(A) this chapter or a rule adopted under this chapter; or

(B) Section 17.46, Business & Commerce Code.

(b) A person required to make an accounting under this section must account for all premiums collected for policies issued by the person during the preceding two years in connection with the acts in violation of this chapter described by Subsection (a)(1) or (2).

(c) The department may require the person described by Subsection (a) to:

(1) give notice to all persons from whom the premiums were collected; and

(2) refund the total of all premiums collected from each person who elects to accept a premium refund in exchange for cancellation of the insurance policy issued.

(d) A person who refunds premiums under this section shall deduct from the amount of premiums refunded the amount of benefits actually paid by the person while the insurance policy was in force.

(V.T.I.C. Art. 21.21, Sec. 14(a) (part).)

Sec. 541.302. TIME TO MAKE REFUNDS. The department shall specify a reasonable time within which a person required to make premium refunds under Section 541.301 must make the refunds. (V.T.I.C. Art. 21.21, Sec. 14(a) (part).)

Sec. 541.303. SANCTION. (a) The department may report to the attorney general a person's failure to comply with the department's requirement to refund premiums within the time specified under Section 541.302. The department may request that the attorney general file an action to enforce the department's requirement to refund premiums.

(b) Venue for the action is in a district court in Travis County.

(c) The court shall enter an appropriate order to enforce the department's requirement to refund premiums if the court finds that:

(1) the requirement was lawfully entered; and

(2) the person failed to comply with the requirement.

(d) The court may enforce its order through contempt proceedings.

(e) The sanction provided by this section is in addition to any other sanctions provided in this code or other applicable laws. (V.T.I.C. Art. 21.21, Sec. 14(b).)

Sec. 541.304. EVIDENTIARY USE OF COMPLIANCE OR ATTEMPT TO COMPLY. (a) Compliance or an attempt to comply with the department's requirement to refund premiums is:

(1) an offer to compromise;

(2) not admissible as evidence; and

(3) not an admission of engaging in an unlawful act or practice.

(b) A defendant may introduce evidence of compliance or an attempt to comply with the department's requirement for the purpose of:

(1) establishing good faith; or

(2) showing compliance with the department's requirement. (V.T.I.C. Art. 21.21, Sec. 14(c).)

[Sections 541.305-541.350 reserved for expansion]

SUBCHAPTER H. ASSURANCE OF VOLUNTARY COMPLIANCE

Sec. 541.351. ACCEPTANCE OF ASSURANCE. (a) In administering this chapter, the department may accept assurance of voluntary compliance from a person who is engaging in, has engaged in, or is about to engage in an act or practice in violation of:

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

(2) Section 17.46, Business & Commerce Code.

(b) The assurance must be in writing and be filed with the department.

(c) The department may condition acceptance of an assurance of voluntary compliance on the stipulation that the person offering the assurance restore to a person in interest money that may have been acquired by the act or practice described in Subsection (a). (V.T.I.C. Art. 21.21, Secs. 22(a), (b).)

Sec. 541.352. EFFECT OF ASSURANCE. (a) An assurance of voluntary compliance is not an admission of a prior violation of:

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

(2) Section 17.46, Business & Commerce Code.

(b) Unless an assurance of voluntary compliance is rescinded by agreement, a subsequent failure to comply with the assurance is prima facie evidence of a violation of:

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

(2) Section 17.46, Business & Commerce Code. (V.T.I.C. Art. 21.21, Sec. 22(c).)

Sec. 541.353. REOPENING. A matter closed by the filing of an assurance of voluntary compliance may be reopened at any time. (V.T.I.C. Art. 21.21, Sec. 22(d) (part).)

Sec. 541.354. RIGHT TO BRING ACTION NOT AFFECTED. An assurance of voluntary compliance does not affect the right of an individual to bring an action under this chapter, except that the right of an individual in relation to money received according to a stipulation under Section 541.351(c) is governed by the terms of the assurance. (V.T.I.C. Art. 21.21, Sec. 22(d) (part).)

[Sections 541.355-541.400 reserved for expansion]

SUBCHAPTER I. RULEMAKING

Sec. 541.401. RULEMAKING AUTHORITY. (a) The commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of this chapter.

(b) Notwithstanding a previous definition or interpretation of a term used in this chapter contained in or derived from the common law or other statutory law of this state, the commissioner

may adopt an express provision necessary to accomplish the purposes of this chapter, including a provision the commissioner considers necessary to:

(1) achieve necessary uniformity with the laws of other states or the United States; or

(2) conform to the adopted procedures of the National Association of Insurance Commissioners. (V.T.I.C. Art. 21.21, Sec. 13(a) (part).)

Sec. 541.402. PETITION. (a) A petition may be submitted to the commissioner to adopt, amend, or repeal a rule. The petition must be:

(1) signed by 100 interested persons; and

(2) supported by evidence that:

(A) a particular act or practice has been or could be false, misleading, or deceptive to the insurance buying public; or

(B) an act or practice defined by department rule to be false, misleading, or deceptive is not false, misleading, or deceptive.

(b) Not later than the 30th day after the date the department receives the petition, the department shall:

(1) deny the petition as provided by Section 541.403; or

(2) initiate hearing proceedings under Section 541.404. (V.T.I.C. Art. 21.21, Sec. 13(b).)

Sec. 541.403. DENIAL OF PETITION. (a) The department must state in writing the reason for denying a petition to adopt, amend,

or repeal a rule.

(b) The department is expressly authorized to deny the petition if the action sought would:

(1) destroy uniformity with the laws of other states or the United States; or

(2) not conform to the adopted procedures of the National Association of Insurance Commissioners. (V.T.I.C. Art. 21.21, Sec. 13(c).)

Sec. 541.404. HEARING ON PETITION. (a) A hearing held by the department in response to a petition to adopt, amend, or repeal a rule must be open to the public.

(b) At the hearing, any person may present to the department in writing or orally testimony, data, or other information regarding the act or practice under consideration. (V.T.I.C. Art. 21.21, Sec. 13(d).)

Sec. 541.405. JUDICIAL REVIEW OF DEPARTMENT ACTION. (a) A person aggrieved by the denial of a petition under Section 541.402 or the adoption, amendment, or repeal of or failure to adopt a rule under this subchapter may file a petition in a district court in Travis County for:

(1) a declaratory judgment on the validity or applicability of an adopted, amended, or repealed rule; or

(2) review of the denial of a petition under Section 541.402.

(b) The commissioner must be made a party to the action.

(c) An action of the commissioner under this subchapter in adopting, amending, repealing, or failing to adopt a rule or

denying a petition may be invalidated only if the court finds that the action:

(1) violates a constitutional or state statutory provision;

(2) exceeds the commissioner's statutory authority;

(3) is arbitrary or capricious or characterized by abuse of discretion or unwarranted exercise of discretion;

(4) is so vague that it does not establish sufficiently definite standards to which conduct can be conformed;

(5) is made following unlawful procedure; or

(6) is clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record as submitted.

(d) The court may issue an injunction in an action under this section. (V.T.I.C. Art. 21.21, Secs. 13(e), (f).)

[Sections 541.406-541.450 reserved for expansion]

SUBCHAPTER J. CONSTRUCTION OF CHAPTER WITH OTHER LAWS

Sec. 541.451. LIABILITY UNDER OTHER LAW. An order of the department under this chapter or an order by a court to enforce that order does not relieve or absolve a person affected by either order from liability under another law of this state. (V.T.I.C. Art. 21.21, Sec. 8.)

Sec. 541.452. POWERS IN ADDITION TO OTHER POWERS AUTHORIZED BY LAW. The powers vested in the department and the commissioner by this chapter are in addition to any other powers to enforce a penalty, fine, or forfeiture authorized by law with respect to a method of competition or act or practice defined as unfair or

deceptive. (V.T.I.C. Art. 21.21, Sec. 11.)

Sec. 541.453. DOUBLE RECOVERY PROHIBITED. A person may not recover damages and penalties for the same act or practice under both this chapter and another law. (V.T.I.C. Art. 21.21, Sec. 11A.)

Sec. 541.454. PENALTIES AND RELATED PAYMENTS BY INSURER. (a) Civil penalties, premium refunds, judgments, compensatory judgments, individual recoveries, orders, class action awards, costs, damages, or attorney's fees assessed or awarded under this chapter:

(1) may be paid only from the capital or surplus funds of the offending insurer; and

(2) may not take precedence over, be in priority to, or in any other manner apply to:

(A) Article 21.28-C or 21.28-D or any other insurance guaranty act; or

(B) Article 21.39-A.

(b) The statutes described by Subsection (a)(2) and the priorities of funds created by those statutes are exempt from the provisions of this chapter. (V.T.I.C. Art. 21.21, Sec. 23.)

CHAPTER 542. PROCESSING AND SETTLEMENT OF CLAIMS

SUBCHAPTER A. UNFAIR CLAIM SETTLEMENT PRACTICES

CHAPTER 542. PROCESSING AND SETTLEMENT OF CLAIMS

SUBCHAPTER A. UNFAIR CLAIM SETTLEMENT PRACTICES

Sec. 542.001. SHORT TITLE. This subchapter may be cited as the Unfair Claim Settlement Practices Act. (V.T.I.C. Art. 21.21-2, Sec. 1.)

Sec. 542.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies to the following insurers whether organized as a proprietorship, partnership, stock or mutual corporation, or unincorporated association:

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

(2) a fire or casualty insurance company;

(3) a hail or storm insurance company;

(4) a title insurance company;

(5) a mortgage guarantee company;

(6) a mutual assessment company;

(7) a local mutual aid association;

(8) a local mutual burial association;

(9) a statewide mutual assessment company;

(10) a stipulated premium company;

(11) a fraternal benefit society;

(12) a group hospital service corporation;

(13) a county mutual insurance company;

(14) a Lloyd's plan;

(15) a reciprocal or interinsurance exchange; and

(16) a farm mutual insurance company. (V.T.I.C. Art. 21.21-2, Sec. 7.)

Sec. 542.003. UNFAIR CLAIM SETTLEMENT PRACTICES PROHIBITED. (a) An insurer engaging in business in this state may not engage in an unfair claim settlement practice.

(b) Any of the following acts by an insurer constitutes unfair claim settlement practices:

(1) knowingly misrepresenting to a claimant pertinent

facts or policy provisions relating to coverage at issue;

(2) failing to acknowledge with reasonable promptness pertinent communications relating to a claim arising under the insurer's policy;

(3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under the insurer's policies;

(4) not attempting in good faith to effect a prompt, fair, and equitable settlement of a claim submitted in which liability has become reasonably clear;

(5) compelling a policyholder to institute a suit to recover an amount due under a policy by offering substantially less than the amount ultimately recovered in a suit brought by the policyholder;

(6) failing to maintain the information required by Section 542.005; or

(7) committing another act the commissioner determines by rule constitutes an unfair claim settlement practice. (V.T.I.C. Art. 21.21-2, Secs. 2(a), (b) (part).)

Sec. 542.004. EXAMINATION OF TAX RETURNS PROHIBITED. (a) An insurer regulated under this code may not require a claimant, as a condition of settling a claim, to produce the claimant's federal income tax returns for examination or investigation by the insurer unless:

(1) the claimant is ordered to produce the tax returns by a court; or

(2) the claim involves:

(A) a fire loss; or

(B) a loss of profits or income.

(b) An insurer that violates this section commits:

(1) a prohibited practice under this subchapter; and

(2) a deceptive trade practice under Subchapter E, Chapter 17, Business & Commerce Code.

(c) A claimant affected by a violation of this section is entitled to remedies under Subchapter E, Chapter 17, Business & Commerce Code. (V.T.I.C. Art. 21.21-2, Sec. 2(c).)

Sec. 542.005. RECORD OF COMPLAINTS. (a) In this section, "complaint" means any written communication primarily expressing a grievance.

(b) An insurer shall maintain a complete record of all complaints received by the insurer during the preceding three years or since the date of the insurer's last examination by the department, whichever period is shorter. The record must indicate:

(1) the total number of complaints;

(2) the classification of complaints by line of insurance;

(3) the nature of each complaint;

(4) the disposition of the complaints; and

(5) the time spent processing each complaint. (V.T.I.C. Art. 21.21-2, Sec. 2(b) (part).)

Sec. 542.006. PERIODIC REPORTING REQUIREMENT. (a) In this section, "claim" means a written claim filed by a resident of this state with an insurer engaging in business in this state.

(b) If, based on complaints of unfair claim settlement

practices under this subchapter, the department finds that an insurer should be subjected to closer supervision with respect to the insurer's claim settlement practices, the department may require the insurer to file periodic reports at intervals the department determines necessary.

(c) The department shall devise a statistical plan for the periodic reports required under Subsection (b). The plan must contain at a minimum:

(1) the following claims information for the preceding 12 months or from the date of the insurer's last periodic report, whichever period is shorter:

(A) the total number of claims filed, including for each individual claim:

(i) the original amount filed for by the insured; and

(ii) the classification by line of insurance;

(B) the total number of claims denied;

(C) the total number of claims settled, including for each individual claim:

(i) the original amount filed for by the insured;

(ii) the amount settled; and

(iii) the classification by line of insurance; and

(D) the total number of claims for which suits have been instituted against the insurer, including for each

individual claim:

(i) the original amount filed for by the insured;

(ii) the amount of final adjudication;

(iii) the reason for the suit; and

(iv) the classification by line of insurance; and

(2) the information required to be maintained by the insurer under Section 542.005.

(d) If at any time the department determines that the requirement to file a periodic report is no longer necessary to accomplish the objectives of this subchapter, the department may rescind the reporting requirement. (V.T.I.C. Art. 21.21-2, Sec. 3.)

Sec. 542.007. COMPARISON OF CERTAIN INSURERS TO MINIMUM STANDARD OF PERFORMANCE; INVESTIGATION. (a) The department shall compile the information received from an insurer under Section 542.006 in a manner that enables the department to compare the insurer's performance to a minimum standard of performance adopted by the commissioner.

(b) If the department determines that the insurer does not meet the minimum standard of performance, the department shall investigate the insurer to determine the reason, if any, that the insurer does not meet the minimum standard. (V.T.I.C. Art. 21.21-2, Sec. 4(b).)

Sec. 542.008. COMPLAINTS AGAINST INSURERS; INVESTIGATION. (a) The department shall establish a system for receiving and

processing individual complaints alleging a violation of this subchapter by an insurer regardless of whether the insurer is required to file a periodic report under Section 542.006.

(b) The department shall investigate an insurer if the department determines that:

(1) based on the number and type of complaints against an insurer, the insurer does not meet the minimum standard of performance adopted under Section 542.007; or

(2) the number and type of complaints against the insurer are not proportionate to the number and type of complaints against other insurers writing similar lines of insurance. (V.T.I.C. Art. 21.21-2, Sec. 4(c).)

Sec. 542.009. REVIEW OF INVESTIGATION RESULTS; HEARING. (a) On receiving the results of an investigation instituted under Section 542.007 or 542.008, the department shall review those results considering the standards of this subchapter to determine whether further action is necessary.

(b) If the department determines that further action is necessary, the department shall:

(1) set a date for a hearing to review the alleged violations of this subchapter; and

(2) notify the insurer of:

(A) the date of the hearing; and

(B) the nature of the charges.

(c) The department shall provide the notice required by Subsection (b)(2) not later than the 30th day before the date of the hearing.

(d) At a hearing under this section, the insurer may present the insurer's case with the assistance of counsel.

(e) Evidence relating to the number and type of complaints or claims prepared by the department from information received or compiled under Section 542.006, 542.007, or 542.008 is admissible in evidence at:

(1) the hearing; and

(2) any related judicial proceeding.

(f) The hearing shall be conducted in accordance with this code and rules adopted by the commissioner.

(g) An insurer may not be found to be in violation of this subchapter solely because of the number and type of complaints or claims against the insurer. (V.T.I.C. Art. 21.21-2, Sec. 5(a).)

Sec. 542.010. CEASE AND DESIST ORDER; ENFORCEMENT. (a) If the department determines that an insurer has violated this subchapter, the department shall issue a cease and desist order to the insurer directing the insurer to stop the unlawful practice.

(b) If the insurer fails to comply with the cease and desist order, the department may:

(1) revoke or suspend the insurer's certificate of authority; or

(2) limit, regulate, and control:

(A) the insurer's line of business;

(B) the insurer's writing of policy forms or other particular forms; and

(C) the volume of the insurer's:

(i) line of business; or

(ii) writing of policy forms or other particular forms.

(c) The department shall exercise authority under this section to the extent that the department determines is necessary to obtain the insurer's compliance with the cease and desist order.

(d) At the request of the department, the attorney general shall assist the department in enforcing the cease and desist order. (V.T.I.C. Art. 21.21-2, Sec. 6(a).)

Sec. 542.011. TIME LIMIT TO APPEAL. An insurer affected by a ruling or order of the department under this subchapter may appeal the ruling or order, in accordance with Subchapter D, Chapter 36, by filing a petition for judicial review not later than the 20th day after the date of the ruling or order. (V.T.I.C. Art. 21.21-2, Sec. 6(b) (part).)

Sec. 542.012. ATTORNEY'S FEES. The department is entitled to reasonable attorney's fees if judicial action is necessary to enforce an order of the department under this subchapter. (V.T.I.C. Art. 21.21-2, Sec. 6(b) (part).)

Sec. 542.013. PERSONNEL. The department may hire employees and examiners as needed to enforce this subchapter. (V.T.I.C. Art. 21.21-2, Sec. 4(a).)

Sec. 542.014. RULES. The commissioner shall adopt reasonable rules as necessary to implement and augment the purposes and provisions of this subchapter. (V.T.I.C. Art. 21.21-2, Sec. 8.)

[Sections 542.015-542.050 reserved for expansion]

SUBCHAPTER B. PROMPT PAYMENT OF CLAIMS

Sec. 542.051. DEFINITIONS. In this subchapter:

(1) "Business day" means a day other than a Saturday, Sunday, or holiday recognized by this state.

(2) "Claim" means a first-party claim that:

(A) is made by an insured or policyholder under an insurance policy or contract or by a beneficiary named in the policy or contract; and

(B) must be paid by the insurer directly to the insured or beneficiary.

(3) "Claimant" means a person making a claim.

(4) "Notice of claim" means any written notification provided by a claimant to an insurer that reasonably apprises the insurer of the facts relating to the claim. (V.T.I.C. Art. 21.55, Secs. 1(1), (2), (3), (5).)

Sec. 542.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any insurer authorized to engage in business as an insurance company or to provide insurance in this state, including:

(1) a stock life, health, or accident insurance company;

(2) a mutual life, health, or accident insurance company;

(3) a stock fire or casualty insurance company;

(4) a mutual fire or casualty insurance company;

(5) a Mexican casualty insurance company;

(6) a Lloyd's plan;

(7) a reciprocal or interinsurance exchange;

(8) a fraternal benefit society;

(9) a stipulated premium company;

(10) a nonprofit legal services corporation;

(11) a statewide mutual assessment company;

(12) a local mutual aid association;

(13) a local mutual burial association;

(14) an association exempt under Section 887.102;

(15) a nonprofit hospital, medical, or dental service corporation, including a corporation subject to Chapter 842;

(16) a county mutual insurance company;

(17) a farm mutual insurance company;

(18) a risk retention group;

(19) a purchasing group;

(20) an eligible surplus lines insurer; and

(21) except as provided by Section 542.053(b), a guaranty association operating under Article 21.28-C or 21.28-D. (V.T.I.C. Art. 21.55, Sec. 1(4).)

Sec. 542.053. EXCEPTION. (a) This subchapter does not apply to:

(1) workers' compensation insurance;

(2) mortgage guaranty insurance;

(3) title insurance;

(4) fidelity, surety, or guaranty bonds;

(5) marine insurance other than inland marine insurance governed by Article 5.53; or

(6) a guaranty association created and operating under Chapter 2602.

(b) A guaranty association operating under Article 21.28-C

or 21.28-D is not subject to the damage provisions of Section 542.060.

(c) This subchapter does not apply to a health maintenance organization except as provided by Section 1271.005(c).

(d) This subchapter does not apply to a claim governed by Subchapter C, Chapter 1301. (V.T.I.C. Art. 21.55, Secs. 5(a), (b) (part), (c).)

Sec. 542.054. LIBERAL CONSTRUCTION. This subchapter shall be liberally construed to promote the prompt payment of insurance claims. (V.T.I.C. Art. 21.55, Sec. 8.)

Sec. 542.055. RECEIPT OF NOTICE OF CLAIM. (a) Not later than the 15th day or, if the insurer is an eligible surplus lines insurer, the 30th business day after the date an insurer receives notice of a claim, the insurer shall:

(1) acknowledge receipt of the claim;

(2) commence any investigation of the claim; and

(3) request from the claimant all items, statements, and forms that the insurer reasonably believes, at that time, will be required from the claimant.

(b) An insurer may make additional requests for information if during the investigation of the claim the additional requests are necessary.

(c) If the acknowledgment of receipt of a claim is not made in writing, the insurer shall make a record of the date, manner, and content of the acknowledgment. (V.T.I.C. Art. 21.55, Sec. 2.)

Sec. 542.056. NOTICE OF ACCEPTANCE OR REJECTION OF CLAIM. (a) Except as provided by Subsection (b) or (d), an insurer shall

notify a claimant in writing of the acceptance or rejection of a claim not later than the 15th business day after the date the insurer receives all items, statements, and forms required by the insurer to secure final proof of loss.

(b) If an insurer has a reasonable basis to believe that a loss resulted from arson, the insurer shall notify the claimant in writing of the acceptance or rejection of the claim not later than the 30th day after the date the insurer receives all items, statements, and forms required by the insurer.

(c) If the insurer rejects the claim, the notice required by Subsection (a) or (b) must state the reasons for the rejection.

(d) If the insurer is unable to accept or reject the claim within the period specified by Subsection (a) or (b), the insurer, within that same period, shall notify the claimant of the reasons that the insurer needs additional time. The insurer shall accept or reject the claim not later than the 45th day after the date the insurer notifies a claimant under this subsection. (V.T.I.C. Art. 21.55, Secs. 3(a), (b), (c), (d), (e).)

Sec. 542.057. PAYMENT OF CLAIM. (a) Except as otherwise provided by this section, if an insurer notifies a claimant under Section 542.056 that the insurer will pay a claim or part of a claim, the insurer shall pay the claim not later than the fifth business day after the date notice is made.

(b) If payment of the claim or part of the claim is conditioned on the performance of an act by the claimant, the insurer shall pay the claim not later than the fifth business day after the date the act is performed.

(c) If the insurer is an eligible surplus lines insurer, the insurer shall pay the claim not later than the 20th business day after the notice or the date the act is performed, as applicable. (V.T.I.C. Art. 21.55, Sec. 4.)

Sec. 542.058. DELAY IN PAYMENT OF CLAIM. (a) Except as otherwise provided, if an insurer, after receiving all items, statements, and forms reasonably requested and required under Section 542.055, delays payment of the claim for a period exceeding the period specified by other applicable statutes or, if other statutes do not specify a period, for more than 60 days, the insurer shall pay damages and other items as provided by Section 542.060.

(b) This section does not apply in a case in which it is found as a result of arbitration or litigation that a claim received by an insurer is invalid and should not be paid by the insurer. (V.T.I.C. Art. 21.55, Secs. 3(f), (g).)

Sec. 542.059. EXTENSION OF DEADLINES. (a) A court may grant a request by a guaranty association for an extension of the periods under this subchapter on a showing of good cause and after reasonable notice to policyholders.

(b) In the event of a weather-related catastrophe or major natural disaster, as defined by the commissioner, the claim-handling deadlines imposed under this subchapter are extended for an additional 15 days. (V.T.I.C. Art. 21.55, Secs. 5(b) (part), (d).)

Sec. 542.060. LIABILITY FOR VIOLATION OF SUBCHAPTER. (a) If an insurer that is liable for a claim under an insurance policy is not in compliance with this subchapter, the insurer is liable to

pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

(b) If a suit is filed, the attorney's fees shall be taxed as part of the costs in the case. (V.T.I.C. Art. 21.55, Sec. 6.)

Sec. 542.061. REMEDIES NOT EXCLUSIVE. The remedies provided by this subchapter are in addition to any other remedy or procedure provided by law or at common law. (V.T.I.C. Art. 21.55, Sec. 7.)

[Sections 542.062-542.100 reserved for expansion]

SUBCHAPTER C. PROVIDING CERTAIN CLAIMS INFORMATION ON REQUEST

Sec. 542.101. REQUEST BY NAMED INSURED UNDER LIABILITY INSURANCE POLICY. (a) In this section, "liability insurance" means:

(1) general liability insurance;

(2) professional liability insurance, including medical professional liability insurance;

(3) commercial automobile liability insurance; and

(4) the liability portion of commercial multiperil insurance.

(b) On written request of a named insured under a liability insurance policy, the insurer that wrote the policy shall provide to the insured information relating to the disposition of a claim filed under the policy. The information must include:

(1) the name of each claimant;

(2) details relating to:

(A) the amount paid on the claim;

(B) settlement of the claim; or

(C) judgment on the claim;

(3) details as to how the claim, settlement, or judgment is to be paid; and

(4) any other information required by rule of the commissioner that the commissioner considers necessary to adequately inform an insured with regard to any claim under a liability insurance policy.

(c) A request for information under this section must be transmitted to the insurer not later than six months after the date of disposition of the claim. (V.T.I.C. Art. 21.59, Secs. (a), (b), (c), (f).)

Sec. 542.102. REQUEST BY POLICYHOLDER UNDER PROPERTY AND CASUALTY INSURANCE POLICY. (a) On written request of a policyholder, an insurer that writes property and casualty insurance in this state shall provide the policyholder with a list of claims charged against the policy and payments made on each claim.

(b) This section does not apply to a workers' compensation insurance policy subject to Article 5.65A. (V.T.I.C. Art. 21.59, Sec. (d).)

Sec. 542.103. DEADLINE FOR PROVIDING REQUESTED INFORMATION. (a) An insurer shall provide the information requested under this subchapter in writing not later than the 30th day after the date the insurer receives the request for the

information.

(b) For purposes of this section, information is considered to be provided on the date the information is deposited with the United States Postal Service or is personally delivered. (V.T.I.C. Art. 21.59, Sec. (e).)

Sec. 542.104. RULES. The commissioner may by rule prescribe forms for requesting information and for providing requested information under this subchapter. (V.T.I.C. Art. 21.59, Sec. (g).)

[Sections 542.105-542.150 reserved for expansion]

SUBCHAPTER D. NOTICE OF SETTLEMENT OF CLAIM UNDER CASUALTY INSURANCE POLICY

Sec. 542.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to the settlement of a claim under a casualty insurance policy that is delivered, issued for delivery, or renewed in this state, including a policy written by:

(1) a county mutual insurance company;

(2) a Lloyd's plan;

(3) an eligible surplus lines insurer; or

(4) a reciprocal or interinsurance exchange. (V.T.I.C. Art. 21.56, Sec. (a) (part).)

Sec. 542.152. EXCEPTION. This subchapter does not apply to:

(1) a casualty insurance policy that requires the insured's consent to settle a claim against the insured;

(2) fidelity, surety, or guaranty bonds; or

(3) marine insurance other than inland marine

insurance governed by Article 5.53. (V.T.I.C. Art. 21.56, Secs. (a) (part), (e).)

Sec. 542.153. NOTICE REQUIRED. (a) Not later than the 10th day after the date an initial offer to settle a claim against a named insured under a casualty insurance policy issued to the insured is made, the insurer shall notify the insured in writing of the offer.

(b) Not later than the 30th day after the date a claim against a named insured under a casualty insurance policy issued to the insured is settled, the insurer shall notify the insured in writing of the settlement. (V.T.I.C. Art. 21.56, Secs. (b), (c).)

Sec. 542.154. RULES. The commissioner may adopt rules to implement this subchapter. (V.T.I.C. Art. 21.56, Sec. (d).)

[Sections 542.155-542.200 reserved for expansion]

SUBCHAPTER E. COLLECTION FROM THIRD PARTIES UNDER CERTAIN AUTOMOBILE INSURANCE POLICIES

Sec. 542.201. PURPOSE. This subchapter is intended to encourage insurers to take appropriate and necessary steps to collect from third parties or the insurers of the third parties. (V.T.I.C. Art. 21.79G, Sec. (e) (part).)

Sec. 542.202. DEFINITION. In this subchapter, "action" includes taking various actions such as reasonable and diligent collection efforts, mediation, arbitration, and litigation against a responsible third party or the third party's insurer. (V.T.I.C. Art. 21.79G, Sec. (e) (part).)

Sec. 542.203. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any insurer that delivers, issues for delivery, or

renews in this state a private passenger automobile insurance policy, including a reciprocal or interinsurance exchange, mutual insurance company, association, Lloyd's plan, or other insurer. (V.T.I.C. Art. 21.79G, Sec. (a).)

Sec. 542.204. ACTION TO RECOVER DEDUCTIBLE. (a) Notwithstanding any other provision of this code and except as provided by Subsection (b), if an insurer is liable to an insured for a claim that is subject to a deductible payable by the insured and a third party may be liable to the insurer or the insured for the amount of the deductible, the insurer shall:

(1) take action to recover the deductible against the third party not later than the first anniversary of the date the insured's claim is paid; or

(2) pay the amount of the deductible to the insured.

(b) An insurer is not required to take action or pay the amount of the deductible as required by Subsection (a) if, not later than the earlier of the first anniversary of the date the insured's claim is paid or the 90th day before the date the statute of limitations for a negligence action expires, the insurer:

(1) notifies the insured in writing that the insurer does not intend to take further collection actions against the third party; and

(2) authorizes the insured to take further collection actions.

(c) This section applies regardless of whether the third party who may be liable for the amount of the deductible is insured or uninsured. (V.T.I.C. Art. 21.79G, Secs. (b), (c), (d).)

Sec. 542.205. ENFORCEMENT; RULES. The commissioner may enforce this subchapter and adopt and enforce reasonable rules necessary to accomplish the purposes of this subchapter. (V.T.I.C. Art. 21.79G, Sec. (f).)

CHAPTER 543. PROHIBITED PRACTICES RELATED TO POLICY OR CERTIFICATE OF MEMBERSHIP

SUBCHAPTER A. PROHIBITIONS

[Sections 543.005-543.050 reserved for expansion]

SUBCHAPTER B. ENFORCEMENT; PENALTY

CHAPTER 543. PROHIBITED PRACTICES RELATED TO POLICY OR CERTIFICATE OF MEMBERSHIP

SUBCHAPTER A. PROHIBITIONS

Sec. 543.001. MISREPRESENTATION PROHIBITED. (a) In this section, "life, health, or casualty insurer" includes a corporation operating on a cooperative or assessment plan, a mutual insurance company, a fraternal benefit society, and any other society or association authorized to issue an insurance policy in this state.

(b) A life, health, or casualty insurer, an officer,

director, agent, or representative of that insurer, or any other person, corporation, or copartnership may not:

(1) issue, circulate, or cause or permit to be issued or circulated any statement, including an illustration or estimate, that misrepresents:

(A) the terms of a policy or certificate of membership issued by a life, health, or casualty insurer;

(B) other benefits or advantages provided by the policy or certificate; or

(C) the dividends or share of surplus to be received on the policy or certificate;

(2) use a name or title of a policy, policy class, certificate of membership, or certificate class that misrepresents the policy, certificate, or class; or

(3) make a misleading representation or incomplete comparison of a policy or certificate of membership to an insured or member for the purpose of inducing or tending to induce the insured or member to forfeit, surrender, or allow the lapse of the insurance or membership.

(c) The commissioner may adopt and enforce reasonable rules as provided by Subchapter I, Chapter 541, to accomplish the purposes of Subsection (b)(1) as those purposes relate to life insurance companies. (V.T.I.C. Art. 21.20; Art. 21.21, Sec. 13 (part); Art. 21.21A, Sec. 2.)

Sec. 543.002. CONTRACT EXPRESSED IN POLICY ONLY. An insurer or an agent of an insurer may not make an insurance contract or an agreement relating to an insurance contract other than as

expressed in the policy issued in connection with the contract. (V.T.I.C. Art. 21.21A, Sec. 1 (part).)

Sec. 543.003. THING OF VALUE NOT SPECIFIED IN POLICY. An insurer or an officer, agent, or representative of an insurer may not:

(1) directly or indirectly pay, allow, or give or offer to pay, allow, or give as an inducement to insurance a thing of value or other inducement that is not specified in the policy, including:

(A) a rebate of premium payable on the policy;

(B) a special favor or advantage in the dividends or other benefits to accrue on the policy; or

(C) paid employment or a contract for service; or

(2) give, sell, or purchase or offer to give, sell, or purchase as an inducement to insurance or in connection with insurance a thing of value that is not specified in the policy, including:

(A) stocks, bonds, or other securities of an insurer or other corporation, association, or partnership; or

(B) dividends or profits to accrue on the stocks, bonds, or other securities of an insurer or other corporation, association, or partnership. (V.T.I.C. Art. 21.21A, Sec. 1 (part).)

Sec. 543.004. SHARING OF OR PARTICIPATION IN SPECIAL FUND PROHIBITED. An insurer or an officer, agent, or representative of an insurer may not issue a policy that contains a special or board contract or similar provision by the terms of which the policy will

share or participate in a special fund derived from a tax or a charge against any portion of the premium on another policy. (V.T.I.C. Art. 21.21A, Sec. 1 (part).)

[Sections 543.005-543.050 reserved for expansion]

SUBCHAPTER B. ENFORCEMENT; PENALTY

Sec. 543.051. SUSPENSION OR REVOCATION OF CERTIFICATE, CHARTER, PERMIT, OR LICENSE. (a) On a hearing, the commissioner may suspend or revoke the certificate, charter, permit, or license to engage in the business of insurance of a society, association, corporation, or person that violates Subchapter A.

(b) The commissioner must give 10 days' notice of the hearing by certified mail to the society, association, corporation, or person. (V.T.I.C. Art. 21.21A, Sec. 4.)

Sec. 543.052. CRIMINAL PENALTY. (a) A person commits an offense if the person violates Subchapter A.

(b) An offense under this section is a Class A misdemeanor.

(c) The penalty provided by this section is in addition to any other penalty specifically provided by law. (V.T.I.C. Art. 21.21A, Sec. 3.)

CHAPTER 544. PROHIBITED DISCRIMINATION

SUBCHAPTER A. GENERAL PROHIBITIONS AGAINST DISCRIMINATION BY AN INSURER OR HEALTH MAINTENANCE ORGANIZATION

Sec. 544.001. APPLICABILITY OF SUBCHAPTER

Sec. 544.002. UNFAIR DISCRIMINATION

Sec. 544.003. EXCEPTIONS

Sec. 544.004. ENFORCEMENT ACTIONS

[Sections 544.005-544.050 reserved for expansion]

Sec. 544.204. PAYMENT FOR DISEASE NOT REQUIRED

[Sections 544.205-544.250 reserved for expansion]

SUBCHAPTER F. CHURCH PROPERTY

Sec. 544.251. DEFINITIONS

Sec. 544.252. APPLICABILITY OF SUBCHAPTER

Sec. 544.253. PROHIBITION

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CHAPTER 544. PROHIBITED DISCRIMINATION

SUBCHAPTER A. GENERAL PROHIBITIONS AGAINST DISCRIMINATION BY AN INSURER OR HEALTH MAINTENANCE ORGANIZATION

Sec. 544.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies to:

(1) any legal entity engaged in the business of insurance in this state, including:

(A) a capital stock insurance company;

(B) a mutual insurance company;

(C) a title insurance company;

(D) a fraternal benefit society;

(E) a local mutual aid association;

(F) a statewide mutual assessment company;

(G) a county mutual insurance company;

(H) a Lloyd's plan;

(I) a reciprocal or interinsurance exchange;

(J) a stipulated premium company;

(K) a group hospital service corporation;

(L) a farm mutual insurance company;

(M) a risk retention group;

(N) an eligible surplus lines insurer; and

(O) an agent, broker, adjuster, or life and health insurance counselor; and

(2) a health maintenance organization. (V.T.I.C. Art. 21.21-6, Sec. 2, as added Acts 74th Leg., R.S., Ch. 415.)

Sec. 544.002. UNFAIR DISCRIMINATION. (a) A person may not refuse to insure or provide coverage to an individual, refuse to continue to insure or provide coverage to an individual, limit the amount, extent, or kind of coverage available for an individual, or charge an individual a rate that is different from the rate charged to other individuals for the same coverage because of the individual's:

(1) race, color, religion, or national origin;

(2) age, gender, marital status, or geographic location; or

(3) disability or partial disability.

(b) Subsection (a)(2) does not prohibit an insurer or health maintenance organization from considering marital status in defining persons eligible for dependent benefits.

(c) Subsection (a) does not prevent requirements to provide title insurance coverage relating to possible community, homestead, or other marital rights in land. (V.T.I.C. Art. 21.21-6, Secs. 1, 3, 4(e) (part), as added Acts 74th Leg., R.S., Ch. 415.)

Sec. 544.003. EXCEPTIONS. (a) A person does not violate Section 544.002 by providing coverage only to persons who are required to obtain or maintain membership or qualification for

membership in a club, group, or organization to be eligible for coverage if:

(1) the requirements are uniform requirements of the insurer or health maintenance organization as a condition of providing coverage and are applied uniformly throughout this state; and

(2) the person does not engage in an act prohibited under Section 544.002 against a qualified member, except as provided by this section.

(b) A person does not violate Section 544.002(a)(2) or (3) if the refusal, limitation, or charge is based on sound underwriting or actuarial principles reasonably related to actual or anticipated loss experience. For the purposes of this subsection, a refusal, limitation, or charge relating to title insurance is based on sound actuarial principles if the action is based on an examination of title or on closing the transaction.

(c) A person does not violate Section 544.002 if the refusal, limitation, or charge is required or authorized by law or a regulatory mandate.

(d) A person does not violate Section 544.002 if policyholders or enrollees with similar expense factors but different loss exposures are charged different premiums or rates under a mass marketing plan. The commissioner by rule shall define selected groups eligible for issuance of policies or evidences of coverage under a mass marketing plan. (V.T.I.C. Art. 21.21-6, Secs. 4(a), (b), (c), (d), (e) (part), as added Acts 74th Leg., R.S., Ch. 415.)

Sec. 544.004. ENFORCEMENT ACTIONS. (a) A legal entity engaged in the business of insurance or a health maintenance organization, that is found to be in violation of or to have failed to comply with this subchapter, is subject to the sanctions provided by Chapter 82, including administrative penalties authorized under Chapter 84.

(b) In addition to the procedures provided by Subsection (a), the commissioner may use the cease and desist procedures authorized by Chapter 83. (V.T.I.C. Art. 21.21-6, Sec. 5, as added Acts 74th Leg., R.S., Ch. 415.)

[Sections 544.005-544.050 reserved for expansion]

SUBCHAPTER B. OTHER GENERAL PROHIBITIONS AGAINST DISCRIMINATION BY INSURERS

Sec. 544.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any individual, corporation, association, partnership, or other legal entity engaged in the business of insurance, including:

(1) a fraternal benefit society;

(2) a county mutual insurance company;

(3) a Lloyd's plan;

(4) a reciprocal or interinsurance exchange;

(5) a farm mutual insurance company; and

(6) an agent, broker, adjuster, or life and health insurance counselor. (V.T.I.C. Art. 21.21-8, Sec. 1.)

Sec. 544.052. UNFAIR DISCRIMINATION. A person may not in any manner engage in unfair discrimination or permit unfair discrimination between individuals of the same class and of

essentially the same hazard, including unfair discrimination in:

(1) the amount of premium, policy fees, or rates charged for a policy or contract of insurance;

(2) the benefits payable under a policy or contract of insurance; or

(3) any of the terms or conditions of a policy or contract of insurance. (V.T.I.C. Art. 21.21-8, Sec. 2.)

Sec. 544.053. EXCEPTIONS. (a) A person does not violate Section 544.052 if the refusal to insure or to continue to insure, the limiting of the amount, extent, or kind of coverage, or the charging of an individual a rate that is different from the rate charged another individual for the same coverage is based on sound actuarial principles.

(b) A person does not violate Section 544.052 by providing insurance coverage only to persons who are required to obtain or maintain membership or qualification for membership in a club, group, or organization to be eligible for coverage if:

(1) the requirements are uniform requirements of the insurer as a condition of providing insurance and are applied uniformly throughout this state; and

(2) the person does not engage in an act prohibited under Section 544.052 against a qualified member, except as provided by this section. (V.T.I.C. Art. 21.21-8, Secs. 4, 5.)

Sec. 544.054. JUDICIAL ACTION; AWARD BY COURT. (a) A person who has sustained economic damages as the result of a violation of Section 544.052 may maintain only in a Travis County district court an action against the person who violated that

section.

(b) An action under this section must be commenced before the first anniversary of the date on which the plaintiff was denied insurance or the unfair act occurred.

(c) A plaintiff who prevails in an action under this section may obtain:

(1) the amount of economic damages, court costs, and attorney's fees; and

(2) an order enjoining the violation.

(d) Court costs under Subsection (c) may include any reasonable and necessary expert witness fees.

(e) If the trier of fact finds that the defendant knowingly committed an act prohibited by Section 544.052, the court may award a civil penalty in an amount of not more than $25,000 for each claimant.

(f) The court shall award the defendant reasonable and necessary attorney's fees if the court finds that an action under this section was:

(1) groundless; and

(2) brought in bad faith or for the purpose of harassment. (V.T.I.C. Art. 21.21-8, Sec. 3.)

[Sections 544.055-544.100 reserved for expansion]

SUBCHAPTER C. ENGLISH FLUENCY

Sec. 544.101. DEFINITIONS. In this subchapter:

(1) "Health benefit plan issuer" means an insurance company, association, organization, group hospital service corporation, or health maintenance organization that delivers or

issues for delivery an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage that provides health insurance or health care benefits. The term includes:

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

(B) a general casualty insurance company operating under Chapter 861;

(C) a fraternal benefit society operating under Chapter 885;

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

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

(F) a statewide mutual assessment company operating under Chapter 881;

(G) a mutual assessment company or mutual assessment life, health, and accident association operating under Chapter 887;

(H) a mutual insurance company operating under Chapter 883 that writes coverage other than life insurance;

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

(J) a reciprocal exchange operating under Chapter 942; and

(K) a stipulated premium company operating under Chapter 884.

(2) "Underwriting guideline" means a written,

electronic, or oral rule, standard, marketing decision, or practice that is used by a health benefit plan issuer or an agent of a health benefit plan issuer to examine, bind, accept, reject, renew or refuse to renew, cancel, or limit coverages available to classes of consumers or charge a different rate for the same coverage. (V.T.I.C. Art. 21.21-7, Sec. 1.)

Sec. 544.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any health insurance policy, agreement, contract, or evidence of coverage delivered or issued for delivery by a health benefit plan issuer. (V.T.I.C. Art. 21.21-7, Sec. 2.)

Sec. 544.103. PROHIBITION ON USE OF CERTAIN GUIDELINES. (a) A health benefit plan issuer may not use an underwriting guideline that is based on:

(1) the ability of an insured or enrollee or an applicant for insurance coverage or health care benefits to speak English fluently; or

(2) the literacy in English of the insured, enrollee, or applicant.

(b) An applicant has the burden of proof to establish a violation of this subchapter. (V.T.I.C. Art. 21.21-7, Sec. 3.)

[Sections 544.104-544.150 reserved for expansion]

SUBCHAPTER D. FAMILY VIOLENCE

Sec. 544.151. DEFINITION. In this subchapter, "family violence" means an act between individuals who reside together or resided together in which one individual:

(1) wilfully attempts to cause bodily injury, or wilfully or wantonly causes bodily injury, to another;

(2) wilfully by physical threat places another in fear of imminent bodily injury;

(3) engages in the act of sexual intercourse with a minor under 16 years of age who is not the spouse of the individual; or

(4) engages, with the intent to arouse or to satisfy the sexual desires of the individual, a minor under 16 years of age who is not the spouse of the individual, or both the individual and the minor, in any lewd fondling or touching of the individual or the minor. (V.T.I.C. Art. 21.21-5, Sec. 1.)

Sec. 544.152. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to:

(1) a life insurer that delivers, issues for delivery, or renews a life insurance contract or policy in this state, including a group contract, policy, or certificate of life insurance; and

(2) a health benefit plan issuer that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885;

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

(E) a health benefit plan issuer under Chapter

1501;

(F) a health maintenance organization operating under Chapter 843;

(G) an employer under a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002), or an analogous benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(H) an issuer of a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss); and

(I) an approved nonprofit health corporation that holds a certificate of authority issued under Chapter 844.

(b) This subchapter does not apply to the issuer of:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) only for limited benefits; or

(F) only for dental or vision care;

(2) hospital confinement indemnity coverage;

(3) a credit insurance policy;

(4) workers' compensation insurance coverage;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a)(2). (V.T.I.C. Art. 21.21-5, Sec. 2.)

Sec. 544.153. PROHIBITIONS. (a) A health benefit plan issuer or life insurer may not, because of an individual's status as a victim of family violence:

(1) deny coverage to the individual;

(2) refuse to renew the individual's coverage;

(3) cancel the individual's coverage;

(4) limit the amount, extent, or kind of coverage available to the individual; or

(5) charge the individual or a group to which the individual belongs a rate that is different from the rate charged to other individuals or groups, respectively, for the same coverage.

(b) A health benefit plan issuer or life insurer may not, as a part of an application for coverage, require an applicant to reveal whether the applicant has been or may become a victim of family violence. (V.T.I.C. Art. 21.21-5, Sec. 3.)

Sec. 544.154. CONFIDENTIALITY OF CERTAIN INFORMATION. (a) Except as provided by Subsection (b), a health benefit plan issuer, life insurer, or person employed by or under contract with a health benefit plan issuer or life insurer may not release information relating to the status as a victim of family violence of an

individual who is clearly a victim of family violence, including:

(1) information about specific acts of family violence directed at the individual;

(2) the individual's address or telephone number at home or at work; and

(3) information about the individual's employment, associations, family membership, or relationships.

(b) A health benefit plan issuer or life insurer may release information to which Subsection (a) applies only:

(1) to the individual;

(2) to another individual designated in writing by the individual;

(3) to a licensed physician designated by the individual;

(4) to a physician or other health care provider for the provision of health care services;

(5) to an attorney who needs the information to effectively represent the issuer or insurer, if the issuer or insurer notifies the attorney of the requirements of this subchapter and requests that the attorney exercise due diligence to protect the information consistent with the attorney's obligation to represent the issuer or insurer;

(6) to an individual covered under, or the owner of, the health benefit plan or life insurance contract or policy that contains information about status as a victim of family violence;

(7) to an individual or entity to whom the commissioner considers the release appropriate;

(8) as required by other law or an order of the commissioner or a court; or

(9) as necessary for a valid business purpose if:

(A) the information cannot be segregated from other information about the individual without undue hardship to the issuer or insurer;

(B) the recipient of the information is:

(i) a reinsurer that seeks to indemnify or indemnifies all or part of a health benefit plan or life insurance contract or policy covering the individual if the reinsurer cannot underwrite or satisfy obligations under the reinsurance agreement without the release of the information;

(ii) a party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the issuer or insurer;

(iii) medical or claims personnel under contract with the issuer or insurer, including a parent or affiliate company under a service agreement with the issuer or insurer, if the release of the information is necessary to process an application, to perform duties under the health benefit plan or life insurance contract or policy, or to protect the safety or privacy of a victim of family violence; or

(iv) an entity with which the issuer transacts business if the information is only the address or telephone number of the individual and the entity cannot transact the business without the address or telephone number; and

(C) the recipient of the information agrees in

writing to be subject to the requirements of this subchapter. (V.T.I.C. Art. 21.21-5, Sec. 8.)

Sec. 544.155. UNDERWRITING CRITERIA. Notwithstanding any other provision of this subchapter, a health benefit plan issuer or life insurer may underwrite a risk on the basis of an individual's physical or mental condition regardless of the underlying cause of the condition or on the basis of any underwriting criteria not prohibited by this code or another insurance law of this state or a rule adopted under this code or another insurance law of this state if the issuer or insurer consistently applies the criteria and does not merely use the criteria as a pretext to evade the application of Section 544.153. (V.T.I.C. Art. 21.21-5, Sec. 6.)

Sec. 544.156. HEALTH BENEFIT PLAN ISSUER OR LIFE INSURER NOT LIABLE FOR DEATH OR BODILY INJURY. A health benefit plan issuer or life insurer that delivers, issues for delivery, or renews a health benefit plan or a life insurance policy or contract for an individual who has been or may become a victim of family violence may not be held civilly or criminally liable for the death of or bodily injuries incurred by that individual as a result of family violence. (V.T.I.C. Art. 21.21-5, Sec. 5.)

Sec. 544.157. RIGHT TO CONTINUED COVERAGE UNAFFECTED. This subchapter does not affect the right of an individual to continued coverage under Subchapter G, Chapter 1251. (V.T.I.C. Art. 21.21-5, Sec. 7.)

Sec. 544.158. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A violation of this subchapter is an unfair or deceptive act or practice under Chapter 541. (V.T.I.C. Art. 21.21-5, Sec. 4.)

[Sections 544.159-544.200 reserved for expansion]

SUBCHAPTER E. FIBROCYSTIC BREAST CONDITION

Sec. 544.201. DEFINITION. In this subchapter, "health benefit plan issuer" means an insurer, a group hospital service corporation operating under Chapter 842, or a health maintenance organization operating under Chapter 843 that delivers or issues for delivery or renews any health insurance policy or contract in this state, including a group policy, contract, or certificate of health insurance or evidence of coverage. (V.T.I.C. Art. 21.21-6, Sec. (a), as added Acts 74th Leg., R.S., Ch. 522.)

Sec. 544.202. PROHIBITION. A health benefit plan issuer may not, solely or in part because an individual has been diagnosed with or has a history of a fibrocystic breast condition:

(1) deny coverage to the individual;

(2) refuse to renew the individual's coverage;

(3) cancel the individual's coverage;

(4) limit the amount, extent, or kind of coverage available to the individual for any other breast condition; or

(5) charge the individual or a group to which the individual belongs a rate that is different from the rate charged to other individuals or groups, respectively, for the same coverage. (V.T.I.C. Art. 21.21-6, Sec. (b), as added Acts 74th Leg., R.S., Ch. 522.)

Sec. 544.203. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A violation of this subchapter is an unfair or deceptive act or practice under Chapter 541. (V.T.I.C. Art. 21.21-6, Sec. (c), as added Acts 74th Leg., R.S., Ch. 522.)

Sec. 544.204. PAYMENT FOR DISEASE NOT REQUIRED. This subchapter does not require a health benefit plan issuer to pay benefits for fibrocystic breast disease. (V.T.I.C. Art. 21.21-6, Sec. (d), as added Acts 74th Leg., R.S., Ch. 522.)

[Sections 544.205-544.250 reserved for expansion]

SUBCHAPTER F. CHURCH PROPERTY

Sec. 544.251. DEFINITIONS. In this subchapter:

(1) "Church" means a facility that is owned by a religious organization and is used primarily for religious services.

(2) "Religious organization" means a church, synagogue, or other organization or association organized primarily for religious purposes. (V.T.I.C. Art. 21.21-9, Sec. 1, as added Acts 75th Leg., R.S., Ch. 1007.)

Sec. 544.252. APPLICABILITY OF SUBCHAPTER. This subchapter applies to an insurer that is admitted to engage in the business of insurance and authorized to write an insurance policy providing coverage for losses resulting from fire in this state, including a county mutual insurance company, a Lloyd's plan, a reciprocal or interinsurance exchange, or a farm mutual insurance company. (V.T.I.C. Art. 21.21-9, Sec. 2, as added Acts 75th Leg., R.S., Ch. 1007.)

Sec. 544.253. PROHIBITION. An insurer writing insurance for a church may not cancel or decline to renew an insurance policy solely because of:

(1) an occurrence of arson against the church, if the religious organization that owns the church cooperated with police,

fire, and other authorities in the investigation of the arson and in the prosecution of those responsible for the arson; or

(2) a verbal or written threat of arson against the church that was directed to the religious organization or an official of the religious organization and that the organization or official reported to the appropriate law enforcement agency within a reasonable amount of time. (V.T.I.C. Art. 21.21-9, Sec. 3, as added Acts 75th Leg., R.S., Ch. 1007.)

Sec. 544.254. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A violation of this subchapter is an unfair or deceptive act or practice in the business of insurance under Chapter 541. (V.T.I.C. Art. 21.21-9, Sec. 4, as added Acts 75th Leg., R.S., Ch. 1007.)

CHAPTER 545. HIV TESTING

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 545.004-545.050 reserved for expansion]

SUBCHAPTER B. ISSUER POWERS AND DUTIES

[Sections 545.058-545.700 reserved for expansion]

SUBCHAPTER O. SANCTIONS; PENALTIES; INJUNCTIONS

Sec. 545.701. SANCTIONS

Sec. 545.702. CIVIL ACTION; PENALTY

Sec. 545.703. CRIMINAL PENALTY

CHAPTER 545. HIV TESTING

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 545.001. DEFINITIONS. In this chapter:

(1) "AIDS" has the meaning assigned by Section 81.101, Health and Safety Code.

(2) "Applicant" means an individual who applies to an issuer for coverage.

(3) "HIV" has the meaning assigned by Section 81.101, Health and Safety Code.

(4) "Issuer" means a person who delivers, issues for delivery, or renews coverage in this state, including a group policy, contract, or certificate of health insurance or evidence of coverage delivered, issued for delivery, or renewed in this state by an insurer, including a group hospital service corporation operating under Chapter 842, or by a health maintenance organization operating under Chapter 843.

(5) "Test result" means a statement:

(A) that an identifiable individual is positive, negative, at risk, or has or does not have a certain level of antigen or antibody; or

(B) that indicates that an identifiable individual has or has not been tested for AIDS or HIV infection,

antibodies to HIV, or infection with any other probable causative agent of AIDS. (V.T.I.C. Art. 21.21-4, Sec. (a); New.)

Sec. 545.002. EXCLUSIVE APPLICABILITY. This chapter and rules adopted under this chapter exclusively govern the practices of an issuer in testing applicants to determine or help determine if an applicant has:

(1) AIDS or HIV infection;

(2) antibodies to HIV; or

(3) an infection with any other probable causative agent of AIDS. (V.T.I.C. Art. 21.21-4, Sec. (p).)

Sec. 545.003. RULES. The commissioner may adopt:

(1) reasonable rules and forms necessary to implement this chapter; and

(2) rules to be followed for an HIV-related test requested or required by an issuer. (V.T.I.C. Art. 21.21-4, Sec. (i).)

[Sections 545.004-545.050 reserved for expansion]

SUBCHAPTER B. ISSUER POWERS AND DUTIES

Sec. 545.051. HIV-RELATED TESTING AUTHORIZED. An issuer may request or require an applicant to take an HIV-related test in connection with the application. (V.T.I.C. Art. 21.21-4, Sec. (b) (part).)

Sec. 545.052. NONDISCRIMINATORY BASIS REQUIRED. (a) An issuer that requests or requires applicants to take an HIV-related test must request or require the test on a nondiscriminatory basis.

(b) An issuer may require an applicant to take an HIV-related test only if:

(1) the test is based on the applicant's current medical condition or medical history; or

(2) underwriting guidelines for the coverage amounts require all applicants in the risk class to be tested.

(c) In determining who will be requested or required to take an HIV-related test, an issuer may not use the marital status, occupation, sex, beneficiary designation, or territorial classification, including zip code, of an applicant. (V.T.I.C. Art. 21.21-4, Secs. (b) (part), (h).)

Sec. 545.053. EXPLANATION AND AUTHORIZATION REQUIRED. (a) An issuer that requests or requires an applicant to take an HIV-related test in connection with an application must:

(1) provide an explanation to the applicant, or another person legally authorized to consent to the test, of how the test will be used; and

(2) obtain a written authorization from the person to whom the explanation is provided.

(b) The authorization must:

(1) be on a form adopted by the commissioner; and

(2) be separate from any other document presented to the applicant or other person legally authorized to consent to the test. (V.T.I.C. Art. 21.21-4, Sec. (c).)

Sec. 545.054. INQUIRIES REGARDING PREVIOUS TESTS. (a) An issuer may inquire whether an applicant has:

(1) tested positive on an HIV-related test; or

(2) been diagnosed with HIV or AIDS.

(b) An issuer may not inquire whether an applicant has been

tested for or has received a negative result from a specific test for:

(1) exposure to HIV; or

(2) a sickness or a medical condition derived from infection with HIV. (V.T.I.C. Art. 21.21-4, Sec. (d).)

Sec. 545.055. NOTICE OF POSITIVE TEST RESULT; FEE. (a) An applicant must be given written notice of a positive HIV-related test result by:

(1) a physician designated by the applicant; or

(2) the Texas Department of Health, if the applicant has not designated a physician.

(b) The Texas Department of Health by rule may set a fee, not to exceed $25, to cover the cost of giving written notice under this section. (V.T.I.C. Art. 21.21-4, Sec. (f).)

Sec. 545.056. ADVERSE UNDERWRITING DECISION; TEST PROTOCOL RULES. An issuer may not make an adverse underwriting decision based on a positive HIV-related test unless a test protocol established by commissioner rule is followed. (V.T.I.C. Art. 21.21-4, Sec. (g).)

Sec. 545.057. CONFIDENTIALITY OF TEST RESULT REQUIRED. (a) An HIV-related test result is confidential.

(b) An issuer may not release or disclose the test result or otherwise allow the test result to become known except as:

(1) required by law; or

(2) requested or authorized in writing by the applicant or a person legally authorized to consent to the test on the applicant's behalf.

(c) A test result released under Subsection (b)(2) may be released only to:

(1) the applicant;

(2) a person legally authorized to consent to the test;

(3) a licensed physician, medical practitioner, or other person designated by the applicant;

(4) an insurance medical information exchange under procedures designed to ensure confidentiality, including the use of general codes that cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular applicant;

(5) a reinsurer, if the reinsurer is involved in the underwriting process, under procedures designed to ensure confidentiality;

(6) persons within the issuer's organization who have the responsibility to make underwriting decisions for the issuer; or

(7) outside legal counsel that needs the information to effectively represent the issuer regarding the applicant. (V.T.I.C. Art. 21.21-4, Sec. (e).)

[Sections 545.058-545.700 reserved for expansion]

SUBCHAPTER O. SANCTIONS; PENALTIES; INJUNCTIONS

Sec. 545.701. SANCTIONS. The commissioner may impose sanctions under Chapter 82 on an issuer that violates this chapter. (V.T.I.C. Art. 21.21-4, Sec. (q).)

Sec. 545.702. CIVIL ACTION; PENALTY. (a) A person who is injured by a violation of Section 545.057 may bring a civil action for damages.

(b) A person may bring an action to restrain a violation or threatened violation of Section 545.057.

(c) If it is found in a civil action that a person or entity has released or disclosed a test result or allowed a test result to become known in violation of Section 545.057, the person or entity is liable for:

(1) actual damages;

(2) a civil penalty of:

(A) not more than $1,000 if the release or disclosure was negligent; or

(B) not less than $1,000 or more than $5,000 if the release or disclosure was wilful; and

(3) court costs and reasonable attorney's fees incurred by the person bringing the action.

(d) A defendant in a civil action brought under this section is not entitled to claim a privilege as a defense to the action. (V.T.I.C. Art. 21.21-4, Secs. (j), (k), (l), (o).)

Sec. 545.703. CRIMINAL PENALTY. (a) A person or entity commits an offense if the person or entity, with criminal negligence, violates Section 545.057 by:

(1) releasing or disclosing a test result or other information; or

(2) allowing a test result or other information to become known.

(b) An offense under this section is a Class A misdemeanor.

(c) Each release or disclosure made or allowance of a test result to become known in violation of this chapter constitutes a separate offense. (V.T.I.C. Art. 21.21-4, Secs. (m), (n).)

CHAPTER 546. USE OF GENETIC TESTING INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 546.001. DEFINITIONS

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CHAPTER 546. USE OF GENETIC TESTING INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 546.001. DEFINITIONS. In this chapter:

(1) "DNA" means deoxyribonucleic acid.

(2) "Genetic characteristic" means a scientifically or medically identifiable genetic or chromosomal variation, composition, or alteration that predisposes an individual to a disease, disorder, or syndrome.

(3) "Genetic information" means information that is:

(A) obtained from or based on a scientific or medical determination of the presence or absence in an individual of a genetic characteristic; or

(B) derived from the results of a genetic test performed on an individual.

(4) "Genetic test" means a presymptomatic laboratory test of an individual's genes, gene products, or chromosomes that:

(A) analyzes the individual's DNA, RNA, proteins, or chromosomes; and

(B) is performed to identify any genetic variation, composition, or alteration that is associated with the individual's having a predisposition for:

(i) developing a clinically recognized disease, disorder, or syndrome; or

(ii) being a carrier of a clinically recognized disease, disorder, or syndrome.

The term does not include a blood test, cholesterol test, urine test, or other physical test used for a purpose other than determining a genetic or chromosomal variation, composition, or alteration in a specific individual; a routine physical examination or a routine test performed as part of a physical examination; a test to determine drug use; or a test to determine the presence of the human immunodeficiency virus.

(5) "RNA" means ribonucleic acid. (V.T.I.C. Art. 21.73, Secs. 1(1), (2), (3), (4), (6).)

Sec. 546.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee

Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a group health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act;

(ii) another entity not authorized under this code or another insurance law of this state that directly contracts for health care services on a risk-sharing basis, including a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.73, Sec. 2(a).)

Sec. 546.003. EXCEPTIONS. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to liability insurance;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) workers' compensation insurance coverage;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care policy, including a nursing home

fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a group health benefit plan as described by Section 546.002. (V.T.I.C. Art. 21.73, Sec. 2(b).)

[Sections 546.004-546.050 reserved for expansion]

SUBCHAPTER B. GENETIC TESTING AND USE OF TEST RESULTS

Sec. 546.051. CERTAIN TESTING PERMITTED; INDUCEMENT PROHIBITED. (a) A group health benefit plan issuer that requests an applicant for coverage under the plan to submit to a genetic test in connection with the application for coverage for a purpose not prohibited under Section 546.052 must:

(1) notify the applicant that the test is required;

(2) disclose to the applicant the proposed use of the test results; and

(3) obtain the applicant's written informed consent before the test is administered.

(b) The applicant shall state in the consent form whether the applicant elects to be informed of the test results. If the applicant elects to be informed, the person or entity that performs the test shall disclose the test results to the applicant and the group health benefit plan issuer. The issuer shall ensure that:

(1) the applicant receives an interpretation of the test results made by a qualified health care practitioner; and

(2) a physician or other health care practitioner designated by the applicant receives a copy of the test results.

(c) A group health benefit plan issuer may not use the results of a genetic test conducted in accordance with Subsection

(a) to induce the purchase of coverage under the plan. (V.T.I.C. Art. 21.73, Secs. 3(b), (c), (d).)

Sec. 546.052. IMPROPER USE OF TEST RESULTS; REFUSAL TO SUBMIT TO TESTING. A group health benefit plan issuer may not use genetic information or the refusal of an applicant to submit to a genetic test to reject, deny, limit, cancel, refuse to renew, increase the premiums for, or otherwise adversely affect eligibility for or coverage under the plan. (V.T.I.C. Art. 21.73, Secs. 3(a), (e).)

Sec. 546.053. TESTING RELATED TO PREGNANCY. (a) In this section, "coerce" means to restrain or dominate a woman's free will by actual or implied:

(1) force; or

(2) threat of rejecting, denying, limiting, canceling, refusing to renew, or otherwise adversely affecting eligibility for coverage under a group health benefit plan.

(b) A group health benefit plan issuer may not:

(1) require as a condition of coverage genetic testing of a child in utero without the pregnant woman's consent; or

(2) use genetic information to coerce or compel a pregnant woman to have an induced abortion. (V.T.I.C. Art. 21.73, Sec. 8.)

Sec. 546.054. DESTRUCTION OF SAMPLE MATERIAL; EXCEPTIONS. A sample of genetic material obtained from an individual for a genetic test shall be destroyed promptly after the purpose for which the sample was obtained is accomplished unless:

(1) the sample is retained under a court order;

(2) the individual authorizes retention of the sample for medical treatment or scientific research;

(3) the sample was obtained for research that is cleared by an institutional review board and retention of the sample is:

(A) under a requirement the institutional review board imposes on a specific research project; or

(B) authorized by the research participant with institutional review board approval under federal law; or

(4) the sample was obtained for a screening test established by the Texas Department of Health under Section 33.011, Health and Safety Code, and performed by that department or a laboratory approved by that department. (V.T.I.C. Art. 21.73, Sec. 6.)

[Sections 546.055-546.100 reserved for expansion]

SUBCHAPTER C. DISCLOSURE OF GENETIC INFORMATION; CONFIDENTIALITY; EXCEPTIONS

Sec. 546.101. DISCLOSURE OF TEST RESULTS TO INDIVIDUAL TESTED. (a) An individual who submits to a genetic test has the right to know the results of the test. On the written request by the individual, the group health benefit plan issuer or other entity that performed the test shall disclose the test results to:

(1) the individual; or

(2) a physician designated by the individual.

(b) The right to receive information under this section is in addition to any right or requirement established under Sections 546.051 and 546.052. (V.T.I.C. Art. 21.73, Sec. 5.)

Sec. 546.102. CONFIDENTIALITY OF GENETIC INFORMATION. (a) Except as provided by Sections 546.103(a) and (b), genetic information is confidential and privileged regardless of the source of the information.

(b) A person or entity that holds genetic information about an individual may not disclose or be compelled to disclose, by subpoena or otherwise, that information unless the disclosure is specifically authorized by the individual as provided by Section 546.104.

(c) This section applies to a redisclosure of genetic information by a secondary recipient of the information after disclosure of the information by an initial recipient. Except as provided by Section 546.103(b), a group health benefit plan issuer may not redisclose genetic information unless the redisclosure is consistent with the disclosures authorized by the tested individual under an authorization executed under Section 546.104. (V.T.I.C. Art. 21.73, Secs. 4(a), (d) (part).)

Sec. 546.103. EXCEPTIONS TO CONFIDENTIALITY. (a) Subject to Subchapter G, Chapter 411, Government Code, genetic information may be disclosed without an authorization under Section 546.104 if the disclosure is:

(1) authorized under a state or federal criminal law relating to:

(A) the identification of individuals; or

(B) a criminal or juvenile proceeding, an inquest, or a child fatality review by a multidisciplinary child-abuse team;

(2) required under a specific order of a state or federal court;

(3) for the purpose of establishing paternity as authorized under a state or federal law;

(4) made to provide genetic information relating to a decedent and the disclosure is made to the blood relatives of the decedent for medical diagnosis; or

(5) made to identify a decedent.

(b) A group health benefit plan issuer may redisclose genetic information without an authorization under Section 546.104:

(1) for actuarial or research studies if:

(A) a tested individual could not be identified in any actuarial or research report; and

(B) any materials that identify a tested individual are returned or destroyed as soon as reasonably practicable;

(2) to the department for the purpose of enforcing this chapter; or

(3) for a purpose directly related to enabling a business decision to be made about:

(A) purchasing, transferring, merging, or selling all or part of an insurance business; or

(B) obtaining reinsurance affecting that insurance business.

(c) A redisclosure authorized under Subsection (b) may contain only information reasonably necessary to accomplish the

purpose for which the information is disclosed. (V.T.I.C. Art. 21.73, Secs. 4(c), (d) (part), (e).)

Sec. 546.104. AUTHORIZED DISCLOSURE. An individual or an individual's legal representative may authorize disclosure of genetic information relating to the individual by an authorization that:

(1) is written in plain language;

(2) is dated;

(3) contains a specific description of the information to be disclosed;

(4) identifies or describes each person authorized to disclose the genetic information to a group health benefit plan issuer;

(5) identifies or describes the individuals or entities to whom the disclosure or subsequent redisclosure of the genetic information may be made;

(6) describes the specific purpose of the disclosure;

(7) is signed by the individual or legal representative and, if the disclosure is made to claim proceeds of an affected life insurance policy, the claimant; and

(8) advises the individual or legal representative that the individual's authorized representative is entitled to receive a copy of the authorization. (V.T.I.C. Art. 21.73, Sec. 4(b).)

[Sections 546.105-546.150 reserved for expansion]

SUBCHAPTER D. ENFORCEMENT

Sec. 546.151. CEASE AND DESIST ORDER. (a) On a finding by

the commissioner that a group health benefit plan issuer is in violation of this chapter, the commissioner may issue a cease and desist order in the manner provided by Chapter 83.

(b) If a group health benefit plan issuer refuses or fails to comply with a cease and desist order issued under this section, the commissioner may, in the manner provided by this code and other insurance laws of this state, revoke or suspend the issuer's certificate of authority or other authorization to operate a group health benefit plan in this state. (V.T.I.C. Art. 21.73, Sec. 7(a).)

Sec. 546.152. ADMINISTRATIVE PENALTY. A group health benefit plan issuer that operates a plan in violation of this chapter is subject to an administrative penalty as provided by Chapter 84. (V.T.I.C. Art. 21.73, Sec. 7(b).)

CHAPTER 547. FALSE ADVERTISING BY UNAUTHORIZED INSURERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 547.001. DEFINITIONS

Sec. 547.002. CONSTRUCTION OF CHAPTER

[Sections 547.003-547.050 reserved for expansion]

SUBCHAPTER B. PROHIBITION; ENFORCEMENT

Sec. 547.051. ACTS PROHIBITED

Sec. 547.052. NOTICE OF VIOLATION TO INSURER'S DOMICILIARY STATE

Sec. 547.053. ENFORCEMENT ACTION

CHAPTER 547. FALSE ADVERTISING BY UNAUTHORIZED INSURERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 547.001. DEFINITIONS. In this chapter:

(1) "Alien or foreign insurer" means an insurance company organized under the laws of:

(A) a country other than the United States; or

(B) a state of the United States other than this state.

(2) "Resident" includes a domestic, alien, or foreign:

(A) corporation;

(B) partnership; or

(C) person. (V.T.I.C. Art. 21.21-1, Secs. 2(a), (c).)

Sec. 547.002. CONSTRUCTION OF CHAPTER. This chapter shall be construed liberally. (V.T.I.C. Art. 21.21-1, Sec. 1(b).)

[Sections 547.003-547.050 reserved for expansion]

SUBCHAPTER B. PROHIBITION; ENFORCEMENT

Sec. 547.051. ACTS PROHIBITED. (a) This section applies only to an insurer's misrepresentation of:

(1) the insurer's financial condition;

(2) the terms of an existing or future contract;

(3) the benefits or advantages promised by an existing or future contract; or

(4) the dividends or share of surplus to be received on an existing or future contract.

(b) An unauthorized alien or foreign insurer may not:

(1) make, issue, circulate, or cause to be made, issued, or circulated to a resident of this state a misrepresentation in an advertisement, estimate, illustration, circular, pamphlet, or letter that violates Chapter 541; or

(2) cause to be made to a resident of this state in a newspaper, magazine, or other publication, or over a radio or television station, a misrepresentation in an announcement or statement that violates Chapter 541. (V.T.I.C. Art. 21.21-1, Sec. 3 (part).)

Sec. 547.052. NOTICE OF VIOLATION TO INSURER'S DOMICILIARY STATE. (a) In this section, the domiciliary state of an alien insurer is the state of entry or the state of the insurer's principal office in the United States.

(b) If the department has reason to believe that an insurer has engaged in an act prohibited by Section 547.051, the department shall notify, by registered mail, the insurer and the insurance supervisory official of the insurer's domiciliary state. (V.T.I.C. Art. 21.21-1, Sec. 3 (part).)

Sec. 547.053. ENFORCEMENT ACTION. The department shall take action under Chapter 541 against an insurer notified under Section 547.052 if:

(1) after the 30th day following the date of notice, the insurer has not stopped making, issuing, or circulating or causing to be made, issued, or circulated in this state the false misrepresentations; and

(2) the department has reason to believe that:

(A) the insurer is issuing or delivering insurance contracts to residents of this state or is collecting premiums on those contracts; and

(B) a department proceeding regarding the misrepresentations is in the public interest. (V.T.I.C. Art.

21.21-1, Sec. 4.)

CHAPTER 548. INSURER INSIDER TRADING AND PROXY REGULATION

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 548.005-548.100 reserved for expansion]

SUBCHAPTER B. REQUIRED ACTS; PROHIBITIONS

[Sections 548.107-548.200 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

CHAPTER 548. INSURER INSIDER TRADING AND PROXY REGULATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 548.001. PURPOSE. (a) The purpose of this chapter is

to provide for protection of the public interest, investors, and shareholders of domestic stock insurers by:

(1) regulating proxy solicitation by domestic stock insurers;

(2) regulating transactions by officers, directors, and principal equity security holders of domestic stock insurers; and

(3) requiring appropriate reporting of those solicitations and transactions.

(b) To that end the misuse of information by certain insiders of domestic stock insurers shall be prevented and a full and fair disclosure of all material matters relevant to the exercise of the corporate franchise of a shareholder of such an insurer will be promoted and the free exercise of that franchise will be assured.

(c) In exercising the authority granted by this chapter to adopt rules, the commissioner shall promote the purposes of this chapter to prevent misuse of information and to encourage good faith dealing and full and fair disclosure. (V.T.I.C. Art. 21.48, Sec. 13.)

Sec. 548.002. DEFINITIONS. In this chapter:

(1) "Domestic stock insurer" includes a domestic title insurance company regulated by Title 11 and a stipulated premium company regulated by Chapter 884.

(2) "Equity security" means:

(A) a stock or similar security;

(B) a security that:

(i) is convertible, with or without consideration, into an equity security; or

(ii) carries a warrant or right to subscribe to or purchase an equity security;

(C) a warrant or right to subscribe to or purchase an equity security; or

(D) any other security defined as an equity security in accordance with Section 548.004(a)(1).

(3) "Federal Securities Exchange Act" means the Securities Exchange Act of 1934 (15 U.S.C. Section 77b et seq.), as amended.

(4) "Officer" means:

(A) a president, vice president, treasurer, actuary, secretary, or controller of a domestic stock insurer; or

(B) any other person who performs for a domestic stock insurer the functions of an officer described by Paragraph (A).

(5) "Person" means an individual, corporation, partnership, association, joint-stock company, business trust, or unincorporated organization. (V.T.I.C. Art. 21.48, Secs. 8(3), (4) (part), (6), (7); New.)

Sec. 548.003. RULEMAKING AUTHORITY. The commissioner may:

(1) adopt rules necessary for the execution of the powers and duties of the department or commissioner under this subchapter and Subchapter B; and

(2) for that purpose classify domestic stock insurers, securities, and other persons or matters under the jurisdiction of

the department or commissioner. (V.T.I.C. Art. 21.48, Sec. 10 (part).)

Sec. 548.004. RULES RELATING TO EQUITY SECURITIES AND EXEMPT SECURITIES. (a) If the commissioner considers it necessary or appropriate in the public interest or for the protection of investors, the commissioner by rule may define:

(1) "equity security" to include a security that is similar in nature to an equity security; and

(2) "exempt security" for purposes of this chapter.

(b) In adopting a rule under Subsection (a)(2), the commissioner may define the term conditionally, on specified terms, or for a stated period. (V.T.I.C. Art. 21.48, Secs. 8(4) (part), (5).)

[Sections 548.005-548.100 reserved for expansion]

SUBCHAPTER B. REQUIRED ACTS; PROHIBITIONS

Sec. 548.101. DEFINITION. In this subchapter, "insider" means a person who:

(1) is directly or indirectly the beneficial owner of more than 10 percent of any class of an equity security of a domestic stock insurer, other than an exempt security; or

(2) is a director or officer of a domestic stock insurer. (V.T.I.C. Art. 21.48, Secs. 2 (part), 3 (part), 4 (part).)

Sec. 548.102. STATEMENT OF BENEFICIAL OWNERSHIP OF EQUITY SECURITIES. (a) Not later than the 10th day after the date a person becomes an insider, the insider shall file with the department a statement of the amount of all equity securities of the insurer of which the insider is a beneficial owner.

(b) If in any month a change occurs in the amount of the equity securities of which the insider is a beneficial owner, the insider shall file with the department not later than the 10th day of the following month a statement that indicates:

(1) the amount of all equity securities of which the insider is a beneficial owner as of the end of that month; and

(2) the changes in the insider's ownership that occurred in that month.

(c) A statement under this section must be in the form prescribed by the department. (V.T.I.C. Art. 21.48, Sec. 2 (part).)

Sec. 548.103. RECOVERY OF CERTAIN PROFITS. (a) The purpose of this section is to prevent the unfair use of information that may be obtained by an insider because of the insider's relationship with the domestic stock insurer.

(b) Any profit realized by the insider from the purchase and sale or from the sale and purchase of an equity security of the domestic stock insurer within a period of less than six months inures to and is recoverable by the insurer.

(c) A suit to recover the profit must be brought not later than the second anniversary of the date the profit is realized. The suit may be instituted at law or in equity by:

(1) the domestic stock insurer; or

(2) the owner of any security of the domestic stock insurer, in the name of and in behalf of the insurer, if the insurer does not:

(A) bring suit not later than the 60th day after

the date a request is made; or

(B) diligently prosecute a suit that is timely brought by the insurer.

(d) Subsection (b) applies regardless of whether:

(1) the insider intended to hold the equity security purchased for longer than six months; or

(2) the insider did not intend to repurchase the sold equity security during the six-month period following the date the insider sold the equity security.

(e) Subsection (b) does not apply to:

(1) a transaction in which an equity security was acquired in good faith in connection with a previously contracted debt;

(2) a transaction in which the beneficial owner of an equity security was not the beneficial owner at both the time of the purchase and the time of the sale, or the sale and purchase, of the security involved;

(3) a transaction involving an exempt security;

(4) a transaction that the commissioner by rule exempts from this section because it is beyond the scope of the purpose of this section; or

(5) a transaction involving an equity security of a domestic stock insurer that is not held by a dealer in an investment account if the transaction:

(A) is in the ordinary course of the dealer's business; and

(B) is incident to the establishment or

maintenance by the dealer of a primary or secondary market, other than on an exchange, as defined by the federal Securities Exchange Act, for the security.

(f) The commissioner may adopt rules the commissioner considers necessary or appropriate in the public interest to define and prescribe terms and conditions with respect to a security held in an investment account and a transaction made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market. (V.T.I.C. Art. 21.48, Secs. 3, 6 (part).)

Sec. 548.104. SALE OR NONDELIVERY OF CERTAIN EQUITY SECURITIES PROHIBITED. (a) An insider may not directly or indirectly sell an equity security of the domestic stock insurer if the insider selling the security or the insider's principal:

(1) does not own the security; or

(2) owns the security, but does not:

(A) deliver the security before the 21st day after the date of the sale; or

(B) deposit the security in the mail or another usual channel of transportation before the sixth day after the date of the sale.

(b) An insider is not considered to have violated Subsection (a)(2) if the insider proves that:

(1) notwithstanding the exercise of good faith, the insider was unable to make a timely delivery or deposit; or

(2) to make a timely delivery or deposit would cause undue inconvenience or expense.

(c) Subsection (a) does not apply to the sale of:

(1) an exempt security; or

(2) an equity security of a domestic stock insurer that is not held by a dealer in an investment account if the sale:

(A) is in the ordinary course of the dealer's business; and

(B) is incident to the establishment or maintenance by the dealer of a primary or secondary market, other than on an exchange, as defined by the federal Securities Exchange Act, for the security.

(d) The commissioner may adopt rules implementing Subsection (c) in the manner prescribed by Section 548.103(f). (V.T.I.C. Art. 21.48, Secs. 4, 6 (part).)

Sec. 548.105. CERTAIN SOLICITATIONS PROHIBITED; DISCLOSURE BY INSURER. (a) A person, in violation of any rule adopted by the commissioner under this section, may not solicit or permit the use of the person's name to solicit a proxy, consent, or authorization with respect to an equity security, other than an exempt security, of a domestic stock insurer that is not listed on a national securities exchange registered as such under the federal Securities Exchange Act.

(b) Unless before an annual or other meeting a proxy, consent, or authorization with respect to a security of a domestic stock insurer covered by Subsection (a) is solicited by or on behalf of the management of the insurer from a holder of record of the security in compliance with rules adopted by the commissioner under this section, the insurer shall, in accordance with rules adopted

by the commissioner, file with the department information substantially equivalent to the information that would be required to be sent if a solicitation were made. The insurer shall send the information to each holder of record of the security.

(c) The commissioner may adopt rules to implement this section that the commissioner considers necessary or appropriate in the public interest or for the protection of investors. (V.T.I.C. Art. 21.48, Sec. 5.)

Sec. 548.106. NONAPPLICABILITY OF SUBCHAPTER. (a) This subchapter does not apply to an equity security of a domestic stock insurer if:

(1) the security is or is required to be registered under Section 12 of the federal Securities Exchange Act; or

(2) the insurer does not have any class of its equity securities held of record by 100 or more persons on the last business day of the year preceding the year in which the equity security would otherwise be subject to this subchapter.

(b) Sections 548.101-548.104 do not apply to a foreign or domestic arbitrage transaction unless the transaction is made in violation of a rule adopted by the commissioner to accomplish the purposes of this chapter.

(c) A provision of this subchapter that imposes liability does not apply to an act or omission made in good faith in conformity with a rule adopted by the commissioner. This subsection applies regardless of whether the rule is subsequently amended, rescinded, or determined by judicial or other authority to be invalid for any reason. (V.T.I.C. Art. 21.48, Secs. 7, 9, 10

(part).)

[Sections 548.107-548.200 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

Sec. 548.201. OFFENSES; CRIMINAL PENALTY. (a) A person commits an offense if the person intentionally:

(1) violates this chapter or a rule adopted under this chapter; or

(2) makes or causes to be made a statement that is false or misleading with respect to a material fact in a document required to be filed by this chapter or a rule adopted under this chapter.

(b) Except as provided by Subsection (c), an offense under this section is punishable by:

(1) a fine not to exceed $10,000;

(2) imprisonment for not more than two years; or

(3) both the fine and imprisonment.

(c) A person may not be punished by imprisonment for violating a rule as prescribed by this section if the person proves that the person had no knowledge of the rule. (V.T.I.C. Art. 21.48, Sec. 11.)

Sec. 548.202. CIVIL PENALTY. (a) A person who wilfully violates this chapter or a rule adopted under this chapter is liable for a civil penalty of not less than $100 or more than $1,000 for:

(1) each act of violation; and

(2) each day of violation.

(b) The attorney general, at the request of the commissioner, shall bring a suit in the name of the state to recover

the civil penalty. The suit must be brought:

(1) in Travis County or the county in which the person resides;

(2) if more than one person commits the violation, in the county in which any of the persons resides; or

(3) in the county in which the violation allegedly occurred. (V.T.I.C. Art. 21.48, Sec. 12 (part).)

Sec. 548.203. INJUNCTIVE ACTION. A suit to enjoin a violation or a threatened violation of this chapter may be brought in any district court in which an action for a civil penalty under Section 548.202 may be brought. (V.T.I.C. Art. 21.48, Sec. 12 (part).)

CHAPTER 549. PROHIBITED PRACTICES RELATING TO PROPERTY INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 549.004-549.050 reserved for expansion]

SUBCHAPTER B. PROHIBITED PRACTICES

CHAPTER 549. PROHIBITED PRACTICES RELATING TO PROPERTY INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 549.001. DEFINITIONS. In this chapter:

(1) "Borrower" means an individual, partnership, corporation, association, or other entity who has or acquires a legal or equitable interest in real or personal property that is or becomes subject to a mortgage, lien, security agreement, deed of trust, or other security instrument.

(2) "Insurance binder" means a contract that provides insurance coverage pending the issuance of an original insurance policy that will be issued on or before the 30th day after the date the insurance binder is issued.

(3) "Lender" means an individual, partnership, corporation, association, or other entity, agent, loan agent, servicing agent, or loan or mortgage broker who lends money and receives or otherwise acquires a mortgage, a lien, a deed of trust, or any other security interest in or on any real or personal

property as security for the loan. (V.T.I.C. Art. 21.48A, Sec. 1.)

Sec. 549.002. INAPPLICABILITY OF CHAPTER TO TITLE INSURANCE. This chapter does not apply to title insurance. (V.T.I.C. Art. 21.48A, Sec. 5.)

Sec. 549.003. CANCELLATION OF POLICY AFTER FORECLOSURE AUTHORIZED. In the event of a foreclosure under a deed of trust, the lender may cancel an insurance policy covering the foreclosed property and is entitled to any unearned premiums from the policy if the lender:

(1) credits the amount of the unearned premiums against any deficiency owed by the borrower; and

(2) delivers to the borrower any excess unearned premiums not credited against a deficiency under Subdivision (1). (V.T.I.C. Art. 21.48A, Sec. 3A.)

[Sections 549.004-549.050 reserved for expansion]

SUBCHAPTER B. PROHIBITED PRACTICES

Sec. 549.051. FEES FOR SUBSTITUTION OR REPLACEMENT OF POLICY. (a) A lender may not require a fee in an amount greater than $10 for the substitution by the borrower of a new insurance policy for another insurance policy in effect, or require a fee for the furnishing by the borrower of a new insurance policy to replace an existing insurance policy on termination of the existing policy, if the new insurance policy is provided through an insurer authorized to engage in business in this state.

(b) On the sale or transfer of the lender's ownership interest in real or personal property, the lender is subject to the payment of a substitution fee as described by Subsection (a) and may

not, directly or indirectly, charge the borrower for the substitution fee. (V.T.I.C. Art. 21.48A, Secs. 2(a), (e).)

Sec. 549.052. REQUIRING POLICY FROM PARTICULAR SOURCE. A lender may not directly or indirectly require as a condition of the financing or lending of money or the renewal or extension of financing or lending of money that the purchaser or borrower or the successors of the purchaser or borrower obtain an insurance policy or the renewal or extension of an insurance policy covering the property involved in the transaction from or through:

(1) a particular agent, insurer, or other person; or

(2) a particular type or class of agent, insurer, or other person. (V.T.I.C. Art. 21.48A, Sec. 2(b).)

Sec. 549.053. USE OF POLICY INFORMATION. (a) Except as otherwise provided by this section, a lender may not:

(1) use or permit the use of any information taken from an insurance policy insuring the borrower's property for the purpose of soliciting insurance business from the borrower; or

(2) make information taken from an insurance policy insuring the borrower's property available to any other person for any purpose.

(b) Subsection (a) does not:

(1) apply if the borrower provides the lender with specific written authority permitting or directing the particular use or disclosure of information before the use or disclosure occurs; or

(2) prevent a lender who is a licensed general property and casualty agent from selling insurance to a borrower.

(V.T.I.C. Art. 21.48A, Sec. 2(c).)

Sec. 549.054. REQUIRING EVIDENCE OF INSURANCE BEFORE TERMINATION OF POLICY. A lender may not require a borrower to provide evidence of insurance earlier than the 15th day before the termination date of an existing insurance policy. (V.T.I.C. Art. 21.48A, Sec. 2(d).)

Sec. 549.055. INSURANCE BINDER AS EVIDENCE OF INSURANCE. (a) A lender that requires a borrower to secure insurance coverage before the lender will provide a residential mortgage or commercial real estate loan must accept an insurance binder as evidence of the required insurance and may not require the borrower to provide an original insurance policy instead of a binder if:

(1) the binder is issued by a licensed general property and casualty agent who is appointed to represent the insurer whose name appears on the binder and who is authorized to issue binders;

(2) the binder is accompanied by evidence of payment of the required premium; and

(3) the binder will be replaced by an original insurance policy for the required coverage on or before the 30th day after the date the binder is issued.

(b) A general property and casualty agent who issues an insurance binder under Subsection (a) must, on request, provide the lender with appropriate evidence for purposes of Subsection (a)(1). (V.T.I.C. Art. 21.48A, Sec. 2(f).)

Sec. 549.056. CERTAIN ACTIONS BY LENDER NOT PROHIBITED. (a) This subchapter does not prevent a lender from requiring

evidence to be produced before the commencement or renewal of a risk that insurance has been obtained that:

(1) has a fixed termination date;

(2) provides adequate coverage in an amount sufficient to cover the debt or loan; and

(3) will not be canceled without reasonable notice to the lender.

(b) This subchapter does not prevent a lender from requiring insurance from an insurer that is authorized to engage in business in this state and that has a licensed resident agent in this state.

(c) This subchapter does not prevent a lender from refusing to accept or approve insurance from a particular insurer on reasonable and nondiscriminatory grounds relating to the financial soundness of the insurer or the insurer's ability to service the policy.

(d) This subchapter does not prevent a lender from providing, in accordance with the terms of the mortgage, security agreement, deed of trust, or other security instrument, insurance coverage adequate to protect the lender's security interest in property in the event the borrower fails to provide on or before the 15th day before the termination date of an existing insurance policy an insurance policy meeting the requirements established by the lender as authorized by this chapter. A lender that provides insurance coverage under this subsection may use information contained in the existing policy for the purpose of determining that the insurance coverage provided is adequate.

(e) Except as provided by this subsection, this subchapter

does not prevent a lender from requiring at or before the time of delivery by a general property and casualty agent or insurer of an insurance policy to the lender a written statement from the borrower designating the agent or insurer as the borrower's agent for the delivery of the policy. A lender may not require a statement described by this subsection when an agent or insurer is providing a renewal of an existing expiring insurance policy provided by the agent or insurer.

(f) This subchapter does not prevent a lender from providing to a person, firm, or corporation that is or becomes the owner or holder of a note or obligation secured by a mortgage, security agreement, deed of trust, or other security instrument an insurance policy or any information contained in an insurance policy that covers property that is security for the loan.

(g) This subchapter does not prevent a lender from processing a claim under the terms of an insurance policy that covers property that is security for a loan. (V.T.I.C. Art. 21.48A, Sec. 3.)

[Sections 549.057-549.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT AND CIVIL REMEDIES

Sec. 549.101. ENFORCEMENT ACTION. The attorney general, commissioner, or department may institute a proceeding to enforce this chapter and to enjoin any individual, partnership, corporation, association, or other entity from engaging or attempting to engage in any activity in violation of this chapter. (V.T.I.C. Art. 21.48A, Sec. 4(a) (part).)

Sec. 549.102. CIVIL DAMAGES. (a) A borrower may recover

from a lender who violates this chapter civil damages in an amount equal to three times the annual premium for the insurance policy in force on the property that is security for the loan.

(b) If the insurance policy is for a period of more than one year, the annual premium is computed by dividing the total premium specified in the policy for the entire period of the policy by the number of years of the duration of the policy. (V.T.I.C. Art. 21.48A, Sec. 4(b).)

CHAPTER 550. PROHIBITED PRACTICES RELATING TO PAYMENTS

CHAPTER 550. PROHIBITED PRACTICES RELATING TO PAYMENTS

Sec. 550.001. SOLICITATION OR COLLECTION OF CERTAIN PAYMENTS. (a) An insurer or an insurer's agent or sponsoring organization may not solicit or collect, in connection with an application for insurance or the issuance of a policy, a payment other than:

(1) a premium;

(2) a tax;

(3) a finance charge;

(4) a policy fee;

(5) an agent fee;

(6) a service fee, including a charge for costs described by Section 4005.003;

(7) an inspection fee; or

(8) membership dues in a sponsoring organization.

(b) The commissioner by rule shall permit a sponsoring organization to solicit a voluntary contribution with a membership renewal solicitation if the membership renewal solicitation is separate from an insurance billing.

(c) Except as otherwise provided by statute, an insurer may require that membership dues in its sponsoring organization be paid as a condition for issuance or renewal of an insurance policy.

(d) Criminal penalties for a violation of this section are the same as criminal penalties provided for a violation under Subchapter K, Chapter 823. (V.T.I.C. Art. 21.35B.)

Sec. 550.002. INCREASE IN CERTAIN PREMIUM PAYMENTS. (a) In this section:

(1) "Account" means a person's account in a financial institution.

(2) "Financial institution" means a state or national bank, a state or federal savings and loan association or corporation, or a state or federal credit union.

(3) "Insurer" means a person or entity engaged in the business of insurance in this state as described by Chapter 101. The term includes a person or entity engaged in the business of surplus lines insurance in this state.

(4) "Person" means an insured, a policy or certificate holder, or an owner of an insurance policy or certificate.

(b) An insurer receiving automatic premium payments through withdrawal of funds from a person's account, including an escrow account, as authorized by that person to pay premiums on insurance

coverage provided through that insurer, may not increase the amount of funds to be withdrawn from the account to pay premiums on that coverage unless:

(1) the insurer, not later than the 30th day before the effective date of the increase in the premium payment amount, notifies the person of the increase and provides the person a postage prepaid form that may be used to object to the increase; and

(2) neither the insurer nor the financial institution receives written objection to the increase on or before the fifth day before the date on which the increase takes effect.

(c) This section does not require an insurer to notify a person of an increase in a premium payment amount if:

(1) the insurance contract or certificate:

(A) when issued contains a schedule of increasing premiums;

(B) expressly specifies the exact amount of each premium; and

(C) specifies the period for which each premium is payable; or

(2) the increase is the result of a change ordered by the insured.

(d) This section does not apply to an increase in a premium payment that is less than $10 or 10 percent of the previous amount per month. (V.T.I.C. Art. 21.57.)

CHAPTER 551. PROHIBITED PRACTICES RELATING TO DECLINATION, CANCELLATION, AND NONRENEWAL OF INSURANCE POLICIES

SUBCHAPTER A. GENERAL REQUIREMENTS

CHAPTER 551. PROHIBITED PRACTICES RELATING TO DECLINATION, CANCELLATION, AND NONRENEWAL OF INSURANCE POLICIES

SUBCHAPTER A. GENERAL REQUIREMENTS

Sec. 551.001. RULES. (a) The commissioner may, as necessary, adopt and enforce reasonable rules, including notice requirements, relating to the cancellation and nonrenewal of any insurance policy regulated by the department under Chapter 5, other than:

(1) a policy subject to Subchapter B or C; or

(2) a marine insurance policy other than inland marine.

(b) In adopting rules under this section, the commissioner shall consider the reasonable needs of the public and the operations of the insurers. (V.T.I.C. Art. 21.49-2 (part).)

Sec. 551.002. WRITTEN STATEMENT OF REASONS FOR DECLINATION, CANCELLATION, OR NONRENEWAL. (a) The commissioner shall require an insurer, on request by an applicant for insurance or a

policyholder, to provide to the applicant or policyholder a written statement of the reasons for the declination, cancellation, or nonrenewal of an insurance policy to which Section 551.001 applies.

(b) An insurer's written statement giving the reasons for the declination, cancellation, or nonrenewal of an insurance policy must fully explain a decision that adversely affects an applicant for insurance or a policyholder by denying the applicant or policyholder insurance coverage or continued coverage.

(c) The statement must:

(1) state the precise incident, circumstance, or risk factors applicable to the applicant for insurance or the policyholder that violates any applicable guidelines;

(2) state the source of information on which the insurer relied regarding the incident, circumstance, or risk factors; and

(3) specify any other information considered relevant by the commissioner.

(d) The commissioner shall adopt rules as necessary to implement this section. (V.T.I.C. Art. 21.49-2 (part); Art. 21.49-2E, Secs. (a) (part), (b).)

Sec. 551.003. IMMUNITY FROM LIABILITY. An insurer or agent or an employee of an insurer or agent is not liable, and a cause of action does not arise against that individual or entity, for a statement, disclosure, or communication made in good faith under this subchapter. Immunity under this section does not apply to:

(1) disclosure of information known to be false; or

(2) a disclosure made with malice or the wilful intent

to injure any person. (V.T.I.C. Art. 21.49-2 (part).)

[Sections 551.004-551.050 reserved for expansion]

SUBCHAPTER B. CANCELLATION AND NONRENEWAL OF CERTAIN LIABILITY INSURANCE POLICIES

Sec. 551.051. DEFINITIONS. In this subchapter:

(1) "Insurer" means an insurance company or other entity admitted to engage in business and authorized to write liability insurance in this state, including a county mutual insurance company, a Lloyd's plan, and a reciprocal or interinsurance exchange. The term does not include a county mutual fire insurance company that writes exclusively industrial fire insurance as described by Section 912.310 or a farm mutual insurance company.

(2) "Liability insurance" means:

(A) general liability insurance;

(B) professional liability insurance other than medical professional liability insurance;

(C) commercial automobile liability insurance;

(D) commercial multiperil insurance; and

(E) any other type or line of liability insurance designated by the department. (V.T.I.C. Art. 21.49-2A, Sec. (a).)

Sec. 551.052. CANCELLATION PROHIBITED; EXCEPTIONS. (a) An insurer may not cancel a liability insurance policy that is a renewal or continuation policy.

(b) An insurer may not cancel a liability insurance policy during the initial policy term after the 60th day following the date on which the policy was issued.

(c) Notwithstanding Subsections (a) and (b), an insurer may cancel a liability insurance policy at any time during the term of the policy for:

(1) fraud in obtaining coverage;

(2) failure to pay premiums when due;

(3) an increase in hazard within the control of the insured that would produce a rate increase; or

(4) loss of the insurer's reinsurance covering all or part of the risk covered by the policy.

(d) Notwithstanding Subsections (a) and (b), an insurer may cancel a liability insurance policy at any time during the term of the policy if the insurer is placed in supervision, conservatorship, or receivership and the cancellation or nonrenewal is approved or directed by the supervisor, conservator, or receiver. (V.T.I.C. Art. 21.49-2A, Secs. (b), (c).)

Sec. 551.053. WRITTEN NOTICE OF CANCELLATION REQUIRED. Not later than the 10th day before the date on which the cancellation of a liability insurance policy takes effect, an insurer must deliver or mail written notice of the cancellation to the first-named insured under the policy at the address shown on the policy. (V.T.I.C. Art. 21.49-2A, Sec. (d).)

Sec. 551.054. WRITTEN NOTICE OF NONRENEWAL REQUIRED. (a) An insurer may refuse to renew a liability insurance policy if the insurer delivers or mails written notice of the nonrenewal to the first-named insured under the policy at the address shown on the policy.

(b) The notice must be delivered or mailed not later than

the 60th day before the date on which the policy expires. If the notice is delivered or mailed later than the 60th day before the date on which the policy expires, the coverage remains in effect until the 61st day after the date on which the notice is delivered or mailed.

(c) Earned premium for any period of coverage that extends beyond the expiration date of the policy shall be computed pro rata based on the previous year's rate. (V.T.I.C. Art. 21.49-2A, Sec. (e).)

Sec. 551.055. REASON FOR CANCELLATION OR NONRENEWAL REQUIRED. In a notice to an insured relating to cancellation or refusal to renew, an insurer must state the reason for the cancellation or nonrenewal. The statement must comply with:

(1) Sections 551.002(b) and (c); and

(2) rules adopted under Section 551.002(d). (V.T.I.C. Art. 21.49-2A, Sec. (g); Art. 21.49-2E, Sec. (a) (part).)

Sec. 551.056. TRANSFER NOT CONSIDERED REFUSAL TO RENEW. For purposes of this subchapter, the transfer of a policyholder between admitted companies within the same insurance group is not considered a refusal to renew. (V.T.I.C. Art. 21.49-2A, Sec. (f).)

[Sections 551.057-551.100 reserved for expansion]

SUBCHAPTER C. CANCELLATION AND NONRENEWAL OF CERTAIN PROPERTY AND CASUALTY POLICIES

Sec. 551.101. DEFINITION. In this subchapter, "insurer" means any authorized insurer writing property and casualty insurance in this state, including:

(1) a county mutual insurance company;

(2) a Lloyd's plan;

(3) a reciprocal or interinsurance exchange; and

(4) a farm mutual insurance company. (V.T.I.C. Art. 21.49-2B, Sec. 1(1).)

Sec. 551.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to:

(1) a personal automobile insurance policy, other than a policy written through the Texas Automobile Insurance Plan Association;

(2) a homeowners or farm or ranch owners insurance policy;

(3) a standard fire insurance policy insuring:

(A) a one-family dwelling or a duplex; or

(B) the contents of a one-family dwelling, a duplex, or an apartment; or

(4) an insurance policy providing property and casualty coverage, other than a fidelity, surety, or guaranty bond, to:

(A) this state;

(B) an agency of this state;

(C) a political subdivision of this state, including:

(i) a municipality or county;

(ii) a school district or junior college district;

(iii) a levee improvement district, drainage district, or irrigation district;

(iv) a water improvement district, water control and improvement district, or water control and preservation district;

(v) a freshwater supply district;

(vi) a navigation district;

(vii) a conservation and reclamation district;

(viii) a soil conservation district;

(ix) a communication district; and

(x) a river authority; or

(D) any other governmental agency whose authority is derived from the laws or constitution of this state. (V.T.I.C. Art. 21.49-2B, Secs. 1(2), 2.)

Sec. 551.103. CANCELLATION. For the purposes of this subchapter, an insurer has canceled an insurance policy if the insurer, without the consent of the insured:

(1) terminates coverage provided under the policy;

(2) refuses to provide additional coverage to which the insured is entitled under the policy; or

(3) reduces or restricts coverage under the policy by endorsement or other means. (V.T.I.C. Art. 21.49-2B, Sec. 3.)

Sec. 551.104. AUTHORIZED CANCELLATION OF POLICIES. (a) An insurer may cancel an insurance policy only as provided by this section.

(b) An insurer may cancel any policy if:

(1) the named insured does not pay any portion of the premium when due;

(2) the insured submits a fraudulent claim; or

(3) the department determines that continuation of the policy would result in a violation of this code or any other law governing the business of insurance in this state.

(c) An insurer may cancel a policy, other than a personal automobile insurance policy, if there is an increase in the hazard covered by the policy that is within the control of the insured and that would produce an increase in the premium rate of the policy.

(d) An insurer may cancel a personal automobile insurance policy if the driver's license or motor vehicle registration of the named insured or any other motor vehicle operator who resides in the same household as the named insured or who customarily operates an automobile covered by the policy is suspended or revoked. An insurer may not cancel a policy under this subsection if the named insured consents to an endorsement terminating coverage under the policy for the person whose license is suspended or revoked.

(e) Cancellation of a policy under Subsection (b), (c), or (d) does not take effect until the 10th day after the date the insurer mails notice of the cancellation to the insured.

(f) An insurer may cancel a personal automobile insurance policy effective on any 12-month anniversary of the original effective date of the policy if the insurer mails to the named insured written notice of the cancellation not later than the 30th day before the effective date of the cancellation.

(g) An insurer may cancel a personal automobile insurance policy if the policy has been in effect less than 60 days. An insurer may cancel any other insurance policy if the policy has been

in effect less than 90 days. (V.T.I.C. Art. 21.49-2B, Sec. 4.)

Sec. 551.105. NONRENEWAL OF POLICIES; NOTICE REQUIRED. Unless the insurer has mailed written notice of nonrenewal to the insured not later than the 30th day before the date on which the insurance policy expires, an insurer must renew an insurance policy, at the request of the insured, on the expiration of the policy. (V.T.I.C. Art. 21.49-2B, Secs. 5, 11(b).)

Sec. 551.106. RENEWAL OF PERSONAL AUTOMOBILE INSURANCE POLICIES. (a) An insurer may not refuse to renew a personal automobile insurance policy solely because of the age of the person covered by the policy.

(b) An insurer shall renew a personal automobile insurance policy that was written for a term of less than one year, except that the insurer may refuse to renew the policy on any 12-month anniversary of the original effective date of the policy. (V.T.I.C. Art. 21.49-2B, Sec. 6.)

Sec. 551.107. RENEWAL OF CERTAIN POLICIES; PREMIUM SURCHARGE AUTHORIZED; NOTICE. (a) This section applies only to a standard fire, homeowners, or farm or ranch owners insurance policy.

(b) A claim under this section does not include a claim:

(1) resulting from a loss caused by natural causes; or

(2) that is filed but is not paid or payable under the policy.

(c) An insurer may assess a premium surcharge at the time an insurance policy is renewed if the insured has filed two or more claims in the preceding policy year. The insurer may assess an

additional premium surcharge if an additional claim is made in the following policy year. The department shall set the amount of any surcharge that may be assessed under this subsection. The amount of the surcharge may not exceed 10 percent of the total premium, including any premium surcharge, actually paid by the insured in the preceding policy year.

(d) Subject to Subsection (e), an insurer may refuse to renew an insurance policy if the insured has filed three or more claims under the policy in any three-year period.

(e) An insurer may notify an insured who has filed two claims in a period of less than three years that the insurer may refuse to renew the policy if the insured files a third claim during the three-year period. If the insurer does not notify the insured in accordance with this subsection, the insurer may not refuse to renew the policy because of losses. The notice form must:

(1) list the policyholder's claims; and

(2) contain the sentence: "Another non-weather related loss could cause us to refuse to renew your policy."

(f) An insurer that renews the insurance policy of an insured who has filed three or more claims under the policy in a three-year period may assess a premium surcharge in an amount set by the department. (V.T.I.C. Art. 21.49-2B, Sec. 7.)

Sec. 551.108. INSURER RECORDS. (a) An insurer shall maintain information regarding cancellation or nonrenewal of insurance policies in accordance with the insurer's ordinary practices for maintaining records of expired policies.

(b) The insurer shall make the information available to the

department on request. (V.T.I.C. Art. 21.49-2B, Sec. 8.)

Sec. 551.109. INSURER STATEMENT. An insurer shall, at the request of an applicant for insurance or an insured, provide a written statement of the reason for a declination, cancellation, or nonrenewal of an insurance policy. The statement must comply with:

(1) Sections 551.002(b) and (c); and

(2) rules adopted under Section 551.002(d). (V.T.I.C. Art. 21.49-2B, Sec. 9; Art. 21.49-2E, Sec. (a) (part).)

Sec. 551.110. LIABILITY FOR DISCLOSURE. An insurer or agent or an employee of an insurer or agent is not liable for a statement or disclosure made in good faith under this subchapter unless the statement or disclosure was:

(1) known to be false; or

(2) made with malice or wilful intent to injure any person. (V.T.I.C. Art. 21.49-2B, Sec. 10.)

Sec. 551.111. EFFECT OF NONCOMPLIANCE. A cancellation of an insurance policy made in violation of this subchapter has no effect. (V.T.I.C. Art. 21.49-2B, Sec. 11(a).)

Sec. 551.112. RULES. The commissioner may adopt rules relating to the cancellation and nonrenewal of insurance policies. (V.T.I.C. Art. 21.49-2B, Sec. 12.)

[Sections 551.113-551.150 reserved for expansion]

SUBCHAPTER D. CANCELLATION OR NONRENEWAL OF CERTAIN POLICIES ISSUED TO ELECTED OFFICIALS

Sec. 551.151. DEFINITION. In this subchapter, "insurer" has the meaning assigned by Section 551.101. (V.T.I.C. Art. 21.49-2D, Sec. (a).)

Sec. 551.152. ELECTED OFFICIALS. An insurer may not cancel or refuse to renew an insurance policy based solely on the fact that the policyholder is an elected official. (V.T.I.C. Art. 21.49-2D, Sec. (b).)

CHAPTER 552. ILLEGAL PRICING PRACTICES

CHAPTER 552. ILLEGAL PRICING PRACTICES

Sec. 552.001. APPLICABILITY OF CHAPTER. This chapter does not apply to the provision of a health care service to a:

(1) Medicaid or Medicare patient; or

(2) medically indigent person who qualifies for a sliding fee scale. (V.T.I.C. Art. 21.79F, Sec. (d).)

Sec. 552.002. FRAUDULENT INSURANCE ACT. An offense under Section 552.003 is a fraudulent insurance act under Chapter 701. (V.T.I.C. Art. 21.79F, Sec. (c).)

Sec. 552.003. CHARGING DIFFERENT PRICES; OFFENSE. (a) A person commits an offense if:

(1) the person knowingly or intentionally charges two different prices for providing the same product or service; and

(2) the higher price charged is based on the fact that an insurer will pay all or part of the price of the product or service.

(b) An offense under this section is a Class B misdemeanor. (V.T.I.C. Art. 21.79F, Secs. (a), (b).)

CHAPTER 553. ENFORCEMENT OF INSURANCE POLICIES

REGARDING HOLOCAUST VICTIMS

CHAPTER 553. ENFORCEMENT OF INSURANCE POLICIES REGARDING HOLOCAUST VICTIMS

Sec. 553.001. DEFINITIONS. In this chapter:

(1) "Holocaust victim" means a person who was killed or injured, or who lost financial assets or other property, as the result of discriminatory laws, policies, or actions directed against any discrete group of which the person was a member, during the period of 1920 to 1945, inclusive, in Germany, areas occupied by Germany, or countries allied with Germany.

(2) "Insurance policy" includes:

(A) a life insurance policy, an annuity, a property insurance policy, a casualty insurance policy, and a liability insurance policy; and

(B) reinsurance on a risk covered under a policy described by Paragraph (A).

(3) "Insurer" means an insurance company or other entity engaged in the business of insurance or reinsurance in this state. The term includes:

(A) a capital stock company, a mutual company, or a Lloyd's plan; and

(B) any parent, subsidiary, or affiliated company, at least 50 percent of the stock of which is in common

ownership with an insurer engaged in the business of insurance in this state. (V.T.I.C. Art. 21.74, Sec. 1.)

Sec. 553.002. SUSPENSION OF LIMITATIONS PERIOD. (a) Notwithstanding any other law, a Holocaust victim, or the heir, assignee, beneficiary, or successor of a Holocaust victim, who resides in this state and has a claim arising out of an insurance policy purchased or in effect in Europe before 1946 that was delivered, issued for delivery, or renewed by an insurer may bring an action in this state against an insurer to recover on that claim.

(b) An action brought under this section before December 31, 2012, may not be dismissed for failure to comply with any applicable limitations period. (V.T.I.C. Art. 21.74, Sec. 2.)

Sec. 553.003. VIOLATION BY INSURER. An insurer violates this chapter if the insurer fails to comply with a claim brought under this chapter by:

(1) denying the claim on the grounds that the claim is not timely; or

(2) asserting a statute of limitations defense in an action brought under Section 553.002. (V.T.I.C. Art. 21.74, Sec. 3(a).)

Sec. 553.004. EXAMINATION; ENFORCEMENT. (a) If the commissioner considers it necessary, the commissioner may initiate an examination of an insurer under Article 1.15.

(b) If the commissioner believes that an insurer is violating or has violated this chapter, the commissioner may:

(1) impose a sanction under Chapter 82;

(2) issue a cease and desist order under Chapter 83;

(3) assess an administrative penalty under Chapter 84; or

(4) refer the matter to the attorney general for appropriate enforcement. (V.T.I.C. Art. 21.74, Secs. 3(b), (c).)

CHAPTER 554. BURDEN OF PROOF AND PLEADING

Sec. 554.001. APPLICABILITY OF CHAPTER

Sec. 554.002. BURDEN OF PROOF AND PLEADING

CHAPTER 554. BURDEN OF PROOF AND PLEADING

Sec. 554.001. APPLICABILITY OF CHAPTER. This chapter applies to each insurer or health maintenance organization engaged in the business of insurance or the business of a health maintenance organization in this state, regardless of form and however organized, including:

(1) a stock life, health, or accident insurance company;

(2) a mutual life, health, or accident insurance company;

(3) a stock fire or casualty insurance company;

(4) a mutual fire or casualty insurance company;

(5) a Mexican casualty insurance company;

(6) a Lloyd's plan;

(7) a reciprocal or interinsurance exchange;

(8) a fraternal benefit society;

(9) a title insurance company;

(10) an attorney's title insurance company;

(11) a stipulated premium company;

(12) a nonprofit legal services corporation;

(13) a statewide mutual assessment company;

(14) a local mutual aid association;

(15) a local mutual burial association;

(16) an association exempt under Section 887.102;

(17) a nonprofit hospital, medical, or dental service corporation, including a corporation subject to Chapter 842;

(18) a county mutual insurance company;

(19) a farm mutual insurance company; and

(20) an insurer or health maintenance organization engaged in the business of insurance or the business of a health maintenance organization in this state that does not hold a certificate of authority issued by the department or is not otherwise authorized to engage in business in this state. (V.T.I.C. Art. 21.58, Subsec. (a).)

Sec. 554.002. BURDEN OF PROOF AND PLEADING. In a suit to recover under an insurance or health maintenance organization contract, the insurer or health maintenance organization has the burden of proof as to any avoidance or affirmative defense that the Texas Rules of Civil Procedure require to be affirmatively pleaded. Language of exclusion in the contract or an exception to coverage claimed by the insurer or health maintenance organization constitutes an avoidance or an affirmative defense. (V.T.I.C. Art. 21.58, Subsec. (b).)

CHAPTER 555. FAILURE TO SATISFY JUDGMENT

CHAPTER 555. FAILURE TO SATISFY JUDGMENT

Sec. 555.001. APPLICABILITY OF CHAPTER. This chapter does not apply to an insurer subject to Chapter 841. (V.T.I.C. Art. 21.36 (part).)

Sec. 555.002. REVOCATION OF CERTIFICATE OF AUTHORITY. If an execution issued on a final judgment rendered against an insurer is not satisfied and discharged before the 31st day after the date of notice of the execution's issuance, the insurer's certificate of authority shall be revoked, and the insurer may not engage in the business of insurance in this state until the execution is satisfied. (V.T.I.C. Art. 21.36 (part).)

CHAPTER 556. UNFAIR METHODS OF COMPETITION AND UNFAIR PRACTICES BY FINANCIAL INSTITUTIONS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 556.003-556.050 reserved for expansion]

SUBCHAPTER B. UNFAIR METHODS OR PRACTICES

[Sections 556.053-556.100 reserved for expansion]

SUBCHAPTER C. REGULATION OF PRACTICES

ACTIVITIES

Sec. 556.104. USE OF CUSTOMER INFORMATION

[Sections 556.105-556.150 reserved for expansion]

SUBCHAPTER D. DISCLOSURES

Sec. 556.151. APPLICABILITY OF SUBCHAPTER

Sec. 556.152. PROMOTIONAL MATERIALS DISCLOSURE

Sec. 556.153. DISCLOSURE AT TIME OF LOAN APPLICATION

Sec. 556.154. FORM OF DISCLOSURE

CHAPTER 556. UNFAIR METHODS OF COMPETITION AND UNFAIR PRACTICES BY FINANCIAL INSTITUTIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 556.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who, directly or indirectly or through one or more intermediaries, controls or is controlled by another person or is under common control with another person.

(2) "Depository institution" has the meaning assigned by Section 4001.003. (V.T.I.C. Art. 21.21-9, Sec. 1, as added Acts 75th Leg., R.S., Ch. 596.)

Sec. 556.002. RULES. The commissioner may adopt reasonable rules to comply with federal law applicable to the sale of insurance and for the implementation and administration of this chapter. (V.T.I.C. Art. 21.21-9, Sec. 7, as added Acts 75th Leg., R.S., Ch. 596.)

[Sections 556.003-556.050 reserved for expansion]

SUBCHAPTER B. UNFAIR METHODS OR PRACTICES

Sec. 556.051. UNFAIR METHOD OF COMPETITION OR UNFAIR

PRACTICE: TYING. (a) A depository institution engages in an unfair method of competition or an unfair practice in the sale of insurance by the depository institution if the depository institution:

(1) is an agent and, as a condition of extending or renewing credit, leasing or selling property, or furnishing services, requires the purchase of insurance from the depository institution or a subsidiary or affiliate of the depository institution, or from or through a particular agent, insurer, or any other person or entity;

(2) conditions the terms of credit or the sale or lease of property on acquisition of insurance from or through the depository institution, a subsidiary or affiliate of the depository institution, or any other particular person or entity;

(3) rejects a required policy solely because the policy has been issued or underwritten by a person or entity that is not associated with the depository institution; or

(4) imposes a requirement on an agent or broker who is not associated with the depository institution that is not imposed on an agent or broker who is associated with the depository institution or a subsidiary or affiliate of the depository institution.

(b) This section does not prevent a person who lends money or extends credit from placing insurance on property if the mortgagor, borrower, or purchaser fails to provide required insurance in accordance with the terms of the loan or credit document. (V.T.I.C. Art. 21.21-9, Secs. 2(a) (part), (b), as added

Acts 75th Leg., R.S., Ch. 596.)

Sec. 556.052. UNFAIR METHOD OF COMPETITION OR UNFAIR PRACTICE: FAILURE TO DISCLOSE. A depository institution engages in an unfair method of competition or an unfair practice in the sale of insurance by the depository institution if, on the premises of the depository institution or in connection with a product offering of the depository institution, the depository institution sells or solicits the purchase of insurance or a person sells or solicits the purchase of insurance recommended or sponsored by the depository institution and the depository institution or person fails to clearly disclose in all promotional materials relating to an insurance product distributed to customers and potential customers that:

(1) an insurance product sold through or in the depository institution or a subsidiary or affiliate of the depository institution is not insured by the Federal Deposit Insurance Corporation;

(2) the insurance product is not issued, guaranteed, or underwritten by the depository institution or the Federal Deposit Insurance Corporation; and

(3) the insurance product involves investment risk, if appropriate, including potential loss of principal. (V.T.I.C. Art. 21.21-9, Sec. 2(a) (part), as added Acts 75th Leg., R.S., Ch. 596.)

[Sections 556.053-556.100 reserved for expansion]

SUBCHAPTER C. REGULATION OF PRACTICES

Sec. 556.101. PROHIBITION ON CERTAIN REFERRALS OR SOLICITATIONS TO PURCHASE INSURANCE. (a) An individual who is an

employee or agent of a depository institution or a subsidiary or affiliate of a depository institution may not directly or indirectly make a referral related to insurance to, or solicit the purchase of any insurance by, a customer knowing that the customer has applied for a loan or other extension of credit from a financial institution, before:

(1) the customer receives a written commitment relating to that loan or extension of credit; or

(2) if a written commitment has not been or will not be issued in connection with the loan or extension of credit, the customer receives notification of approval of that loan or extension of credit by the financial institution and the financial institution creates a written record of the approval.

(b) This section does not prohibit a depository institution from:

(1) informing a customer that insurance is required in connection with a loan;

(2) contacting a person in the course of a direct or mass mailing to a group of persons in a manner that is not related to the person's loan application or credit decision; or

(3) selling credit life, credit disability, credit property, or involuntary unemployment insurance that is:

(A) specifically authorized by this code;

(B) approved for sale in this state; and

(C) sold in connection with a credit transaction.

(c) This section does not apply to an insurance policy described by Section 556.151. (V.T.I.C. Art. 21.21-9, Secs. 3(c),

(e) (part), as added Acts 75th Leg., R.S., Ch. 596.)

Sec. 556.102. INSURANCE SALE WITH LOAN TRANSACTION. (a) If insurance is offered or sold to a depository institution's customer in connection with a loan transaction by the depository institution, the insurance salesperson involved in that insurance transaction may not be involved in that loan transaction and may not be the person making that loan.

(b) This section does not apply to:

(1) a depository institution that has $40 million or less in total assets, as reported in the most recent Consolidated Report of Condition and Income by the Federal Financial Institutions Examination Council or any successor report required by federal or state law; or

(2) a credit life, credit disability, credit property, or involuntary unemployment insurance product that is:

(A) specifically authorized by this code;

(B) approved for sale in this state; and

(C) sold in connection with a credit transaction.

(V.T.I.C. Art. 21.21-9, Sec. 4, as added Acts 75th Leg., R.S., Ch. 596.)

Sec. 556.103. DESIGNATION OF PLACE OF INSURANCE ACTIVITIES. (a) The place where a depository institution sells or solicits the purchase of insurance or the place on the premises of a depository institution where insurance is sold or solicited for purchase shall be clearly and conspicuously indicated by signs so that the public can readily distinguish the sale or solicitation as separate from the lending and deposit-taking activities of the depository

institution.

(b) The commissioner may grant a waiver from the requirements of this section to a person who files a written request that:

(1) demonstrates that, due to the size of the physical premises of the person, compliance with the requirements is not possible; and

(2) identifies other steps that will be taken to minimize customer confusion. (V.T.I.C. Art. 21.21-9, Sec. 6, as added Acts 75th Leg., R.S., Ch. 596.)

Sec. 556.104. USE OF CUSTOMER INFORMATION. (a) In this section:

(1) "Customer" means a person with an investment, security, deposit, trust, or credit relationship with a financial institution.

(2) "Nonpublic customer information" means information relating to an individual that is derived from a bank record, including information concerning insurance premiums, the terms and conditions of insurance coverage, insurance expirations, insurance claims, and insurance history of the individual. The term does not include a customer's name, address, or telephone number.

(b) A person may not use nonpublic customer information for the purpose of selling or soliciting the purchase of insurance, or provide nonpublic customer information to a third party for the purpose of another's selling or soliciting the purchase of insurance, unless:

(1) it is clearly and conspicuously disclosed that the nonpublic customer information may be used for that purpose; and

(2) the customer has been provided an opportunity to object before the time the information is used. (V.T.I.C. Art. 21.21-9, Sec. 5, as added Acts 75th Leg., R.S., Ch. 596.)

[Sections 556.105-556.150 reserved for expansion]

SUBCHAPTER D. DISCLOSURES

Sec. 556.151. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a credit life, credit accident and health, credit property, or credit involuntary unemployment insurance policy that is:

(1) specifically authorized by this code;

(2) approved for sale in this state; and

(3) sold in connection with a credit transaction. (V.T.I.C. Art. 21.21-9, Sec. 3(e), as added Acts 75th Leg., R.S., Ch. 596.)

Sec. 556.152. PROMOTIONAL MATERIALS DISCLOSURE. (a) This section applies to each agent that is a depository institution or that, on the premises of a depository institution or in connection with a product offering of a depository institution, sells or solicits the purchase of insurance recommended or sponsored by the depository institution.

(b) Promotional materials relating to an insurance product distributed to a customer or potential customer must clearly disclose that an insurance product sold through an agent affiliated with a depository institution:

(1) is not insured by the Federal Deposit Insurance

Corporation;

(2) is not issued, guaranteed, or underwritten by the depository institution or the Federal Deposit Insurance Corporation; and

(3) involves investment risk, if appropriate, including potential loss of principal. (V.T.I.C. Art. 21.21-9, Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 596.)

Sec. 556.153. DISCLOSURE AT TIME OF LOAN APPLICATION. (a) At the time a loan application is made, a depository institution shall provide to the customer a written disclosure as required by this section and Section 556.154.

(b) The disclosure must be separate from any loan application or loan document.

(c) The depository institution employee who presents the disclosure and the customer shall sign and date the disclosure.

(d) The depository institution shall maintain one copy of the disclosure in the loan file and shall provide one copy to the customer. (V.T.I.C. Art. 21.21-9, Sec. 3(b) (part), as added Acts 75th Leg., R.S., Ch. 596.)

Sec. 556.154. FORM OF DISCLOSURE. (a) The disclosure required by Section 556.153 must be in substantially the following form:

"CUSTOMER DISCLOSURE

"You have applied for a loan with the depository institution. As permitted by Title 4, Finance Code, the depository institution is requiring that collateral used to secure the loan be insured to cover the amount of the loan to the extent insurance is available on

the property to be insured, against the usual and customary casualty losses.

"You have the right to provide this insurance either through existing policies already owned or controlled by you or by obtaining the insurance through any insurance agent or insurer authorized to engage in business in Texas.

"The depository institution, through its own insurance agency, can also make this insurance available to you. However, federal and state laws provide that the depository institution cannot require you to obtain insurance through the depository institution, its subsidiary, an affiliate, or any particular unaffiliated third party, either as a condition to obtaining this credit or to obtain special terms or consideration.

"Insurance products sold through or in the depository institution or its affiliate or subsidiary are not insured by the Federal Deposit Insurance Corporation and are not issued, guaranteed, or underwritten by the depository institution or the Federal Deposit Insurance Corporation.

"You are not required or obligated to purchase insurance from the depository institution or any subsidiary, affiliate, or particular unaffiliated third party as a condition to obtaining your loan, and your decision as to insurance agents will not affect your credit terms in any way.

_____ _____

Customer Date

_____

Employee of Depository Institution"

(b) The commissioner may amend the disclosure form as necessary to comply with federal or state law. (V.T.I.C. Art. 21.21-9, Secs. 3(b) (part), (d), as added Acts 75th Leg., R.S., Ch. 596.)

CHAPTER 557. INSURED PROPERTY SUBJECT TO SECURITY INTEREST

SUBCHAPTER A. INSURANCE PROCEEDS HELD BY LENDER PENDING REPAIR OF RESIDENTIAL REAL PROPERTY

Sec. 557.001. DEFINITIONS

Sec. 557.002. NOTIFICATION BY LENDER TO INSURED CONCERNING INSURANCE PROCEEDS

Sec. 557.003. LENDER'S RELEASE OR REFUSAL TO RELEASE INSURANCE PROCEEDS

Sec. 557.004. PAYMENT OF INTEREST; RATE

Sec. 557.005. ACCRUAL OF INTEREST

Sec. 557.006. INTEREST NOT REQUIRED ON INSURANCE PROCEEDS APPLIED TO REDUCE NOTE

[Sections 557.007-557.050 reserved for expansion]

SUBCHAPTER B. LIENHOLDER APPROVAL OF INSURANCE CLAIM PAYMENT RELATING TO PERSONAL PROPERTY

Sec. 557.051. LIENHOLDER APPROVAL OF PAYMENT

Sec. 557.052. CIVIL PENALTY

CHAPTER 557. INSURED PROPERTY SUBJECT TO SECURITY INTEREST

SUBCHAPTER A. INSURANCE PROCEEDS HELD BY LENDER PENDING REPAIR OF RESIDENTIAL REAL PROPERTY

Sec. 557.001. DEFINITIONS. In this subchapter:

(1) "Lender" means a person holding a mortgage, lien, deed of trust, or other security interest in property.

(2) "Residential real property" means:

(A) a single-family house;

(B) a duplex, triplex, or quadraplex; or

(C) a unit in a multi-unit residential structure in which title to an individual unit is transferred to the owner of the unit under a condominium or cooperative system. (V.T.I.C. Art. 21.48B, Sec. 1.)

Sec. 557.002. NOTIFICATION BY LENDER TO INSURED CONCERNING INSURANCE PROCEEDS. (a) If a claim under an insurance policy for damage to residential real property is paid to the insured and a lender, and the lender holds all or part of the proceeds from the insurance claim payment pending completion of all or part of the repairs to the property, the lender shall notify the insured of each requirement with which the insured must comply for the lender to release the insurance proceeds.

(b) The notice required under this section must be provided not later than the 10th day after the date the lender receives payment of the insurance proceeds. (V.T.I.C. Art. 21.48B, Sec. 2(a).)

Sec. 557.003. LENDER'S RELEASE OR REFUSAL TO RELEASE INSURANCE PROCEEDS. Not later than the 10th day after the date a lender receives from the insured a request for release of all or part of the insurance proceeds held by the lender, the lender shall:

(1) if the lender has received sufficient evidence of the insured's compliance with the requirements specified by the

lender under Section 557.002 for release of the proceeds, release to the insured, as requested, all or part of the proceeds; or

(2) provide notice to the insured that explains specifically:

(A) the reason for the lender's refusal to release the proceeds to the insured; and

(B) each requirement with which the insured must comply for the lender to release the proceeds. (V.T.I.C. Art. 21.48B, Sec. 2(b).)

Sec. 557.004. PAYMENT OF INTEREST; RATE. A lender who fails to provide notice as required by Section 557.002 or 557.003 or to release insurance proceeds as required by Section 557.003 shall pay to the insured interest at the rate of 10 percent a year on the proceeds held by the lender. (V.T.I.C. Art. 21.48B, Sec. 3(a).)

Sec. 557.005. ACCRUAL OF INTEREST. (a) If a lender fails to provide notice as required by Section 557.002 or 557.003, interest begins to accrue on the date the lender received the insurance proceeds.

(b) If a lender fails to release insurance proceeds as required by Section 557.003, interest begins to accrue on the date the lender receives sufficient evidence of the insured's compliance with the requirements specified by the lender under Section 557.002 or 557.003 for release of the proceeds.

(c) Interest stops accruing on the date the lender complies with Section 557.002 or 557.003, as applicable. (V.T.I.C. Art. 21.48B, Secs. 3(b), (c).)

Sec. 557.006. INTEREST NOT REQUIRED ON INSURANCE PROCEEDS

APPLIED TO REDUCE NOTE. A lender is not required to pay interest on insurance proceeds applied, in accordance with the terms and conditions of a deed of trust or other security agreement, to reduce a note. (V.T.I.C. Art. 21.48B, Sec. 3(d).)

[Sections 557.007-557.050 reserved for expansion]

SUBCHAPTER B. LIENHOLDER APPROVAL OF INSURANCE CLAIM PAYMENT RELATING TO PERSONAL PROPERTY

Sec. 557.051. LIENHOLDER APPROVAL OF PAYMENT. If payment of an insurance claim relating to personal property requires the endorsement of a check or draft by a holder of a lien on the property or otherwise requires approval of the lienholder, not later than the 14th business day after the date the lienholder receives a request for the endorsement or other approval, the lienholder shall provide:

(1) the endorsement or approval; or

(2) a written statement of the reason for denial of the endorsement or approval to the person who requested the endorsement or approval. (V.A.C.S. Art. 9031, Sec. 1.)

Sec. 557.052. CIVIL PENALTY. (a) A lienholder who violates Section 557.051 is liable for a civil penalty not to exceed $500 for each violation.

(b) The attorney general may bring an action to collect a civil penalty under this section. (V.A.C.S. Art. 9031, Sec. 2.)

CHAPTER 558. REFUND OF UNEARNED PREMIUM

Sec. 558.001. DEFINITION

Sec. 558.002. APPLICABILITY OF CHAPTER; REFUND OF UNEARNED PREMIUM

Sec. 558.003. RULES AND GUIDELINES

Sec. 558.004. EFFECT ON INSURANCE PREMIUM FINANCE COMPANY

CHAPTER 558. REFUND OF UNEARNED PREMIUM

Sec. 558.001. DEFINITION. In this chapter, "insurer" means an insurance company or other entity authorized to engage in the business of insurance in this state. The term includes:

(1) a stock life, health, or accident insurance company;

(2) a mutual life, health, or accident insurance company;

(3) a stock fire or casualty insurance company;

(4) a mutual fire or casualty insurance company;

(5) a Mexican casualty insurance company;

(6) a farm mutual insurance company;

(7) a county mutual insurance company;

(8) a Lloyd's plan;

(9) a reciprocal or insurance exchange;

(10) a fraternal benefit society;

(11) a stipulated premium company;

(12) a nonprofit legal services corporation;

(13) a statewide mutual assessment company;

(14) a local mutual aid association;

(15) a local mutual burial association;

(16) an association exempt under Section 887.102;

(17) a nonprofit hospital, medical, or dental service corporation, including a corporation subject to Chapter 842;

(18) a risk retention group;

(19) a purchasing group;

(20) an eligible surplus lines insurer; and

(21) a guaranty association operating under Article 21.28-C or 21.28-D. (V.T.I.C. Art. 21.29, Sec. (a).)

Sec. 558.002. APPLICABILITY OF CHAPTER; REFUND OF UNEARNED PREMIUM. (a) This chapter applies to an insurer that issues an insurance policy that requires the insurer to maintain an unearned premium reserve for the portion of the written policy premium applicable to the unexpired or unused part of the policy period for which the premium has been paid.

(b) An insurer shall promptly refund the appropriate portion of any unearned premium to the policyholder if the policy:

(1) has a remaining unearned premium reserve; and

(2) is canceled or terminated by the insured or the insurer before the end of its term.

(c) A guaranty association shall promptly refund any unearned premium as described by Section 5(8), Article 21.28-C, or Sections 5(10) and 8(n), Article 21.28-D. (V.T.I.C. Art. 21.29, Secs. (b), (c).)

Sec. 558.003. RULES AND GUIDELINES. The commissioner shall:

(1) adopt rules necessary to implement this chapter; and

(2) establish appropriate guidelines to determine the portion of an unearned premium that must be refunded to a policyholder under this chapter. (V.T.I.C. Art. 21.29, Sec. (d).)

Sec. 558.004. EFFECT ON INSURANCE PREMIUM FINANCE COMPANY. This chapter does not affect the obligation of an insurer to pay an unearned premium to an insurance premium finance company in accordance with Section 651.162. (V.T.I.C. Art. 21.29, Sec. (e).)

[Chapters 559-600 reserved for expansion]

SUBTITLE D. PRIVACY

CHAPTER 601. PRIVACY

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 601.005-601.050 reserved for expansion]

SUBCHAPTER B. DEPARTMENT POWERS AND DUTIES

[Sections 601.053-601.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

CHAPTER 601. PRIVACY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 601.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a company that controls, is controlled by, or is under common control with another company. For

the purposes of this subdivision, "control" has the meaning described by Sections 823.005 and 823.151.

(2) "Authorization" has the meaning assigned by Section 82.001.

(3) "Covered entity" means an individual or entity that receives an authorization from the department. The term includes an individual or entity described by Section 82.002.

(4) "Nonaffiliated third party" means an entity that is not an affiliate of, or related to by common ownership or affiliated by corporate control with, the covered entity. The term does not include a joint employee of the entity. (V.T.I.C. Art. 28A.01.)

Sec. 601.002. COMPLIANCE WITH FEDERAL LAW REQUIRED. (a) A covered entity shall comply with 15 U.S.C. Sections 6802 and 6803, as amended, in the same manner as a financial institution is required to comply under those sections.

(b) An entity that is a nonaffiliated third party in relation to a covered entity shall comply with 15 U.S.C. Section 6802(c), as amended. (V.T.I.C. Art. 28A.02.)

Sec. 601.003. EXEMPTION. Section 601.002(a) does not apply to a covered entity to the extent that the entity is acting solely as an insurance agent, employee, or other authorized representative for another covered entity. (V.T.I.C. Art. 28A.03.)

Sec. 601.004. TREATMENT OF CERTAIN HEALTH INFORMATION; STRICTER RULES NOT PRECLUDED. This chapter does not affect the authority of the department or another state agency to adopt stricter rules governing the treatment of health information by a

covered entity if another law gives the department or agency that authority, including a law or rule of this state related to the privacy of individually identifiable health information under Subtitle F, Title II, Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), as amended. (V.T.I.C. Art. 28A.04.)

[Sections 601.005-601.050 reserved for expansion]

SUBCHAPTER B. DEPARTMENT POWERS AND DUTIES

Sec. 601.051. RULES. (a) The commissioner shall adopt:

(1) rules to implement this chapter; and

(2) any other rules necessary to carry out Subtitle A, Title V, Gramm-Leach-Bliley Act (15 U.S.C. Section 6801 et seq.), as amended, to make this state eligible to override federal regulations as described by 15 U.S.C. Section 6805(c), as amended.

(b) In adopting rules under this chapter, the commissioner shall attempt to keep state privacy requirements consistent with federal regulations adopted under Subtitle A, Title V, Gramm-Leach-Bliley Act (15 U.S.C. Section 6801 et seq.), as amended. (V.T.I.C. Art. 28A.51.)

Sec. 601.052. IMPLEMENTATION OF CERTAIN STANDARDS. The department shall implement standards as required by 15 U.S.C. Section 6805(b), as amended. (V.T.I.C. Art. 28A.52.)

[Sections 601.053-601.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

Sec. 601.101. ENFORCEMENT BY DEPARTMENT. The department shall enforce 15 U.S.C. Sections 6801-6805, as amended, to the extent required by 15 U.S.C. Section 6805, as amended, and this

chapter. (V.T.I.C. Art. 28A.101.)

Sec. 601.102. INJUNCTIVE OR DECLARATORY RELIEF; CIVIL PENALTY. (a) The attorney general, after conferring with the commissioner, may institute an action for injunctive or declaratory relief to restrain a violation of this chapter.

(b) In addition to instituting an action for injunctive relief under Subsection (a), the attorney general, after conferring with the commissioner, may institute an action for civil penalties against a covered entity or nonaffiliated third party for a violation of this chapter. A civil penalty assessed under this section may not exceed $3,000 for each violation.

(c) If the court in which an action under Subsection (b) is pending finds that violations of this chapter have occurred with a frequency that constitutes a pattern or practice, the court may assess a civil penalty not to exceed $250,000.

(d) If the attorney general substantially prevails in an action for injunctive relief or a civil penalty under this section, the attorney general may recover reasonable attorney's fees, costs, and expenses incurred obtaining the relief or penalty, including court costs and witness fees. (V.T.I.C. Art. 28A.102.)

CHAPTER 602. PRIVACY OF HEALTH INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

CHAPTER 602. PRIVACY OF HEALTH INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 602.001. DEFINITIONS. In this chapter:

(1) "Covered entity" means a person who holds or is required to hold a license, registration, certificate of authority, or other authorization under this code or another insurance law of this state. The term includes:

(A) an insurance company, including:

(i) a county mutual insurance company;

(ii) a farm mutual insurance company;

(iii) a fraternal benefit society;

(iv) a group hospital service corporation;

(v) a Lloyd's plan;

(vi) a local mutual aid association;

(vii) a mutual insurance company;

(viii) a reciprocal or interinsurance exchange;

(ix) a statewide mutual assessment company; and

(x) a stipulated premium company;

(B) a health maintenance organization; and

(C) an insurance agent.

(2) "Health information" means information regarding an individual, other than the individual's age or gender, whether provided orally or recorded in any medium or form, that is created by or derived from the individual or a health care provider and that relates to:

(A) the past, present, or future physical, mental, or behavioral health or condition of the individual;

(B) the provision of health care to the individual; or

(C) payment for the provision of health care to the individual.

(3) "Nonpublic personal health information" means health information:

(A) that identifies an individual who is the subject of the information; or

(B) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual. (V.T.I.C. Art. 28B.01.)

Sec. 602.002. APPLICABILITY OF CHAPTER TO COVERED ENTITY REQUIRED TO COMPLY WITH CERTAIN FEDERAL STANDARDS. This chapter does not apply to a covered entity that is required to comply with the standards governing the privacy of individually identifiable health information adopted by the United States secretary of health and human services under Section 262(a), Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.). (V.T.I.C. Art. 28B.05.)

Sec. 602.003. CONSTRUCTION OF CHAPTER. (a) This chapter does not preempt or supersede state law in effect on July 1, 2002, that relates to the privacy of medical records, health information, or insurance information.

(b) This chapter may not be construed to modify, limit, or supersede the operation of the federal Fair Credit Reporting Act (15 U.S.C. Section 1681 et seq.).

(c) This chapter may not be used as a basis for drawing an inference that information is or is not transaction or experience information under Section 603 of the federal Fair Credit Reporting Act (15 U.S.C. Section 1681a). (V.T.I.C. Art. 28B.06.)

Sec. 602.004. RULES. The commissioner may adopt rules as necessary to implement this chapter. (V.T.I.C. Art. 28B.08.)

[Sections 602.005-602.050 reserved for expansion]

SUBCHAPTER B. AUTHORIZED DISCLOSURE OF CERTAIN HEALTH INFORMATION

Sec. 602.051. AUTHORIZATION FOR DISCLOSURE OF CERTAIN HEALTH INFORMATION. (a) Except as provided by Section 602.053, a covered entity must obtain authorization to disclose nonpublic personal health information before disclosing the information.

(b) A request for authorization to disclose nonpublic personal health information may be in written or electronic form and must:

(1) state the identity of the consumer or customer who is the subject of the information;

(2) describe:

(A) each type of information to be disclosed;

(B) each party to whom the covered entity intends to disclose the information;

(C) the purpose of the disclosure;

(D) how the information will be used; and

(E) the procedure for revoking the authorization;

(3) include the signature of:

(A) the consumer or customer who is the subject of the information; or

(B) the individual who is legally empowered to grant authorization;

(4) state the date the authorization is signed; and

(5) provide notice of:

(A) the period for which the authorization is valid; and

(B) the consumer's or customer's right to revoke

the authorization at any time.

(c) The period for which the authorization is valid may not exceed 24 months.

(d) The right of a consumer or customer to revoke an authorization at any time is subject to the rights of an individual who, before receiving notice of a revocation, acted in reliance on the authorization.

(e) The covered entity shall retain the original or a copy of the authorization in the records of the individual who is the subject of the nonpublic personal health information. (V.T.I.C. Art. 28B.02.)

Sec. 602.052. DELIVERY OF AUTHORIZATION FORM AND REQUEST FOR AUTHORIZATION. (a) A covered entity may deliver to a consumer or customer a request for authorization and an authorization form only if the request and form are clear and conspicuous.

(b) A covered entity is required to include delivery of the authorization form in a notice to a consumer or customer only if the covered entity intends to disclose health information protected under this chapter. (V.T.I.C. Art. 28B.03.)

Sec. 602.053. EXCEPTIONS. A covered entity may disclose nonpublic personal health information to the extent that the disclosure is necessary to perform the following insurance or health maintenance organization functions on behalf of the covered entity:

(1) the investigation or reporting of actual or potential fraud, misrepresentation, or criminal activity;

(2) underwriting;

(3) the placement or issuance of an insurance policy or evidence of coverage;

(4) loss control services;

(5) ratemaking or guaranty fund functions;

(6) reinsurance or excess loss insurance;

(7) risk management;

(8) case management;

(9) disease management;

(10) quality assurance;

(11) quality improvement;

(12) performance evaluation;

(13) health care provider credentialing verification;

(14) utilization review;

(15) peer review activities;

(16) actuarial, scientific, medical, or public policy research;

(17) grievance procedures;

(18) the internal administration of compliance, managerial, and information systems;

(19) policyholder or enrollee services;

(20) auditing;

(21) reporting;

(22) database security;

(23) the administration of consumer disputes and inquiries;

(24) external accreditation standards;

(25) the replacement of a group benefit plan or

workers' compensation policy or program;

(26) activities in connection with a sale, merger, transfer, or exchange of all or part of a business or operating unit;

(27) any activity that permits disclosure without authorization under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), as amended;

(28) disclosure that is required, or that is a lawful or appropriate method to enforce the covered entity's rights or the rights of other persons engaged, in carrying out a transaction or providing a product or service that the consumer requests or authorizes;

(29) claims administration, adjustment, and management;

(30) any activity that is:

(A) otherwise permitted by law;

(B) required by a governmental reporting authority; or

(C) required to comply with legal process; and

(31) any other insurance or health maintenance organization functions the commissioner approves that are:

(A) necessary for appropriate performance of insurance or health maintenance organization functions; and

(B) fair and reasonable to the interests of consumers. (V.T.I.C. Art. 28B.04.)

[Sections 602.054-602.100 reserved for expansion]

SUBCHAPTER C. PENALTIES AND ENFORCEMENT

Sec. 602.101. PROHIBITION. A covered entity may not knowingly or wilfully violate this chapter. (V.T.I.C. Art. 28B.07.)

Sec. 602.102. INJUNCTION. The attorney general may bring an action for injunctive relief to restrain a violation of this chapter. (V.T.I.C. Art. 28B.09, Sec. (a).)

Sec. 602.103. CIVIL PENALTY. (a) The attorney general may bring an action for a civil penalty against a covered entity or health care entity for a violation of this chapter.

(b) A civil penalty assessed under this section may not be less than $3,000 for each violation.

(c) If the court in which an action under this section is pending finds that the violations have occurred with a frequency as to constitute a pattern or practice, the court may assess a civil penalty not to exceed $250,000.

(d) A civil penalty authorized by this section is in addition to any other civil, administrative, or criminal action provided by law, including an action for injunctive relief provided by Section 602.102. (V.T.I.C. Art. 28B.09, Secs. (b), (c), (d).)

Sec. 602.104. DISCIPLINARY ACTION. (a) In addition to a penalty prescribed by this subchapter, a covered entity that violates this chapter is subject to investigation, disciplinary proceedings, and probation or suspension of the covered entity's license or other form of authorization to engage in business.

(b) If there is evidence that a covered entity has engaged in a pattern or practice of violating this chapter, the covered

entity's license or other form of authorization to engage in business may be revoked. (V.T.I.C. Art. 28B.10.)

Sec. 602.105. EXCLUSION FROM STATE PROGRAMS. If there is evidence that a covered entity has engaged in a pattern or practice of violating this chapter, in addition to the other penalties prescribed by this subchapter, the covered entity shall be excluded from participating in any state-funded health care program. (V.T.I.C. Art. 28B.11.)

Sec. 602.106. REMEDIES AVAILABLE. This subchapter does not affect any right of a person under other law to bring a cause of action or otherwise seek relief with respect to conduct that violates this chapter. (V.T.I.C. Art. 28B.12.)

[Chapters 603-650 reserved for expansion]

SUBTITLE E. PREMIUM FINANCING

CHAPTER 651. FINANCING OF INSURANCE PREMIUMS

SUBCHAPTER A. GENERAL PROVISIONS

CHAPTER 651. FINANCING OF INSURANCE PREMIUMS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 651.001. DEFINITIONS. In this chapter:

(1) "Annual percentage rate" means the annual percentage rate of finance charge determined under the Consumer

Credit Protection Act and Regulation Z.

(2) "Consumer Credit Protection Act" means the Consumer Credit Protection Act of 1970 (15 U.S.C. Section 1601 et seq.; 18 U.S.C. Section 891 et seq.).

(3) "Insurance premium finance company" means:

(A) a person engaged in the business of making loans under this chapter by entering into premium finance agreements with insureds or prospective insureds;

(B) a person engaged in the business of acquiring premium finance agreements from insurance agents or brokers or from other insurance premium finance companies; or

(C) an insurance agent or broker making loans under this chapter who holds premium finance agreements made and delivered by insureds that are payable to the agent or broker or to the agent's or broker's order.

(4) "Insured" means a person who enters into a premium finance agreement with an insurance premium finance company.

(5) "Insurer" means an entity organized or authorized to engage in the business of insurance under this code as a capital stock insurance company, title insurance company, reciprocal or interinsurance exchange, Lloyd's plan, fraternal benefit society, mutual or mutual assessment company of any kind, statewide mutual assessment company, local mutual aid association, burial association, county or farm mutual insurance company, fidelity, guaranty, or surety company, or trust company.

(6) "License holder" means an insurance premium finance company that holds a license issued under Subchapter B.

(7) "Person" means an individual, partnership, corporation, joint venture, trust, association, or other legal entity, regardless of organization.

(8) "Premium finance agreement" means an agreement by which an insured or prospective insured promises to pay to an insurance premium finance company the amount advanced or to be advanced under the agreement to an insurer or to an insurance agent in payment of the premiums on an insurance contract.

(9) "Regulation Z" means the federal regulations adopted under the Consumer Credit Protection Act as 12 C.F.R. Section 226.1 et seq. (V.T.I.C. Art. 24.01, Subdivs. (1) (part), (2), (4), (5), (6), (7), (8); New.)

Sec. 651.002. CERTAIN CONDUCT NOT ENGAGING IN BUSINESS AS INSURANCE PREMIUM FINANCE COMPANY. (a) The preparation or delivery by an insurance agent of a premium finance agreement or disclosure statement required by Section 651.155 on behalf of the insured does not constitute engaging in business as an insurance premium finance company.

(b) Subsection (a) does not apply to a premium finance agreement held for the benefit of the insurance agent as provided by Section 651.001(3)(C). (V.T.I.C. Art. 24.01, Subdiv. (1)(A) (part); Art. 24.04, Sec. (c) (part).)

Sec. 651.003. RULES. (a) The commissioner may adopt and enforce rules necessary to administer this chapter.

(b) The rules may contain classifications, differentiations, or other provisions and provide for adjustments or exceptions for any class of transactions necessary to:

(1) accomplish the purposes of this chapter;

(2) prevent circumvention or evasion of this chapter; or

(3) facilitate compliance with this chapter.

(c) A rule adopted by the commissioner may not contain any classification, differentiation, or other provision with respect to any class of transactions or provide for any adjustment or exception for any class of transactions that would result in a less stringent disclosure requirement than required for that class of transactions by the Consumer Credit Protection Act or Regulation Z. (V.T.I.C. Art. 24.09.)

Sec. 651.004. EMPLOYMENT OF EXAMINERS AND INVESTIGATORS; PAYMENT OF EXPENSES. The department may:

(1) employ persons as necessary to examine or investigate and make reports on alleged violations of this chapter and compliance with any other provision of this code by a license holder;

(2) pay the salaries and expenses of persons described by Subdivision (1) and of all office employees; and

(3) pay an expense necessary to enforce this chapter. (V.T.I.C. Art. 24.06, Sec. (d) (part).)

Sec. 651.005. DEPOSIT AND USE OF FEES. Each fee collected under this chapter:

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

(2) may be used by the department to enforce this chapter. (V.T.I.C. Art. 24.03, Sec. (h) (part); Art. 24.06, Sec.

(d) (part).)

Sec. 651.006. ASSESSMENTS. (a) A license holder shall pay to the department:

(1) an amount imposed by the department to cover the direct and indirect cost of examinations and investigations made under this chapter; and

(2) a proportionate share of the general administrative expense attributable to the regulation of license holders.

(b) Each amount required by this section is in addition to any investigation or license fee imposed under Subchapter B. (V.T.I.C. Art. 24.06, Sec. (c).)

Sec. 651.007. APPLICABILITY OF CONSUMER CREDIT PROTECTION ACT AND REGULATION Z. A transaction that is subject to this chapter is also subject to:

(1) the Consumer Credit Protection Act; and

(2) the applicable provisions of Regulation Z. (V.T.I.C. Art. 24.12.)

Sec. 651.008. AUTHORITY OF GENERAL PROPERTY AND CASUALTY AGENTS TO CHARGE INTEREST TO CERTAIN PERSONS. (a) Notwithstanding any other law, a general property and casualty agent who holds a license under Chapter 4051 may enter into a written agreement with a purchaser of insurance from the agent that provides for the payment of interest to the agent on any amount due to the agent for the insurance purchased. The interest is computed at a rate not to exceed the greater of:

(1) a rate allowed by Chapter 303, Finance Code; or

(2) the rate of one percent a month.

(b) A claim or defense of usury may not be raised in connection with a written agreement under this section. (V.T.I.C. Art. 24.20.)

[Sections 651.009-651.050 reserved for expansion]

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 651.051. LICENSE REQUIRED. Unless the person is a license holder, a person may not:

(1) negotiate, transact, or engage in the business of insurance premium financing in this state; or

(2) contract for, charge, or receive directly or indirectly on or in connection with an insurance premium financing any charge, regardless of whether the charge is for interest, compensation, consideration, expense, or otherwise, if in the aggregate the amount of the charge exceeds the amount the person would be permitted by law to charge if the person were not a license holder. (V.T.I.C. Art. 24.02, Sec. (a) (part).)

Sec. 651.052. LICENSE FEE. (a) The department shall establish the fee for a license under this subchapter in an amount not to exceed $200.

(b) The fee for a license issued after June 30 may not exceed $100.

(c) Section 201.001 applies to fees collected under this section. (V.T.I.C. Art. 24.03, Secs. (f) (part), (h) (part).)

Sec. 651.053. ENTITLEMENT OF BANKS AND SAVINGS AND LOAN ASSOCIATIONS TO LICENSE. (a) A bank or a savings and loan association is entitled to receive a license under this subchapter

if the bank or savings and loan association:

(1) is engaging in business under the laws of this state or the United States; and

(2) notifies the department of its intention to operate under this chapter.

(b) On receipt of notice under Subsection (a)(2), the department shall immediately issue a license to the bank or savings and loan association. (V.T.I.C. Art. 24.02, Sec. (b).)

Sec. 651.054. APPLICATION FOR LICENSE; INVESTIGATION FEE; EXEMPTION. (a) An application for a license to engage in the business of insurance premium financing must:

(1) be in writing on a form prescribed by the commissioner; and

(2) be accompanied by a nonrefundable investigation fee in an amount not to exceed $400 as established by the department.

(b) A person who on January 1, 1980, held a license under Chapter 3, Title 79, Revised Statutes (Article 5069-3.01 et seq., Vernon's Texas Civil Statutes), is not required to pay an investigation fee.

(c) Section 201.001 applies to fees collected under this section. (V.T.I.C. Art. 24.03, Secs. (a), (e), (g), (h) (part).)

Sec. 651.055. REFUSAL TO ISSUE LICENSE. The department may refuse to issue a license to an applicant if the department determines that:

(1) the financial responsibility, experience, character, or general fitness of the applicant or any person

associated with the applicant does not command the confidence of the community and does not warrant the belief that the applicant will engage in the business of insurance premium financing honestly, fairly, and efficiently; or

(2) the applicant does not have available for the operation of the business net assets of at least $25,000. (V.T.I.C. Art. 24.03, Sec. (c).)

Sec. 651.056. NOTICE OF ACTION ON APPLICATION. Not later than the 90th day after the date the department receives an application under Section 651.054, the department shall notify the applicant that:

(1) the application has been approved and the department will issue a license to the applicant on payment of the required license fee; or

(2) the application has been denied. (V.T.I.C. Art. 24.03, Sec. (b).)

Sec. 651.057. ISSUANCE OF LICENSE. After approval of an application and on receipt of the required license fee, the department shall:

(1) issue a license authorizing the license holder to engage in business as an insurance premium finance company at the location specified in the license holder's application; and

(2) send the license to the applicant. (V.T.I.C. Art. 24.03, Secs. (d), (f) (part).)

Sec. 651.058. RECIPROCAL LICENSE. The department may waive any license requirement for an applicant who holds a valid license from another state that has license requirements substantially

equivalent to the requirements prescribed by this state. (V.T.I.C. Art. 24.03, Sec. (k).)

Sec. 651.059. ISSUANCE OF MULTIPLE LICENSES. The department may issue a person more than one license under this subchapter but may not issue one person more than 60 of those licenses. (V.T.I.C. Art. 24.02, Sec. (a) (part).)

Sec. 651.060. SINGLE BUSINESS LOCATION AUTHORIZED BY LICENSE. A license authorizes the license holder to maintain only one location where the business of insurance premium financing may be conducted. (V.T.I.C. Art. 24.02, Sec. (a) (part).)

Sec. 651.061. APPEARANCE OF LICENSE; POSTING. (a) A license must state the name and address of the license holder.

(b) The license must be conspicuously posted at the location where the license holder engages in the business of insurance premium financing. (V.T.I.C. Art. 24.04, Sec. (a) (part).)

Sec. 651.062. TRANSFER OR ASSIGNMENT OF LICENSE PROHIBITED. A license may not be transferred or assigned. (V.T.I.C. Art. 24.04, Sec. (a) (part).)

Sec. 651.063. TERM OF LICENSE. Unless a staggered renewal system is adopted under Section 651.065, a license is issued for the calendar year and remains valid until December 31 of that year, unless suspended, revoked, or surrendered in accordance with Section 651.204 or 651.206. (V.T.I.C. Art. 24.03, Sec. (f) (part).)

Sec. 651.064. PROCEDURE FOR LICENSE RENEWAL. (a) A license holder may renew an unexpired license by paying the required renewal fee to the department.

(b) A person whose license has been expired for 90 days or less may renew the license by paying to the department:

(1) the required renewal fee; and

(2) an additional fee equal to one-half of the original license fee.

(c) A person whose license has been expired for more than 90 days but less than two years may renew the license by paying to the department:

(1) all unpaid renewal fees; and

(2) an additional fee equal to the original license fee.

(d) A person whose license has been expired for two years or more may not renew the license. The person may obtain a new license by complying with the requirements and procedures for obtaining an original license.

(e) Not later than the 30th day before the date a person's license expires, the department shall send written notice of the impending license expiration to the person at the person's last known address.

(f) This section may not be construed to prevent the department from denying or refusing to renew a license under an applicable law or a rule adopted by the commissioner. (V.T.I.C. Art. 24.03, Sec. (i).)

Sec. 651.065. STAGGERED RENEWAL SYSTEM. (a) The commissioner by rule may adopt a system under which licenses expire on various dates during the year.

(b) For a year in which the license expiration date is less

than one year from the date of license issuance or the anniversary of that date, the license fee shall be prorated so that each license holder pays only that portion of the license fee allocable to the number of months during which the license is valid. On each subsequent renewal of the license, a license holder must pay the total renewal fee. (V.T.I.C. Art. 24.03, Sec. (j).)

[Sections 651.066-651.100 reserved for expansion]

SUBCHAPTER C. REGULATION OF INSURANCE PREMIUM FINANCE COMPANIES

Sec. 651.101. BOOKS, ACCOUNTS, AND RECORDS. (a) A license holder shall maintain books, accounts, and records in sufficient detail to enable a representative of the department to determine whether the license holder is in compliance with this chapter and rules adopted by the commissioner.

(b) A license holder shall maintain for inspection the license holder's books, accounts, and records, including any cards used in a card system, for at least four years after the date the final entry of any premium finance agreement is recorded in those books, accounts, and records. (V.T.I.C. Art. 24.10, Sec. (a).)

Sec. 651.102. ANNUAL REPORT. On or before April 1 of each year, a license holder shall file with the department a report containing information required by the department concerning the business and operations of the license holder during the preceding calendar year at each licensed location where the license holder engages in the business of insurance premium financing in this state. (V.T.I.C. Art. 24.10, Sec. (b).)

Sec. 651.103. BUSINESS NAME. A license holder may not

engage in the business of insurance premium financing under any name other than the name stated on the license. (V.T.I.C. Art. 24.04, Sec. (c) (part).)

Sec. 651.104. BUSINESS LOCATION. A license holder may not engage in the business of insurance premium financing at any location other than the address stated on the license. (V.T.I.C. Art. 24.04, Sec. (c) (part).)

Sec. 651.105. RELOCATION OF PLACE OF BUSINESS. (a) A license holder who proposes to relocate the place where the holder engages in the business of insurance premium financing shall give written notice of the proposed change to the department.

(b) If the department approves the proposed relocation, the department shall issue an endorsement to the license holder indicating the change and the date of the change.

(c) The endorsement authorizes the license holder to engage in the business of insurance premium financing at the new location. The license holder shall attach the endorsement to the license for that location. (V.T.I.C. Art. 24.04, Sec. (a) (part).)

Sec. 651.106. BUSINESS PREMISES. (a) Except as provided by Subsection (b), a license holder may engage in the business of insurance premium financing:

(1) in any office, suite, room, or place of business in which any other business is solicited or engaged in; or

(2) in association or in conjunction with any other business.

(b) Subsection (a) does not apply if the department:

(1) determines, after a hearing, that the conduct by

the license holder of the other business at the location for which the license was issued has concealed evasions of this chapter; and

(2) orders the license holder in writing to stop engaging in the business of insurance premium financing at that location. (V.T.I.C. Art. 24.04, Sec. (b).)

Sec. 651.107. ENGAGING IN BUSINESS BY MAIL OR OUTSIDE THE COMMUNITY. This chapter does not prohibit a license holder from engaging in the business of insurance premium financing:

(1) by mail; or

(2) with persons who do not reside in the same community as the licensed location. (V.T.I.C. Art. 24.04, Sec. (d).)

Sec. 651.108. CERTAIN CHARGES PROHIBITED. In connection with a premium finance agreement entered into under this chapter, an insurance charge or any other charge or fee may not be imposed unless the charge or fee is authorized by this chapter. (V.T.I.C. Art. 24.15 (part).)

Sec. 651.109. LIMITATIONS ON RATES AND CHARGES. (a) An insurance premium finance company may not take or receive from an insured a greater rate or charge than is authorized by Chapter 342, Finance Code.

(b) For purposes of this section, a charge begins on the earlier of:

(1) the date from which the insurer requires payment of the premium and payment was made to the insurer for the financed policy; or

(2) the effective date of the policy.

(c) The finance charge is computed on the balance of the premiums due after subtracting any down payment made by the insured in accordance with the premium finance agreement. (V.T.I.C. Art. 24.15 (part).)

Sec. 651.110. REBATE OF FINANCE CHARGE. (a) An insurance premium finance company or an employee of an insurance premium finance company may not:

(1) pay, allow, or offer to pay or allow in any manner to an insurance agent or broker or an employee of an insurance agent or broker or to any other person any consideration or compensation, from the charge for financing specified in the premium finance agreement or from another source; or

(2) give or offer to give any valuable consideration or inducement of any kind directly or indirectly to an insurance agent or broker or an employee of an insurance agent or broker.

(b) Subsection (a)(2) does not prohibit the giving or offering of an article of merchandise that has a value of $1 or less on which there is an advertisement of the insurance premium finance company.

(c) Subsection (a) does not prohibit an insurance premium finance company from making a payment under a contractual agreement with a validly organized and operating association of insurance agents or a subsidiary of the association if no part of a payment received under the agreement:

(1) is distributed to an insurance agent or broker or an employee of an insurance agent or broker; or

(2) inures directly to the benefit of a member of the

association or an employee of the member.

(d) A contractual agreement under Subsection (c):

(1) must be in writing; and

(2) is not valid until department approval is received. (V.T.I.C. Art. 24.14, Sec. (a).)

Sec. 651.111. DECEPTIVE ADVERTISING PROHIBITED. (a) A license holder may not advertise or cause to be advertised in any manner any false, misleading, or deceptive statement or representation with regard to the rates, terms, or conditions of a premium finance agreement.

(b) If rates or charges are stated in advertising, the license holder must express the rates or charges in terms of a simple annual percentage rate as defined by federal law. (V.T.I.C. Art. 24.13.)

[Sections 651.112-651.150 reserved for expansion]

SUBCHAPTER D. PREMIUM FINANCE AGREEMENTS

Sec. 651.151. REQUIRED FORM AND CONTENTS OF PREMIUM FINANCE AGREEMENT. (a) A premium finance agreement must be in writing on a form approved by the commissioner.

(b) A premium finance agreement must be dated and signed by the insured. An agreement may be signed on behalf of the insured by the insured's agent if:

(1) the agreement contains policies for other than personal, family, or household purposes; and

(2) the premiums for the policies exceed $1,000.

(c) A premium finance agreement must contain:

(1) the name and business address of the insurance

agent or broker negotiating the related insurance contract;

(2) the name and residence or business address of the insured as specified by the insured;

(3) the name and business location of the insurance premium finance company to which payments are to be made;

(4) a description of each insurance contract involved;

(5) the amount of the premium for each insurance contract;

(6) the total amount of the premiums for all insurance contracts;

(7) the amount of any down payment;

(8) the principal balance, which is the difference between the amounts under Subdivisions (6) and (7);

(9) the total amount of the finance charge, which must describe each amount included and use the term "finance charge"; and

(10) the balance payable by the insured, which is the sum of the amounts under Subdivisions (8) and (9). (V.T.I.C. Art. 24.11, Secs. (a), (b), (c).)

Sec. 651.152. OTHER REQUIRED CONTENTS. In addition to the items required by Section 651.151, a premium finance agreement must contain the following, as applicable:

(1) the finance charge expressed as an annual percentage rate, using the term "annual percentage rate";

(2) the number of installments required under the agreement;

(3) the amount of each installment expressed in

dollars;

(4) the due date or period of each installment;

(5) the amount or method of computing the amount of any default or delinquency charge that is payable in the event of late payment; and

(6) the method of computing any unearned portion of the finance charge in the event of prepayment of the obligation. (V.T.I.C. Art. 24.11, Sec. (d).)

Sec. 651.153. FORM OF DISCLOSURES. (a) The disclosures required by Sections 651.151 and 651.152 must be made clearly, conspicuously, and in meaningful sequence.

(b) If the term "finance charge" or "annual percentage rate" is required to be used, the term must be printed more conspicuously than other required terminology.

(c) Each numerical amount or percentage must be expressed as a figure and:

(1) legibly handwritten; or

(2) printed in not less than the equivalent of 10-point type, 75/1,000-inch computer type, or elite-size typewritten numerals. (V.T.I.C. Art. 24.11, Sec. (e).)

Sec. 651.154. CONSOLIDATION OF INCREASE ATTRIBUTABLE TO AMENDMENT OF RATE CLASSIFICATION. (a) If, in a premium finance agreement, a change in an insured's policy that is caused by an amendment of the rate classification by endorsement or otherwise results in an increased principal balance and the amount under the previous contract has not been fully paid, the subsequent increase, at the insured's option, may be consolidated with the previous

contract if the agreement provides for consolidation.

(b) A consolidation under this section may be accomplished by a memorandum of agreement between the agent and the insured if, before the first scheduled payment date of the amended transaction, the insurance premium finance company provides to the insured the following information in writing:

(1) the amount of the premium increase;

(2) the down payment on the increase;

(3) the principal amount of the increase;

(4) the total amount of any finance charge on the increase;

(5) the total of the additional balance due;

(6) the outstanding balance due under the original agreement;

(7) the balance due under the consolidated agreement;

(8) the annual percentage rate of any finance charge on the additional balance due;

(9) the revised schedule of payments;

(10) the amount or method of computing the amount of any default, deferment, or similar charge authorized by Chapter 342, Finance Code, that is payable in the event of late payment; and

(11) the method of computing any unearned portion of the finance charge in the event of prepayment of the obligation. (V.T.I.C. Art. 24.11, Secs. (g), (h).)

Sec. 651.155. RESPONSIBILITIES OF INSURANCE AGENT. An insurance agent shall:

(1) prepare a premium finance agreement; and

(2) deliver to the insured each disclosure statement required by law. (V.T.I.C. Art. 24.11, Sec. (f) (part).)

Sec. 651.156. TAKING OF INCOMPLETE PREMIUM FINANCE AGREEMENT PROHIBITED. A license holder may not take a premium finance agreement that has not been fully completed and executed at the time the agreement is executed. (V.T.I.C. Art. 24.11, Sec. (f) (part).)

Sec. 651.157. PERFECTION OF PREMIUM FINANCE AGREEMENT AS SECURED TRANSACTION: FILING NOT REQUIRED. Filing of a premium finance agreement or a financing statement is not necessary to perfect the agreement as a secured transaction against a creditor, subsequent purchaser, pledgee, encumbrancer, successor, or assign of the insured or any other party. (V.T.I.C. Art. 24.14, Sec. (b).)

Sec. 651.158. PREPAYMENT AND REFUND. (a) Notwithstanding the provisions of any premium finance agreement to the contrary, an insured may pay the balance due under the agreement in full at any time before the maturity of the final installment of the balance.

(b) If an insured pays a premium finance agreement in full as authorized by this section and the agreement included an amount for a charge, the insured is entitled to receive for the prepayment by cash or renewal a refund credit in accordance with Subchapter H, Chapter 342, Finance Code, and rules adopted under that subchapter. If the amount of the credit for prepayment is less than $1, the insured is not entitled to a refund credit. (V.T.I.C. Art. 24.16.)

Sec. 651.159. DEFAULT CHARGE. A premium finance agreement may provide for the payment of a default charge by the insured as provided by Section 342.203, Finance Code, this code, or a rule

adopted under those statutes. (V.T.I.C. Art. 24.17, Sec. (a).)

Sec. 651.160. POWER OF ATTORNEY. A premium finance agreement may contain a power of attorney that enables the insurance premium finance company to cancel any or all of the insurance contracts listed in the agreement as provided by Section 651.161. (V.T.I.C. Art. 24.17, Sec. (b) (part).)

Sec. 651.161. CANCELLATION OF INSURANCE CONTRACT. (a) An insurance premium finance company may not cancel an insurance contract listed in a premium finance agreement except as provided by this section for an insured's failure to make a payment at the time and in the amount provided in the agreement.

(b) The insurance premium finance company must mail to the insured a written notice that the company will cancel the insurance contract because of the insured's default in payment unless the default is cured at or before the time stated in the notice. The stated time may not be earlier than the 10th day after the date the notice is mailed.

(c) The insurance premium finance company must also mail a copy of the notice to the insurance agent or broker identified in the premium finance agreement.

(d) After the time stated in the notice required by Subsection (b), the insurance premium finance company may cancel each applicable insurance contract by mailing a notice of cancellation to the insurer. Each insurance contract shall be canceled as if the insured had canceled the contract, except that the return of a canceled contract is not required.

(e) The insurance premium finance company must also mail a

notice of cancellation to:

(1) the insured at the insured's last known address; and

(2) the insurance agent or broker identified in the premium finance agreement.

(f) A statutory, regulatory, or contractual restriction that provides that an insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party applies to a cancellation under this section. The insurer shall:

(1) give the prescribed notice on behalf of the insurer or the insured to each governmental agency, mortgagee, or other third party on or before the second business day after the date the insurer receives the notice of cancellation from the insurance premium finance company; and

(2) determine the effective date of cancellation, taking into consideration the number of days' notice required to complete the cancellation. (V.T.I.C. Art. 24.17, Secs. (b) (part), (c), (d), (e).)

Sec. 651.162. RETURN OF UNEARNED PREMIUMS AND COMMISSIONS. (a) This section applies only to a premium finance agreement that contains an assignment or power of attorney for the benefit of the insurance premium finance company.

(b) If an insurance contract listed in a premium finance agreement is canceled, the insurer shall return all unearned premiums that are due under the contract directly to the insurance premium finance company before the 61st day after the cancellation

date.

(c) The insurer may deduct from the unearned premiums returned to the insurance premium finance company the amount of any unearned commission due from the agent writing the insurance if the insurer notifies the agent to return the unearned commission to the insurance premium finance company. If the agent does not return the unearned commission to the insurance premium finance company before the 91st day after the cancellation date, the insurer shall remit the unearned commission to the insurance premium finance company before the 121st day after the cancellation date.

(d) Notwithstanding Subsections (a)-(c), an agent is liable for the return of unearned commissions on an insurance contract written through the Texas Windstorm Insurance Association, the Texas Automobile Insurance Plan Association, or the Texas Medical Liability Insurance Underwriting Association. An agent placing business through one of those plans shall return the unearned commissions to the insurance premium finance company before the 61st day after the date the agent is notified of the cancellation.

(e) An insurer, other than the Texas Windstorm Insurance Association, the Texas Automobile Insurance Plan Association, or the Texas Medical Liability Insurance Underwriting Association, may return the unearned premiums to the producing agent. The insurer remains liable and shall remit the unearned premiums to the insurance premium finance company before the 121st day after the cancellation date if:

(1) the producing agent does not return the unearned premiums to the insurance premium finance company before the 91st

day after the cancellation date; and

(2) the insurance premium finance company complied with Section 651.165.

(f) If the insurance premium finance company failed to comply with Section 651.165, the insurer, including the Texas Windstorm Insurance Association, the Texas Automobile Insurance Plan Association, and the Texas Medical Liability Insurance Underwriting Association, may comply with its legal duty to return the unearned premiums due under the insurance contract to the insurance premium finance company by returning those unearned premiums to the producing agent.

(g) If the crediting of return premiums to the account of an insured results in a surplus over the amount due from the insured, the insurance premium finance company shall refund the excess to the insured. If the amount of the excess is less than $1, the insured is not entitled to a refund. (V.T.I.C. Art. 24.17, Secs. (f), (g).)

Sec. 651.163. ASSIGNMENT OF PREMIUM FINANCE AGREEMENT. Unless the insured has notice of an actual or intended assignment of a premium finance agreement, payment by an insured under the agreement to the last known holder of the agreement is binding on all subsequent holders or assignees. (V.T.I.C. Art. 24.18.)

Sec. 651.164. RESTRICTIONS ON PREMIUM FINANCE AGREEMENTS. (a) A premium finance agreement may not contain any provision under which, absent default by the insured, the insurance premium finance company holding the agreement may arbitrarily or without reasonable cause accelerate the maturity of all or any part of the amount owing

under the agreement.

(b) For purposes of Subsection (a), reasonable cause includes a proceeding in bankruptcy, receivership, or insolvency instituted by or against the insured or the insolvency of or suspension of business or cessation of the right to engage in business by an insurer writing policies that are financed for the insured under the premium finance agreement.

(c) A license holder may not take:

(1) an instrument in which the insured waives any right accruing to the insured under this chapter;

(2) an instrument that has not been fully completed and executed by the insured;

(3) an assignment of wages as security for an insurance premium finance agreement entered into under this chapter;

(4) a lien on real property as security for a premium finance agreement entered into under this chapter, except any lien created by law on the recording of an abstract of judgment; or

(5) a confession of judgment or a power of attorney in favor of the license holder or a third person to confess judgment or to appear for an insured in a judicial proceeding. (V.T.I.C. Art. 24.19.)

Sec. 651.165. REQUIRED NOTICE OF CERTAIN PREMIUM FINANCE AGREEMENTS. (a) An insurance premium finance company that enters into a premium finance agreement that includes an assignment or power of attorney shall notify the insurer or the Texas Windstorm Insurance Association, the Texas Automobile Insurance Plan

Association, or the Texas Medical Liability Insurance Underwriting Association whose premiums are being financed:

(1) of the existence of the agreement; and

(2) to whom the premium payment has been made.

(b) An insurance premium finance company shall notify and fund all premiums to a county mutual insurance company unless the insurance premium finance company is authorized in writing by the county mutual insurance company to notify or fund an agent or managing general agent.

(c) Notice required under this section must be made before the 31st day after the date the premium finance agreement is accepted by the insurance premium finance company. (V.T.I.C. Art. 24.22.)

Sec. 651.166. TAKING, RECEIVING, OR CHARGING UNAUTHORIZED AMOUNT. (a) Taking or receiving from an insured or the charging of an insured by an insurance premium finance company of a charge greater than authorized by this chapter does not invalidate:

(1) the premium finance agreement; or

(2) the principal balance payable under the agreement.

(b) An action described by Subsection (a) may be adjudged a forfeiture of all charges that:

(1) are authorized under the premium finance agreement; or

(2) the insured has agreed to pay.

(c) A person who pays an unauthorized charge or the person's legal representative may bring an action against the insurance premium finance company to recover twice the total amount of the

charge paid. The action must be brought within two years after the date the unauthorized charge is paid. (V.T.I.C. Art. 24.08, Sec. (b).)

Sec. 651.167. EFFECT OF LICENSE REVOCATION, SUSPENSION, OR SURRENDER ON PREMIUM FINANCE AGREEMENT. The revocation, suspension, or surrender of a license does not affect the obligation of an insured under a lawful premium finance agreement previously acquired or held by the person whose license was revoked, suspended, or surrendered. (V.T.I.C. Art. 24.05, Sec. (d).)

[Sections 651.168-651.200 reserved for expansion]

SUBCHAPTER E. DISCIPLINARY PROCEDURES AND PENALTIES; OFFENSES

Sec. 651.201. EXAMINATIONS AND INVESTIGATIONS OF LICENSE HOLDERS. (a) The department may conduct an examination or investigation that is necessary to determine whether a license holder:

(1) is in compliance with this chapter; or

(2) has engaged in conduct that would warrant the revocation or suspension of the license holder's license.

(b) The department or an authorized representative of the department may:

(1) require the attendance of any person;

(2) examine the person under oath; and

(3) compel the production of any relevant book, record, account, or document. (V.T.I.C. Art. 24.06, Sec. (a).)

Sec. 651.202. CONFIDENTIALITY OF REPORTS AND RELATED

MATERIAL. (a) A report of an examination or investigation under Section 651.201 and any correspondence or memoranda concerning or arising from the examination or investigation:

(1) are confidential communications;

(2) are not subject to subpoena; and

(3) may not be made public, except in connection with a hearing under Section 651.204 or an appearance in connection with the hearing.

(b) Subsection (a) applies to an authenticated copy of a report described by Subsection (a) in the possession of the commissioner, the department, or a license holder.

(c) Information obtained in the course of an examination or investigation may be made available to another governmental agency if the information involves a matter within the scope or jurisdiction of the agency. (V.T.I.C. Art. 24.06, Sec. (b).)

Sec. 651.203. HEARINGS AND INVESTIGATIONS; SUBPOENA POWER. In conducting a hearing or investigation under this chapter, the department or a person designated by the department may:

(1) administer oaths;

(2) subpoena witnesses;

(3) take depositions of witnesses who reside outside of this state in the manner provided for in a civil action in district court; and

(4) pay to those witnesses a fee and mileage for attendance as provided for a witness in a civil action in district court. (V.T.I.C. Art. 24.07.)

Sec. 651.204. REVOCATION OR SUSPENSION OF LICENSE. After

notice and hearing, the department may revoke or suspend a license if:

(1) the department finds:

(A) that the license holder has violated this chapter or a rule adopted by the commissioner under this chapter; or

(B) the existence of a fact or condition that, if the fact or condition existed at the time of the original application for the license, clearly would have warranted the refusal of the license; or

(2) the department learns from any source that the license holder has failed to return all amounts due from an insurance premium finance company to the person whose insurance policy has been canceled as required by Section 651.162. (V.T.I.C. Art. 24.05, Secs. (a), (b).)

Sec. 651.205. ISSUANCE OF REVOCATION OR SUSPENSION ORDER. If the department revokes or suspends a license, the department shall:

(1) immediately issue in duplicate a written order of revocation or suspension;

(2) file one copy of the order in the office of the secretary of state; and

(3) mail one copy of the order to the license holder. (V.T.I.C. Art. 24.05, Sec. (e).)

Sec. 651.206. SURRENDER OF LICENSE; EFFECT. (a) A license holder may surrender a license by delivering to the department written notice that the license holder surrenders the license.

(b) The surrender of a license does not affect any civil or

criminal liability of the person for an act committed before the surrender. (V.T.I.C. Art. 24.05, Sec. (c).)

Sec. 651.207. LICENSE REINSTATEMENT. The department may reinstate a suspended license or issue a new license to a person whose license has been revoked if no fact or condition exists that clearly would have warranted the refusal to issue the license originally. (V.T.I.C. Art. 24.05, Sec. (f).)

Sec. 651.208. OFFENSE. (a) A person commits an offense if the person:

(1) intentionally, knowingly, recklessly, or negligently engages in the operation of an insurance premium finance company and does not hold a license issued under this chapter;

(2) intentionally, knowingly, recklessly, or negligently violates this chapter;

(3) intentionally or knowingly omits to state a material fact necessary to give the commissioner or the department information lawfully required of the person; or

(4) refuses to permit an investigation or examination authorized under this chapter.

(b) An offense under this section is a Class B misdemeanor. (V.T.I.C. Art. 24.08, Sec. (a).)

Sec. 651.209. SANCTIONS; CEASE AND DESIST ORDERS. In addition to each penalty provided by Sections 651.166 and 651.208, the commissioner or a person designated by the commissioner may:

(1) order a sanction under Subchapter B, Chapter 82; or

(2) issue a cease and desist order under Chapter 83.

(V.T.I.C. Art. 24.08, Sec. (c).)

[Chapters 652-700 reserved for expansion]

SUBTITLE F. INSURANCE FRAUD

CHAPTER 701. INSURANCE FRAUD INVESTIGATIONS

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Sec. 701.001. DEFINITIONS

Sec. 701.002. BUSINESS OF INSURANCE

Sec. 701.003. EFFECT OF CHAPTER

[Sections 701.004-701.050 reserved for expansion]

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Sec. 701.051. DUTY TO REPORT

Sec. 701.052. IMMUNITY FOR FURNISHING INFORMATION RELATING TO A FRAUDULENT INSURANCE ACT

[Sections 701.053-701.100 reserved for expansion]

SUBCHAPTER C. INVESTIGATIONS

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Sec. 701.103. DISCIPLINARY ACTION; REPORT TO OTHER AGENCIES

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Sec. 701.106. SUBPOENA AUTHORITY

Sec. 701.107. CERTAIN AGENCIES' DUTY TO PROVIDE INFORMATION

Sec. 701.108. INSURER'S DUTY TO PROVIDE INFORMATION

Sec. 701.109. REQUEST FOR INVESTIGATION BY INSURER

[Sections 701.110-701.150 reserved for expansion]

SUBCHAPTER D. INSURANCE FRAUD INFORMATION; CONFIDENTIALITY

Sec. 701.151. CONFIDENTIALITY OF DEPARTMENT INFORMATION

Sec. 701.152. CONFIDENTIALITY OF AUTHORIZED GOVERNMENTAL AGENCY INFORMATION

Sec. 701.153. DISCLOSURE OF INFORMATION TO CERTAIN AGENCIES

Sec. 701.154. DISCLOSURE OF INFORMATION TO PUBLIC

CHAPTER 701. INSURANCE FRAUD INVESTIGATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 701.001. DEFINITIONS. In this chapter:

(1) "Authorized governmental agency" means:

(A) a municipal, county, or state law enforcement agency of this state or another state or a law enforcement agency of the United States; or

(B) the prosecuting attorney of a municipality, county, or judicial district of this state or another state or the prosecuting attorney of the United States.

(2) "Fraudulent insurance act" means an act that is a violation of a penal law and is:

(A) committed or attempted while engaging in the business of insurance;

(B) committed or attempted as part of or in support of an insurance transaction; or

(C) part of an attempt to defraud an insurer.

(3) "Insurer" means a person who is engaged in the business of insurance as a principal or agent. The term includes:

(A) an unauthorized insurer; and

(B) an entity that is self-insured and provides health care benefits to the entity's employees.

(4) "Person" means an individual, corporation, organization, governmental entity, business trust or another trust, estate, partnership, joint venture, association, or any other legal entity. (V.T.I.C. Art. 1.10D, Sec. 1(a).)

Sec. 701.002. BUSINESS OF INSURANCE. A person is engaged in the business of insurance for purposes of this chapter if the person performs any act described by Subchapter B, Chapter 101. (V.T.I.C. Art. 1.10D, Sec. 1(b).)

Sec. 701.003. EFFECT OF CHAPTER. This chapter does not:

(1) preempt the authority or relieve the duty of an authorized governmental agency to investigate and prosecute suspected criminal acts;

(2) prevent or prohibit a person from voluntarily disclosing information to an authorized governmental agency;

(3) limit powers or duties granted to the commissioner by any other law; or

(4) prohibit or limit the authority of an insurer to conduct an independent investigation of suspected insurance claim fraud. (V.T.I.C. Art. 1.10D, Secs. 2(e) (part); 7.)

[Sections 701.004-701.050 reserved for expansion]

SUBCHAPTER B. REPORTING FRAUDULENT INSURANCE ACTS

Sec. 701.051. DUTY TO REPORT. (a) A person who determines

a fraudulent insurance act has been or is about to be committed shall report the information in writing to the department or an authorized governmental agency not later than the 30th day after the date the person makes the determination.

(b) A report made to one authorized governmental agency or the department constitutes notice to each other authorized governmental agency and the department. (V.T.I.C. Art. 1.10D, Secs. 4(a), (b).)

Sec. 701.052. IMMUNITY FOR FURNISHING INFORMATION RELATING TO A FRAUDULENT INSURANCE ACT. (a) A person is not liable in a civil action, including an action for libel or slander, and a civil action may not be brought against the person, for furnishing information relating to a suspected, anticipated, or completed fraudulent insurance act if the information is provided to:

(1) an authorized governmental agency or the department;

(2) a law enforcement officer or an agent or employee of the officer;

(3) the National Association of Insurance Commissioners or an employee of the association;

(4) a state or federal governmental agency established to detect and prevent fraudulent insurance acts or to regulate the business of insurance or an employee of the agency; or

(5) a special investigative unit of an insurer, including a person who contracts to provide special investigative unit services to the insurer or an employee of the insurer who is responsible for the investigation of suspected fraudulent

insurance acts.

(b) A person may furnish information as described in Subsection (a) orally or in writing, including through publishing, disseminating, or filing a bulletin or report.

(c) Subsection (a) does not apply to a person who acts with malice, fraudulent intent, or bad faith.

(d) A person to whom Subsection (a) applies who prevails in a civil action arising from furnishing information as described in Subsection (a) is entitled to attorney's fees and costs.

(e) This section does not affect any common law or statutory privilege or immunity.

(f) An insurer shall exercise reasonable care concerning the accuracy of information conveyed to an authorized governmental agency, the insurance fraud unit, or another insurer, person, or entity. (V.T.I.C. Art. 1.10D, Secs. 6(a), (b), (c), (d), (e) (part).)

[Sections 701.053-701.100 reserved for expansion]

SUBCHAPTER C. INVESTIGATIONS

Sec. 701.101. INSURANCE FRAUD UNIT. (a) The purpose of the department's insurance fraud unit is to enforce laws relating to fraudulent insurance acts.

(b) The insurance fraud unit may receive, review, and investigate in a timely manner insurer antifraud reports submitted under Chapter 704.

(c) The insurance fraud unit shall report annually to the commissioner in writing regarding:

(1) the number of cases completed by the insurance

fraud unit; and

(2) recommendations for regulatory and statutory responses to the types of fraudulent activities encountered by the insurance fraud unit. (V.T.I.C. Art. 1.10D, Secs. 2(a); 3A.)

Sec. 701.102. INVESTIGATION OF CERTAIN ACTS OF FRAUD. If the commissioner has reason to believe a person has engaged in, is engaging in, has committed, or is about to commit a fraudulent insurance act or the offense of insurance fraud under Section 35.02(a), Penal Code, the commissioner may conduct any investigation necessary inside or outside this state to:

(1) determine whether the act or offense occurred; or

(2) aid in enforcing laws relating to fraudulent insurance acts or insurance fraud. (V.T.I.C. Art. 1.10D, Sec. 2(b).)

Sec. 701.103. DISCIPLINARY ACTION; REPORT TO OTHER AGENCIES. (a) The commissioner shall take appropriate disciplinary action as provided by this code if the commissioner believes a fraudulent insurance act has occurred. The commissioner shall report information concerning the commissioner's belief that a person has committed a fraudulent insurance act to an authorized governmental agency.

(b) The commissioner shall:

(1) provide all material, documents, reports, complaints, or other evidence to an authorized governmental agency on request; and

(2) assist the authorized governmental agency as requested. (V.T.I.C. Art. 1.10D, Secs. 2(c), (d).)

Sec. 701.104. DEPARTMENT INVESTIGATORS. (a) The commissioner may:

(1) employ investigators as necessary to enforce this chapter; and

(2) commission those investigators as peace officers.

(b) If the commissioner commissions investigators as peace officers, the commissioner shall appoint a chief investigator who:

(1) is commissioned as a peace officer; and

(2) is qualified by training and experience in law enforcement to supervise, direct, and administer the activities of the commissioned investigators.

(c) An investigator employed by the department as a peace officer must meet the requirements for a peace officer under Chapter 1701, Occupations Code. (V.T.I.C. Art. 1.10D, Sec. 2(f).)

Sec. 701.105. ASSISTANCE FROM LAW ENFORCEMENT. An investigator employed by the department may request assistance from local law enforcement officers in conducting an investigation authorized by this chapter. (V.T.I.C. Art. 1.10D, Sec. 2(g).)

Sec. 701.106. SUBPOENA AUTHORITY. (a) The commissioner may issue a subpoena to compel the attendance and testimony of a witness or, except as provided by Subsection (b), the production of materials relevant to an investigation under this chapter.

(b) A person is not required to produce an item subpoenaed under Subsection (a) if the item can only be identified by writing and executing a special computer program for that purpose.

(c) A person possessing materials located outside this state that are requested by the commissioner may make the materials

available to the commissioner or a representative of the commissioner for examination at the place where the materials are located. The commissioner may designate a representative, including an official of the state in which the materials are located, to examine the materials. The commissioner may respond to a similar request from an official of another state or the United States. (V.T.I.C. Art. 1.10D, Secs. 3(a), (b).)

Sec. 701.107. CERTAIN AGENCIES' DUTY TO PROVIDE INFORMATION. (a) On the insurance fraud unit's request, an authorized governmental agency or a state licensing agency shall provide material, documents, reports, complaints, or other evidence to the insurance fraud unit.

(b) Compliance with Subsection (a) by an authorized governmental agency or a state licensing agency does not constitute waiver of any otherwise applicable privilege or confidentiality requirement. (V.T.I.C. Art. 1.10D, Sec. 2(d-1) (part).)

Sec. 701.108. INSURER'S DUTY TO PROVIDE INFORMATION. On the written request of an authorized governmental agency, an insurer shall provide to the agency any relevant information or material relating to a matter under investigation. (V.T.I.C. Art. 1.10D, Sec. 4(c).)

Sec. 701.109. REQUEST FOR INVESTIGATION BY INSURER. An insurer must complete an investigation of suspected insurance claim fraud and draft a report of the insurer's findings before requesting that the commissioner conduct an investigation. The insurer must submit the report and the related investigation file to the commissioner as part of the insurer's request that the

commissioner conduct an investigation. (V.T.I.C. Art. 1.10D, Sec. 2(e) (part).)

[Sections 701.110-701.150 reserved for expansion]

SUBCHAPTER D. INSURANCE FRAUD INFORMATION; CONFIDENTIALITY

Sec. 701.151. CONFIDENTIALITY OF DEPARTMENT INFORMATION. (a) Information or material acquired by the department that is relevant to an investigation by the insurance fraud unit is not a public record for the period the commissioner considers reasonably necessary to:

(1) complete the investigation;

(2) protect the person under investigation from unwarranted injury; or

(3) serve the public interest.

(b) The information or material is not subject to a subpoena by another governmental entity, other than a grand jury subpoena, until:

(1) the information or material is released for public inspection by the commissioner; or

(2) after notice and a hearing a district court determines that obeying the subpoena would not jeopardize the public interest and any investigation by the commissioner.

(c) This section does not affect the conduct of a contested case under Chapter 2001, Government Code. (V.T.I.C. Art. 1.10D, Sec. 5(a).)

Sec. 701.152. CONFIDENTIALITY OF AUTHORIZED GOVERNMENTAL AGENCY INFORMATION. Information or material acquired under this

chapter by an authorized governmental agency is privileged and is not a public record. The information or material is not subject to a subpoena, other than a grand jury subpoena, unless, after reasonable notice to the insurer and agency and a hearing, a district court determines that obeying the subpoena would not jeopardize the public interest and any investigation by the agency. (V.T.I.C. Art. 1.10D, Sec. 5(b) (part).)

Sec. 701.153. DISCLOSURE OF INFORMATION TO CERTAIN AGENCIES. An authorized governmental agency may release to another authorized governmental agency or the department and the department may release to an authorized governmental agency information or material provided under this chapter. (V.T.I.C. Art. 1.10D, Sec. 5(c).)

Sec. 701.154. DISCLOSURE OF INFORMATION TO PUBLIC. (a) Except as otherwise provided by law, an authorized governmental agency or an insurer that possesses or receives information or material under this chapter may not release that information or material to the public.

(b) Information provided under this chapter by an insurer to the insurance fraud unit or an authorized governmental agency is not subject to public disclosure. The information may be used by the insurance fraud unit or authorized governmental agency only in performing duties described by this chapter.

(c) Notwithstanding Section 701.151, the commissioner may not release evidence obtained under Section 701.107 for public inspection if releasing the evidence would violate a privilege held by or a confidentiality requirement imposed on the agency from

which the evidence was obtained. (V.T.I.C. Art. 1.10D, Secs. 2(d-1) (part); 5(b) (part); 6(e) (part).)

CHAPTER 702. MOTOR VEHICLE THEFT AND MOTOR VEHICLE INSURANCE FRAUD REPORTING

Sec. 702.001. DEFINITIONS

Sec. 702.002. INSURER'S DUTY TO PROVIDE INFORMATION

Sec. 702.003. INSURER'S DUTY TO NOTIFY GOVERNMENTAL AGENCY

Sec. 702.004. DISCLOSURE OF INFORMATION TO CERTAIN AGENCIES

Sec. 702.005. INFORMATION PRIVILEGED

Sec. 702.006. IMMUNITY FOR PROVIDING INFORMATION

CHAPTER 702. MOTOR VEHICLE THEFT AND MOTOR VEHICLE INSURANCE FRAUD REPORTING

Sec. 702.001. DEFINITIONS. In this chapter:

(1) "Authorized governmental agency" means:

(A) the Department of Public Safety;

(B) a police department of a municipality;

(C) a sheriff's department;

(D) a criminal investigative department or agency of the United States; or

(E) the prosecuting attorney of:

(i) a municipality, judicial district, or county of this state;

(ii) the United States; or

(iii) a judicial district of the United States.

(2) "Insurer" means an insurer that is:

(A) authorized to write motor vehicle insurance in this state; or

(B) liable for a loss due to motor vehicle theft or motor vehicle insurance fraud. (V.T.I.C. Art. 21.78, Sec. 1.)

Sec. 702.002. INSURER'S DUTY TO PROVIDE INFORMATION. (a) On the written request of an authorized governmental agency to an insurer, the insurer or an agent authorized by the insurer to act on the insurer's behalf shall release to the agency any relevant information the insurer has that:

(1) is requested by the agency; and

(2) relates to a specific motor vehicle theft or motor vehicle insurance fraud.

(b) In this section, relevant information includes:

(1) insurance policy information relevant to the specific motor vehicle theft or motor vehicle insurance fraud under investigation, including any application for the policy;

(2) available policy premium payment records;

(3) the history of previous claims made by the insured; and

(4) information relating to the investigation of the motor vehicle theft or motor vehicle insurance fraud, including statements of any person, proofs of loss, and notices of loss. (V.T.I.C. Art. 21.78, Sec. 2(a).)

Sec. 702.003. INSURER'S DUTY TO NOTIFY GOVERNMENTAL AGENCY. (a) An insurer or an agent authorized by an insurer to act on the insurer's behalf shall notify an authorized governmental agency if

it:

(1) knows or reasonably believes it knows the identity of a person who it has reason to believe committed a criminal or fraudulent act relating to a motor vehicle theft or motor vehicle insurance claim; or

(2) knows of a criminal fraudulent act relating to a motor vehicle theft or motor vehicle insurance claim that it reasonably believes has not been reported to an authorized governmental agency.

(b) Notice provided under this section to one authorized governmental agency is sufficient notice to each other authorized governmental agency. This subsection does not affect the rights and duties created under Section 702.002. (V.T.I.C. Art. 21.78, Secs. 2(b), (c).)

Sec. 702.004. DISCLOSURE OF INFORMATION TO CERTAIN AGENCIES. An authorized governmental agency provided information under Section 702.002 or 702.003 may provide the information to another authorized governmental agency. (V.T.I.C. Art. 21.78, Sec. 2(d).)

Sec. 702.005. INFORMATION PRIVILEGED. (a) Information provided under this chapter is privileged and is not a public record. Except as otherwise provided by law, an entity that receives information provided under this chapter may not release the information to the public.

(b) Evidence or information provided under this chapter is not subject to a subpoena ad testificandum or a subpoena duces tecum in a civil or criminal proceeding unless, after reasonable notice

to an insurer, agent authorized by an insurer to act on the insurer's behalf, or authorized governmental agency that has an interest in the information and after a hearing, a court determines that obeying the subpoena would not jeopardize the public interest and any ongoing investigation by the insurer, agent, or authorized governmental agency. (V.T.I.C. Art. 21.78, Sec. 3.)

Sec. 702.006. IMMUNITY FOR PROVIDING INFORMATION. (a) An insurer or a person who provides information on an insurer's behalf is not liable for damages in a civil action or subject to criminal prosecution for oral or written statements made or any other action taken necessary to provide information as required by this chapter.

(b) Subsection (a) does not apply to an insurer or person who acts with malice or fraudulent intent. (V.T.I.C. Art. 21.78, Sec. 4.)

CHAPTER 703. COVERED ENTITY'S ANTIFRAUD ACTION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 703.001. DEFINITION

Sec. 703.002. RIGHT OF INTERVENTION

[Sections 703.003-703.050 reserved for expansion]

SUBCHAPTER B. ANTIFRAUD ACTION; CERTIFICATION

Sec. 703.051. ANTIFRAUD ACTION AUTHORIZED

Sec. 703.052. REQUEST FOR CERTIFICATION

Sec. 703.053. NOTICE OF REQUEST FOR CERTIFICATION

Sec. 703.054. HEARING ON REQUEST FOR CERTIFICATION

Sec. 703.055. CERTIFICATION

[Sections 703.056-703.100 reserved for expansion]

SUBCHAPTER C. EXPENSES OF ANTIFRAUD ACTION

CHAPTER 703. COVERED ENTITY'S ANTIFRAUD ACTION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 703.001. DEFINITION. In this chapter, "covered entity" means a health maintenance organization or insurer regulated by the department, including:

(1) a stock life, health, or accident insurance company;

(2) a mutual life, health, or accident insurance company;

(3) a stock fire or casualty insurance company;

(4) a mutual fire or casualty insurance company;

(5) a Mexican casualty insurance company;

(6) a Lloyd's plan;

(7) a reciprocal or interinsurance exchange;

(8) a fraternal benefit society;

(9) a title insurance company;

(10) an attorney's title insurance company;

(11) a stipulated premium company;

(12) a nonprofit legal services corporation;

(13) a statewide mutual assessment company;

(14) a local mutual aid association;

(15) a local mutual burial association;

(16) an association exempt under Section 887.102;

(17) a nonprofit hospital, medical, or dental service corporation, including a corporation subject to Chapter 842;

(18) a county mutual insurance company; and

(19) a farm mutual insurance company. (V.T.I.C. Art. 21.79D, Sec. 1(2).)

Sec. 703.002. RIGHT OF INTERVENTION. This chapter does not affect the right of any person, including a state agency, to intervene in an antifraud action brought under this chapter. (V.T.I.C. Art. 21.79D, Sec. 6.)

[Sections 703.003-703.050 reserved for expansion]

SUBCHAPTER B. ANTIFRAUD ACTION; CERTIFICATION

Sec. 703.051. ANTIFRAUD ACTION AUTHORIZED. (a) A covered entity acting alone or through a person, corporation, or legal entity affiliated with the covered entity may bring an action in a court, including a counter-action or cross-action, to:

(1) prevent a person from fraudulently engaging in the business of insurance or the business of a health maintenance organization in this state; or

(2) redress the effects of a person who has fraudulently engaged in the business of insurance or the business of a health maintenance organization in this state.

(b) An action may be brought under this section if:

(1) the acts of the person may adversely affect or have adversely affected at least 10 residents of this state; and

(2) the department has not brought an antifraud action

in a court against the person.

(c) An action may be brought under this section regardless of whether the covered entity is directly affected by the person's acts. (V.T.I.C. Art. 21.79D, Sec. 2.)

Sec. 703.052. REQUEST FOR CERTIFICATION. A covered entity may request the court to certify that the action is an antifraud action under this chapter. (V.T.I.C. Art. 21.79D, Sec. 3(a).)

Sec. 703.053. NOTICE OF REQUEST FOR CERTIFICATION. (a) When a covered entity files a request for certification, the covered entity shall provide at least 10 days' notice of the request to the department and the attorney general by serving each with a copy of the request in the manner provided for service of notice under Rule 21a, Texas Rules of Civil Procedure.

(b) The covered entity shall provide the notice regardless of whether the department or the state is a party to the action. (V.T.I.C. Art. 21.79D, Sec. 3(b).)

Sec. 703.054. HEARING ON REQUEST FOR CERTIFICATION. As soon as practicable after a covered entity files a request for certification, the court shall hold a hearing to determine whether the action is an antifraud action under this chapter. (V.T.I.C. Art. 21.79D, Sec. 3(c).)

Sec. 703.055. CERTIFICATION. The court shall certify that the action is an antifraud action if the court determines that:

(1) the requirements of Section 703.051 are met; and

(2) the pleadings and evidence demonstrate that the covered entity has a probable right of recovery. (V.T.I.C. Art. 21.79D, Sec. 3(d).)

[Sections 703.056-703.100 reserved for expansion]

SUBCHAPTER C. EXPENSES OF ANTIFRAUD ACTION

Sec. 703.101. DETERMINATION OF EXPENSES. (a) The court that certifies an action as an antifraud action by order may determine the amount of reasonable and necessary expenses incurred in bringing the action, including court costs, reasonable attorney's fees, witness fees, fees of experts, and deposition expenses.

(b) In making the determination, the court may consider the contribution to the action of any person, including a state agency, that has intervened in the action. (V.T.I.C. Art. 21.79D, Sec. 4.)

Sec. 703.102. DEDUCTION OR OFFSET FOR EXPENSES; REIMBURSEMENT. (a) Subject to Subsection (b), a covered entity has a deduction or offset against any obligation, assessment, or debt owed by the covered entity to this state in the amount of the reasonable and necessary expenses determined by the court order.

(b) The covered entity shall reimburse the state the amount of any expenses actually recovered from the parties to the private antifraud action under a final judgment awarding, wholly or partly, expenses to or for the covered entity's benefit. The amount of reimbursement may not exceed the actual amount of deductions or offsets taken by the covered entity. (V.T.I.C. Art. 21.79D, Sec. 5(a) (part).)

Sec. 703.103. ASSIGNMENT OF DEDUCTION OR OFFSET. The covered entity may assign the covered entity's deduction or offset to any other covered entity or reinsurer. (V.T.I.C. Art. 21.79D, Sec. 5(a) (part).)

Sec. 703.104. TREATMENT OF DEDUCTION OR OFFSET AS ADMITTED ASSET. A covered entity or a covered entity's assignee entitled to an offset or deduction that has not been used may show, in the covered entity's or assignee's books and records, the balance of the deduction or offset as an admitted asset for any purpose. (V.T.I.C. Art. 21.79D, Sec. 5(b).)

CHAPTER 704. ANTIFRAUD PROGRAMS

SUBCHAPTER A. GENERAL PROVISIONS

CHAPTER 704. ANTIFRAUD PROGRAMS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 704.001. DEFINITION. In this chapter, "plan issuer" means:

(1) a health insurer, including a life, health, and accident insurer, a health and accident insurer, a health maintenance organization, and any other person operating under Chapter 841, 842, 843, 884, 885, 982, or 1501 who is authorized to

issue, issue for delivery, or deliver insurance policies, certificates, contracts, or evidences of coverage in this state;

(2) an approved nonprofit health corporation that holds a certificate of authority issued under Chapter 844; or

(3) an insurer authorized by the department to write workers' compensation insurance in this state. (V.T.I.C. Art. 3.97-1, Subdiv. (2).)

Sec. 704.002. NOTICE RELATING TO FALSE OR FRAUDULENT CLAIMS REQUIRED. (a) A plan issuer who provides a form for a person to make a claim against or to give notice of the person's intent to make a claim against a policy, certificate, contract, or evidence of coverage issued by the issuer must include on the form, in comparative prominence with the other content on the form, a statement that is substantially similar to the following: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

(b) This section does not apply to a form provided to make a claim against a policy issued by a reinsurer. (V.T.I.C. Art. 3.97-2.)

[Sections 704.003-704.050 reserved for expansion]

SUBCHAPTER B. ANTIFRAUD PLANS

Sec. 704.051. ANTIFRAUD PLAN REQUIRED FOR CERTAIN PLAN ISSUERS. A plan issuer who collects direct written premium shall adopt an antifraud plan under this subchapter. (V.T.I.C. Art. 3.97-3, Sec. (a) (part).)

Sec. 704.052. ANTIFRAUD PLAN REQUIREMENTS. An antifraud

plan adopted by a plan issuer under this subchapter must include a description of the issuer's procedures for:

(1) detecting and investigating possible fraudulent insurance acts; and

(2) reporting possible fraudulent insurance acts to the insurance fraud unit. (V.T.I.C. Art. 3.97-3, Sec. (a) (part).)

Sec. 704.053. FILING OF ANTIFRAUD PLAN. A plan issuer may annually file the issuer's antifraud plan adopted under this subchapter with the insurance fraud unit. (V.T.I.C. Art. 3.97-3, Sec. (a) (part).)

Sec. 704.054. FRAUD AND ABUSE PLANS UNDER CERTAIN STATE PROGRAMS; ENFORCEMENT. (a) A fraud and abuse plan put in place by a plan issuer participating in the Medicaid STAR or STAR + Plus program or the child health plan program under Chapter 62, Health and Safety Code, and approved by a health and human services agency meets the requirements of this subchapter.

(b) If a plan issuer described by Subsection (a) is required by law to report possible fraudulent insurance acts to a health and human services agency or the office of the attorney general, the issuer is not required to report those acts to the insurance fraud unit.

(c) The insurance fraud unit, the office of the attorney general, and the health and human services agencies shall coordinate enforcement efforts with respect to fraudulent insurance acts covered by this chapter relating to the Medicaid program or the child health plan program. (V.T.I.C. Art. 3.97-3, Secs. (b), (c).)

CHAPTER 705. MISREPRESENTATIONS BY POLICYHOLDERS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 705.006-705.050 reserved for expansion]

SUBCHAPTER B. SPECIAL PROVISIONS RELATED TO LIFE, ACCIDENT, AND HEALTH INSURANCE POLICIES

[Sections 705.052-705.100 reserved for expansion]

SUBCHAPTER C. SPECIAL PROVISIONS RELATED TO LIFE INSURANCE POLICIES

CHAPTER 705. MISREPRESENTATIONS BY POLICYHOLDERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 705.001. DEFINITION. In this subchapter, "insurance policy" means a contract or policy of insurance. (V.T.I.C. Arts.

21.16 (part), 21.17 (part), 21.19 (part).)

Sec. 705.002. APPLICABILITY OF SUBCHAPTER. Except as provided by Section 705.005, this subchapter applies to each insurance policy issued or contracted for in this state. (V.T.I.C. Arts. 21.16 (part), 21.17 (part), 21.19 (part).)

Sec. 705.003. POLICY PROVISION: MISREPRESENTATION IN PROOF OF LOSS OR DEATH. (a) An insurance policy provision that states that a misrepresentation, including a false statement, made in a proof of loss or death makes the policy void or voidable:

(1) has no effect; and

(2) is not a defense in a suit brought on the policy.

(b) Subsection (a) does not apply if it is shown at trial that the misrepresentation:

(1) was fraudulently made;

(2) misrepresented a fact material to the question of the insurer's liability under the policy; and

(3) misled the insurer and caused the insurer to waive or lose a valid defense to the policy. (V.T.I.C. Art. 21.19 (part).)

Sec. 705.004. POLICY PROVISION: MISREPRESENTATION IN POLICY APPLICATION. (a) An insurance policy provision that states that false statements made in the application for the policy or in the policy make the policy void or voidable:

(1) has no effect; and

(2) is not a defense in a suit brought on the policy.

(b) Subsection (a) does not apply if it is shown at trial that the matter misrepresented:

(1) was material to the risk; or

(2) contributed to the contingency or event on which the policy became due and payable.

(c) It is a question of fact whether a misrepresentation made in the application for the policy or in the policy itself was material to the risk or contributed to the contingency or event on which the policy became due and payable. (V.T.I.C. Art. 21.16 (part).)

Sec. 705.005. NOTICE TO INSURED OF MISREPRESENTATIONS. (a) This section applies to any suit brought on an insurance policy issued or contracted for after June 29, 1903.

(b) A defendant may use as a defense a misrepresentation made in the application for or in obtaining an insurance policy only if the defendant shows at trial that before the 91st day after the date the defendant discovered the falsity of the representation, the defendant gave notice that the defendant refused to be bound by the policy:

(1) to the insured, if living; or

(2) to the owners or beneficiaries of the insurance policy, if the insured was deceased.

(c) This section does not:

(1) make available as a defense an immaterial misrepresentation; or

(2) affect the provisions of Section 705.004. (V.T.I.C. Art. 21.17 (part).)

[Sections 705.006-705.050 reserved for expansion]

SUBCHAPTER B. SPECIAL PROVISIONS RELATED TO LIFE,

ACCIDENT, AND HEALTH INSURANCE POLICIES

Sec. 705.051. IMMATERIAL MISREPRESENTATION IN LIFE, ACCIDENT, OR HEALTH INSURANCE APPLICATION. A misrepresentation in an application for a life, accident, or health insurance policy does not defeat recovery under the policy unless the misrepresentation:

(1) is of a material fact; and

(2) affects the risks assumed. (V.T.I.C. Art. 21.18.)

[Sections 705.052-705.100 reserved for expansion]

SUBCHAPTER C. SPECIAL PROVISIONS RELATED TO LIFE INSURANCE POLICIES

Sec. 705.101. DEFINITION. In this subchapter, "insurance policy" means a contract or policy of insurance. (V.T.I.C. Art. 21.35 (part).)

Sec. 705.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any insurance policy issued or contracted for in this state. (V.T.I.C. Art. 21.35 (part).)

Sec. 705.103. DOCUMENTS TO ACCOMPANY POLICY. Except as otherwise provided by this code, a life insurance policy must be accompanied by a copy of:

(1) the policy application; and

(2) any questions and answers given in connection with the application. (V.T.I.C. Art. 21.35 (part).)

Sec. 705.104. MISREPRESENTATION IN APPLICATION FOR LIFE INSURANCE. A defense based on a misrepresentation in the application for, or in obtaining, a life insurance policy on the life of a person in or residing in this state is not valid or

enforceable in a suit brought on the policy on or after the second anniversary of the date of issuance of the policy if premiums due on the policy during the two years have been paid to and received by the insurer, unless:

(1) the insurer has notified the insured of the insurer's intention to rescind the policy because of the misrepresentation; or

(2) it is shown at the trial that the misrepresentation was:

(A) material to the risk; and

(B) intentionally made. (V.T.I.C. Art. 21.35 (part).)

Sec. 705.105. APPLICABILITY OF OTHER LAW. Subchapter A does not apply to a life insurance policy:

(1) that contains a provision making the policy incontestable after two years or less; and

(2) on which premiums have been duly paid. (V.T.I.C. Art. 21.35 (part).)

SECTION 3. SUBTITLES A-G, TITLE 8, INSURANCE CODE. Title 8, Insurance Code, is amended by adding Subtitles A-G to read as follows:

SUBTITLE A. HEALTH COVERAGE IN GENERAL

CHAPTER 1201. ACCIDENT AND HEALTH INSURANCE

CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES IN GENERAL

CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS

CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH

[Sections 1201.275-1201.700 reserved for expansion]

SUBCHAPTER O. ENFORCEMENT

Sec. 1201.701. CIVIL PENALTY

Sec. 1201.702. ACTION AGAINST CERTIFICATE OF AUTHORITY OR LICENSE

CHAPTER 1201. ACCIDENT AND HEALTH INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1201.001. DEFINITIONS. In this chapter:

(1) "Accident and health insurance policy" includes any policy or contract that provides insurance against loss resulting from:

(A) accidental bodily injury;

(B) accidental death; or

(C) sickness.

(2) "Policy" means the entire contract between an insurer and an insured and includes riders, endorsements, and the application, if attached. (V.T.I.C. Art. 3.70-1, Secs. (B)(3), (4).)

Sec. 1201.002. PURPOSE. The purpose of this chapter is to:

(1) provide for reasonable standardization, readability, and simplification of terms and coverages in individual accident and health insurance policies;

(2) promote public understanding of coverages;

(3) eliminate provisions in individual accident and health insurance policies that may be unjust, unfair, misleading, or unreasonably confusing in connection with:

(A) the purchase of coverage; or

(B) the settlement of claims; and

(4) provide for full and fair disclosure in sales of accident and health coverage. (V.T.I.C. Art. 3.70-1, Sec. (A).)

Sec. 1201.003. APPLICABILITY OF CHAPTER. (a) This chapter applies only to an accident and health insurance policy delivered or issued for delivery in this state.

(b) Except as otherwise provided by this chapter, this chapter applies only to an individual accident and health insurance policy delivered or issued for delivery by:

(1) a life, health, and accident insurance company;

(2) a mutual insurance company, including:

(A) a mutual life insurance company; and

(B) a mutual assessment life insurance company;

(3) a local mutual aid association;

(4) a mutual or natural premium life or casualty insurance company;

(5) a general casualty company;

(6) a Lloyd's plan;

(7) a reciprocal or interinsurance exchange;

(8) a nonprofit hospital, medical, or dental service corporation, including a corporation operating under Chapter 842; or

(9) another insurer required by law to be authorized by the department.

(c) This chapter applies to an accident and health insurance policy issued by a stipulated premium company subject to Chapter 884.

(d) This chapter does not apply to:

(1) any society, company, or other insurer whose activities are exempt by statute from the control of the department and that is entitled by statute to a certificate from the department that shows the entity's exempt status;

(2) a credit accident and health insurance policy issued under Chapter 1153;

(3) a workers' compensation insurance policy;

(4) a liability insurance policy, with or without supplementary expense coverage;

(5) a reinsurance policy or contract;

(6) a blanket or group insurance policy, except as otherwise provided by this chapter; or

(7) a life insurance endowment or annuity contract or a contract supplemental to a life insurance endowment or annuity contract if the contract or supplemental contract contains only provisions relating to accident and health insurance that:

(A) provide additional benefits in case of accidental death, accidental dismemberment, or accidental loss of sight; or

(B) operate to:

(i) safeguard the contract or supplemental contract against lapse; or

(ii) give a special surrender value, a special benefit, or an annuity if the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

(e) Subchapters C and D do not apply to a conversion policy issued under a contractual conversion privilege under a group accident and health insurance policy. (V.T.I.C. Art. 3.70-1, Sec. (C) (part); Art. 3.70-8, Secs. (a) (part), (b).)

Sec. 1201.004. CONSTRUCTION OF CHAPTER. This chapter does not enlarge the powers of an entity listed in Section 1201.003. (V.T.I.C. Art. 3.70-1, Sec. (C) (part).)

Sec. 1201.005. REFERENCES TO CHAPTER. In this chapter, a reference to this chapter includes a reference to:

(1) Section 1202.052;

(2) Section 1271.005(a), to the extent that the subsection relates to the applicability of Section 1201.105, and Sections 1271.005(d) and (e);

(3) Chapter 1351;

(4) Subchapters C and E, Chapter 1355;

(5) Chapter 1356;

(6) Chapter 1365;

(7) Subchapter A, Chapter 1367; and

(8) Subchapters A, B, and G, Chapter 1451. (New.)

Sec. 1201.006. RULEMAKING AUTHORITY. The commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of this chapter. (V.T.I.C. Art. 3.70-1, Sec. (D).)

Sec. 1201.007. NOTICE AND HEARING. The commissioner may adopt a general rule or order relating to a matter covered by this chapter only after a hearing held after the 10th day following the date the department by mail notifies each insurer to which this chapter applies. (V.T.I.C. Art. 3.70-10 (part).)

Sec. 1201.008. JUDICIAL REVIEW. An insurer that is dissatisfied with an order, act, rule, administrative ruling, or decision of the commissioner under this chapter may, after failing to get relief from the commissioner, file a petition seeking judicial review of the order, act, rule, ruling, or decision in accordance with Subchapter D, Chapter 36. The action has precedence over all other causes on the docket of a different nature. (V.T.I.C. Art. 3.70-10 (part).)

Sec. 1201.009. NONCONFORMING POLICY. (a) This chapter governs the rights, duties, and obligations of the insurer, the insured, and the beneficiary of an accident and health insurance policy regardless of a provision in the policy that conflicts with this chapter.

(b) An accident and health insurance policy that violates this chapter is a valid policy, but the policy shall be construed in a manner to make the policy consistent with this chapter. (V.T.I.C. Art. 3.70-4, Sec. (B).)

Sec. 1201.010. THIRD-PARTY OWNERSHIP OF POLICY. The use of "insured" in this chapter does not prevent a person with an insurable interest, other than the insured, from:

(1) applying for and owning an individual accident and health insurance policy covering the insured; or

(2) being entitled to an indemnity, right, or benefit provided for in an individual accident and health insurance policy covering the insured. (V.T.I.C. Art. 3.70-3, Sec. (E).)

Sec. 1201.011. COVERAGE FOR PREMIUM PERIOD WITH LIMITATIONS BY AGE OR DATE; MISSTATEMENT OF AGE OF INSURED. (a) Regardless of a

provision in an individual accident and health insurance policy that specifies a date, by age limitation or otherwise, after which coverage under the policy is not effective, coverage continues in force, subject to any right of cancellation, until the end of the period for which the insurer accepts a premium if:

(1) the insurer accepts the premium after the specified date; or

(2) the specified date falls before the end of the period for which the insurer accepts the premium.

(b) Notwithstanding Subsection (a), if the age of the insured is misstated and, because of the insured's correct age, coverage of the insured would not have become effective or would have terminated before the insurer's acceptance of a premium, the liability of the insurer is limited to the refund, on request, of the premiums paid for the period not covered by the policy. (V.T.I.C. Art. 3.70-7.)

Sec. 1201.012. DEFENSE OF CLAIM. The following actions by an insurer do not operate as a waiver of the insurer's rights in defense of a claim that arises under an individual accident and health insurance policy:

(1) acknowledgment of the receipt of notice given under the policy;

(2) provision of a form for filing a proof of loss;

(3) acceptance of a proof of loss; or

(4) investigation of a claim under the policy. (V.T.I.C. Art. 3.70-6.)

[Sections 1201.013-1201.050 reserved for expansion]

SUBCHAPTER B. POLICY TERMS

Sec. 1201.051. ENTIRE CONSIDERATION. An individual accident and health insurance policy must state the entire monetary and other consideration for the policy in the policy or in the application, if the application is made a part of the policy. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Sec. 1201.052. TIME OF EFFECTIVENESS AND TERMINATION. An individual accident and health insurance policy must state the time the insurance takes effect and the time the insurance terminates. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Sec. 1201.053. PERSONS INSURED. (a) Except as provided by this section, an individual accident and health insurance policy may not insure more than one individual.

(b) On the application of an adult member of a family, an individual accident and health insurance policy may, at the time of original issuance or by subsequent amendment, insure two or more eligible members of the adult's family, including a spouse, unmarried children younger than 25 years of age, including a grandchild of the adult as described by Section 1201.062(a)(1), a child the adult is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in this state, and any other individual dependent on the adult.

(c) The adult who applies for the individual accident and health insurance policy is considered the policyholder. (V.T.I.C. Art. 3.70-2, Sec. (A) (part), as amended Acts 77th Leg., R.S., Chs. 396 and 1027.)

Sec. 1201.054. APPEARANCE OF TEXT. (a) In this section,

"text" includes all printed matter of an individual accident and health insurance policy except:

(1) the name and address of the insurer;

(2) the name or title of the policy;

(3) the brief description, if any; and

(4) captions and subcaptions.

(b) An individual accident and health insurance policy must have:

(1) a style, arrangement, or overall appearance that does not give undue prominence to any portion of the text; and

(2) every printed portion of its text and of any endorsements or attached papers printed plainly in a lightfaced type:

(A) of a style in general use; and

(B) in a uniform size not less than 10-point with a lowercase unspaced alphabet length not less than 120-point.

(c) Subsection (b)(2) does not apply to a copy of an application or identification card. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Sec. 1201.055. EXCEPTIONS AND REDUCTIONS OF INDEMNITY. (a) An individual accident and health insurance policy must state each exception to or reduction of indemnity for the policy.

(b) Except as provided by Subchapter E, each exception to or reduction of indemnity for the policy must be printed, at the insurer's option:

(1) with the benefit provision to which the exception or reduction applies; or

(2) under an appropriate caption such as:

(A) "Exceptions"; or

(B) "Exceptions and Reductions."

(c) Notwithstanding Subsection (b), if an exception or reduction specifically applies only to a particular benefit of an individual accident and health insurance policy, the statement of the exception or reduction must be included with the benefit provision to which the exception or reduction applies. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Sec. 1201.056. FORM NUMBER. Each form that constitutes a part of an individual accident and health insurance policy, including each rider or endorsement, must be identified by a form number placed in the lower left corner of the first page of the form. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Sec. 1201.057. INCORPORATION OF OR REFERENCE TO OTHER DOCUMENTS. (a) An individual accident and health insurance policy that provides that a portion of the charter, rules, constitution, or bylaws of the insurer are a part of the policy must state that portion fully in the policy.

(b) An individual accident and health insurance policy may incorporate or refer to:

(1) a statement of rates or classification of risks; or

(2) a short-rate table filed with the department. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Sec. 1201.058. NOTIFICATION THAT POLICY IS RETURNABLE; EFFECT OF RETURN. (a) An individual accident and health insurance

policy must include a notice that states in substance that the individual to whom the policy is issued is entitled to have the premium paid refunded if, after the individual examines the policy, the individual is not satisfied with the policy for any reason and returns the policy not later than the 10th day after the date the policy is delivered to the individual.

(b) An individual accident and health insurance policy returned to the insurer at the insurer's home or branch office or to the agent through whom the policy was purchased within the time provided by the notice is void from the date the policy was issued, and the parties are in the same position as if the policy had not been issued.

(c) The notice required by this section may be printed on the policy or attached to the policy.

(d) This section does not apply to a single premium nonrenewable policy. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Sec. 1201.059. TERMINATION OF COVERAGE BASED ON AGE OF CHILD IN INDIVIDUAL, BLANKET, OR GROUP POLICY. (a) An accident and health insurance policy, including an individual, blanket, or group policy, and including a policy issued by a corporation operating under Chapter 842, that provides that coverage of a child terminates when the child attains a limiting age specified in the policy must provide in substance that the child's attainment of that age does not terminate coverage while the child is:

(1) incapable of self-sustaining employment because of mental retardation or physical disability; and

(2) chiefly dependent on the insured or group member

for support and maintenance.

(b) To obtain coverage for a child as described by Subsection (a), the insured or group member must provide to the insurer proof of the child's incapacity and dependency:

(1) not later than the 31st day after the date the child attains the limiting age; and

(2) subsequently as the insurer requires, except that the insurer may not require proof more frequently than annually after the second anniversary of the date the child attains the limiting age. (V.T.I.C. Art. 3.70-2, Sec. (C); Art. 3.70-8, Sec. (a) (part).)

Sec. 1201.060. REQUIRED DEFINITION OF "EMERGENCY CARE" IN INDIVIDUAL OR GROUP POLICY. An individual or group accident and health insurance policy that provides an emergency care benefit, including a policy issued by a corporation operating under Chapter 842, must define "emergency care" as follows:

"Emergency care" means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part. (V.T.I.C. Art. 3.70-2, Sec. (I).)

Sec. 1201.061. COVERAGE FOR ADOPTED CHILD. (a) An individual accident and health insurance policy that provides

coverage for an insured's immediate family or children may not, solely because the insured's child is adopted:

(1) exclude the child from coverage; or

(2) limit coverage for the child.

(b) For the purposes of this section, a child is an insured's child if the insured is a party to a suit in which the insured seeks to adopt the child. (V.T.I.C. Art. 3.70-2, Sec. (K).)

Sec. 1201.062. COVERAGE FOR CERTAIN CHILDREN IN INDIVIDUAL OR GROUP POLICY OR IN PLAN OR PROGRAM. (a) An individual or group accident and health insurance policy that is delivered, issued for delivery, or renewed in this state, including a policy issued by a corporation operating under Chapter 842, or a self-funded or self-insured welfare or benefit plan or program, to the extent that regulation of the plan or program is not preempted by federal law, that provides coverage for a child of an insured or group member, on payment of a premium, must provide coverage for:

(1) each grandchild of the insured or group member if the grandchild is:

(A) unmarried;

(B) younger than 25 years of age; and

(C) a dependent of the insured or group member for federal income tax purposes at the time application for coverage of the grandchild is made; and

(2) each child for whom the insured or group member must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

(b) Coverage for a grandchild of the insured or group member

may not be terminated solely because the grandchild is no longer a dependent of the insured or group member for federal income tax purposes. (V.T.I.C. Art. 3.70-2, Sec. (L) (part), as amended Acts 77th Leg., R.S., Chs. 396 and 1027.)

Sec. 1201.063. PROHIBITION OF CERTAIN CRITERIA RELATING TO CHILD'S COVERAGE IN INDIVIDUAL OR GROUP POLICY. Regarding a natural or adopted child of an insured or group member or a child for whom the insured or group member must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state, an individual or group accident and health insurance policy that provides coverage for a child of an insured or group member may not set a different premium for the child, exclude the child from coverage, or discontinue coverage of the child because:

(1) the child does not reside with the insured or group member; or

(2) the insured or group member does not claim the child as an exemption for federal income tax purposes under Section 151(c)(1)(B), Internal Revenue Code of 1986. (V.T.I.C. Art. 3.70-2, Sec. (M)(1).)

Sec. 1201.064. COVERAGE FOR CHILD OF SPOUSE IN INDIVIDUAL OR GROUP POLICY. An individual or group accident and health insurance policy that provides coverage for a child of an insured or group member may not:

(1) set a premium for a child that is different from the premium for other children because the child is the natural or adopted child of the spouse of the insured or group member;

(2) exclude a child described by Subdivision (1) from coverage; or

(3) discontinue coverage of a child described by Subdivision (1). (V.T.I.C. Art. 3.70-2, Sec. (M)(2).)

Sec. 1201.065. AGE AND SCHOOL ENROLLMENT ELIGIBILITY CRITERIA FOR DEPENDENT CHILDREN IN INDIVIDUAL OR GROUP POLICY; LATE ENROLLMENT. (a) An individual or group accident and health insurance policy may contain criteria relating to a maximum age or enrollment in school to establish continued eligibility for coverage of a child younger than 25 years of age.

(b) In the case of a late enrollment, an insurer may require evidence of insurability that is satisfactory to the insurer before a child is included for coverage under the policy. (V.T.I.C. Art. 3.70-2, Sec. (M)(3).)

[Sections 1201.066-1201.100 reserved for expansion]

SUBCHAPTER C. GENERAL POLICY STANDARDS AND PROVISIONS

Sec. 1201.101. STANDARDS FOR POLICY PROVISIONS. (a) The commissioner shall adopt reasonable rules establishing specific standards for:

(1) the content of an individual accident and health insurance policy; and

(2) the manner of sale of an individual accident and health insurance policy, including disclosures required to be made in connection with the sale.

(b) Rules adopted under this section must establish standards for:

(1) policy readability; and

(2) full and fair policy disclosures.

(c) Standards established under this section may include standards that address:

(1) terms of policy renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) coverage of dependents;

(5) preexisting conditions;

(6) termination of insurance;

(7) probationary periods;

(8) limitations;

(9) exceptions;

(10) reductions;

(11) elimination periods;

(12) requirements for replacement;

(13) recurrent conditions; and

(14) definitions of terms, including definitions of:

(A) "accident";

(B) "accidental means";

(C) "guaranteed renewable and noncancellable";

(D) "hospital";

(E) "injury";

(F) "nervous disorder";

(G) "partial disability";

(H) "physician";

(I) "sickness"; and

(J) "total disability."

(d) A definition of "hospital" adopted under Subsection (c) may not apply to a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-1, Sec. (E)(1).)

Sec. 1201.102. PROHIBITION OF POLICY PROVISIONS. The commissioner may adopt rules prohibiting specific individual accident and health insurance policy provisions not specifically authorized by statute that the commissioner determines are unjust, unfair, or unfairly discriminatory to:

(1) the policyholder;

(2) an insured under the policy; or

(3) a beneficiary. (V.T.I.C. Art. 3.70-1, Sec. (E)(2).)

Sec. 1201.103. COMPLIANCE WITH MINIMUM STANDARDS FOR BENEFITS. (a) An individual accident and health insurance policy must meet the minimum standards for benefits established under Section 1201.104 for each category of coverage provided under the policy.

(b) Subsection (a) does not apply if the commissioner determines that the policy is a supplemental policy or experimental policy or determines that the policy will fulfill a reasonable public need and the policy meets the requirements of Chapter 1701. (V.T.I.C. Art. 3.70-1, Sec. (F)(3).)

Sec. 1201.104. MINIMUM STANDARDS FOR BENEFITS. (a) For individual accident and health insurance policies, the commissioner shall adopt rules establishing minimum standards for benefits under each of the following categories of coverage:

(1) basic hospital expense;

(2) basic medical-surgical expense;

(3) hospital confinement indemnity;

(4) major medical expense;

(5) disability income protection;

(6) accident only;

(7) specified disease;

(8) specified accident; and

(9) limited benefit.

(b) This section does not prohibit the issuance of an individual accident and health insurance policy that combines categories of coverage listed by this section. (V.T.I.C. Art. 3.70-1, Secs. (F)(1), (2).)

Sec. 1201.105. MINIMUM STANDARDS FOR BENEFITS FOR LONG-TERM CARE IN INDIVIDUAL, GROUP, OR BLANKET POLICY. (a) The commissioner shall adopt rules establishing minimum standards for benefits for long-term care coverage under individual, group, and blanket accident and health insurance policies and certificates delivered or issued for delivery in this state.

(b) Rules adopted under this section apply to group coverages delivered or issued for delivery by a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-1, Sec. (F)(5) (part); Art. 3.70-8, Sec. (a) (part).)

Sec. 1201.106. IDENTIFICATION OF POLICIES ACCORDING TO COVERAGE PROVIDED. The commissioner shall prescribe the method to identify an individual accident and health insurance policy according to the coverages the policy provides. (V.T.I.C. Art. 3.70-1, Sec. (F)(4).)

Sec. 1201.107. OUTLINE OF COVERAGE REQUIRED. (a) An outline of coverage for an individual accident and health insurance policy must be delivered to the applicant at the time application is made, and an acknowledgment of receipt or certificate of delivery of an outline of coverage must be provided to the insurer with the application.

(b) If the policy issued differs from the policy for which the applicant applied, an outline of coverage that properly describes the policy must:

(1) accompany the policy when delivered; and

(2) clearly state that the policy is not the policy for which the applicant applied.

(c) Subsection (a) does not apply to a direct response insurance product.

(d) An outline of coverage under a direct response insurance product must accompany the policy. (V.T.I.C. Art. 3.70-1, Sec. (G)(1).)

Sec. 1201.108. FORMAT AND CONTENT OF OUTLINE OF COVERAGE. (a) In this section, "format" means style, arrangement, and overall appearance, including:

(1) the size, color, and prominence of type; and

(2) the arrangement of text and captions.

(b) The commissioner shall prescribe the format and content of an outline of coverage required by Section 1201.107.

(c) An outline of coverage must include:

(1) a statement that identifies the applicable categories of coverage listed by Section 1201.104 and provided by

the policy;

(2) a description of the principal benefits and coverage provided by the policy;

(3) a statement of the exceptions, reductions, and limitations in the policy;

(4) a statement of the renewal provision, including any reservation of the insurer's right to change premiums;

(5) a statement that:

(A) the outline is a summary of the policy issued or applied for; and

(B) the policy should be consulted to determine governing contractual provisions;

(6) as the commissioner determines necessary to carry out the purposes of this chapter, a summary of the provisions required by Subchapter E to be in the policy; and

(7) any other statement, description, or outline that the commissioner determines is reasonably necessary to carry out the purposes of this chapter. (V.T.I.C. Art. 3.70-1, Sec. (G)(2).)

[Sections 1201.109-1201.150 reserved for expansion]

SUBCHAPTER D. PREEXISTING CONDITIONS

Sec. 1201.151. COMPLIANCE WITH SUBCHAPTER; PROHIBITION OF DEFENSE. Except as provided by this subchapter, an individual accident and health insurance policy may not include a provision that permits a defense based on a preexisting condition. (V.T.I.C. Art. 3.70-1, Sec. (H)(3).)

Sec. 1201.152. COVERAGE UNDER SIMPLIFIED APPLICATION FORM. (a) Notwithstanding Clause (b) of the provision required by

Section 1201.208(a), an individual accident and health insurance policy must cover any loss that occurs after 12 months from a preexisting condition if the insurer uses a simplified application form that does not include a question concerning the applicant's health history or medical treatment history.

(b) This section applies regardless of whether the simplified application form includes a question regarding the applicant's health at the time of application.

(c) This section does not require an insurer to cover a loss from a condition that the policy specifically excludes from coverage. (V.T.I.C. Art. 3.70-1, Sec. (H)(1).)

Sec. 1201.153. COVERAGE FOR INDIVIDUALS AGE 65 OR OLDER. (a) Notwithstanding Section 1201.152 or Clause (b) of the provision required by Section 1201.208(a), an individual accident and health insurance policy delivered or issued for delivery to an individual who is 65 years of age or older may not include a provision that excludes from coverage a loss that occurs from a preexisting condition more than six months after the effective date of coverage under the policy.

(b) Notwithstanding Subsection (a), the commissioner may authorize a policy provision that excludes coverage for a preexisting condition for a period of not more than one year if the commissioner determines that the provision would serve the public interest.

(c) This section does not require an insurer to provide coverage for a loss from a preexisting condition specifically excluded from coverage by name or specific description in an

exclusion endorsement or rider that is effective on the date of the loss. (V.T.I.C. Art. 3.70-1, Sec. (H)(2).)

Sec. 1201.154. COVERAGE FOR CERTAIN PREVIOUSLY COVERED PERSONS. (a) In this section, "creditable coverage" has the meaning assigned by Section 1205.004.

(b) A preexisting condition provision in an individual accident and health insurance policy may not apply to an individual:

(1) who was continuously covered for an aggregate period of 18 months by creditable coverage that was in effect up to a date not more than 63 days before the effective date of the individual coverage, excluding any waiting period; and

(2) whose most recent creditable coverage was under:

(A) a group health plan;

(B) a governmental plan; or

(C) a church plan.

(c) In determining whether a preexisting condition provision of an individual accident and health insurance policy applies to an individual, an insurer shall credit the time the individual previously was covered under creditable coverage if the previous coverage was in effect at any time during the 18 months preceding the effective date of the individual coverage. (V.T.I.C. Art. 3.70-1, Sec. (H)(4).)

[Sections 1201.155-1201.200 reserved for expansion]

SUBCHAPTER E. REQUIRED POLICY PROVISIONS

Sec. 1201.201. POLICY PROVISIONS REQUIRED. (a) Except as provided by Subsections (b) and (c), an individual accident and

health insurance policy must contain the provisions required by this subchapter in the words provided by this subchapter.

(b) An insurer may substitute for a policy provision required by this subchapter a provision with different wording approved by the commissioner in accordance with reasonable rules adopted by the commissioner. A substituted provision may not be less favorable to an insured or a beneficiary of the policy than the provision required by this subchapter.

(c) If a policy provision required by this subchapter is wholly or partly inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the commissioner's approval, shall:

(1) omit from the policy each inapplicable provision or part of a provision; and

(2) modify each inconsistent provision or part of a provision so that the provision as contained in the policy is consistent with the coverage provided by the policy.

(d) A policy provision required by this subchapter must be preceded by the caption for the provision provided by this subchapter or, at the option of the insurer, by an appropriate individual or group caption or subcaption approved by the commissioner. (V.T.I.C. Art. 3.70-3, Secs. (A) (part), (B) (part), (C).)

Sec. 1201.202. ORDER OF REQUIRED POLICY PROVISIONS. (a) Except as provided by Subsection (b), policy provisions required by this subchapter or corresponding substitute provisions must be printed in the same consecutive order as provided by this

subchapter.

(b) An insurer may print a policy provision required by this subchapter or a corresponding substitute provision as a unit in any part of the policy with other provisions to which the provision is logically related.

(c) A policy printed under Subsection (b) may not be wholly or partly unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued. (V.T.I.C. Art. 3.70-3, Sec. (D).)

Sec. 1201.203. OTHER POLICY PROVISIONS. A policy provision that is not otherwise subject to this subchapter may not make an individual accident and health insurance policy or any portion of the policy less favorable in any way to the insured or the beneficiary than the policy provisions that are subject to this chapter. (V.T.I.C. Art. 3.70-4, Sec. (A).)

Sec. 1201.204. POLICY PROVISIONS REQUIRED BY OTHER JURISDICTION. An individual accident and health insurance policy of a foreign or alien insurer may contain any provision that is:

(1) not less favorable to the insured or the beneficiary than the provisions of this chapter; and

(2) prescribed or required by the law of the state under which the insurer is organized. (V.T.I.C. Art. 3.70-3, Sec. (F)(1).)

Sec. 1201.205. POLICY PROVISIONS FOR POLICY DELIVERED OUTSIDE THIS STATE. An individual accident and health insurance policy issued by a domestic insurer for delivery in another state or country may contain any provision permitted or required by the laws

of that state or country. (V.T.I.C. Art. 3.70-3, Sec. (F)(2).)

Sec. 1201.206. FILING PROCEDURE. (a) The commissioner may adopt reasonable rules regarding the procedure for submitting policies subject to this chapter that are necessary, proper, or advisable for the administration of this chapter.

(b) This section does not limit any authority otherwise granted by law to the commissioner or department. (V.T.I.C. Art. 3.70-3, Sec. (G).)

Sec. 1201.207. POLICY PROVISION: ENTIRETY OF CONTRACT; POLICY CHANGES. An individual accident and health insurance policy must contain the following provision:

"Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this policy is not valid until the change is approved by an executive officer of the insurer and unless the approval is endorsed on or attached to the policy. An agent does not have authority to change this policy or to waive any of its provisions." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Sec. 1201.208. POLICY PROVISION: INCONTESTABILITY. (a) Except as provided by Subsection (c), an individual accident and health insurance policy must contain the following provision:

"Time Limit on Certain Defenses: (a) After the second anniversary of the date this policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) beginning after that anniversary.

"(b) A claim for loss incurred or disability (as defined in the policy) beginning after the second anniversary of the date this policy is issued may not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the effective date of coverage of this policy."

(b) Clause (a) of the provision required by Subsection (a) does not:

(1) affect any legal requirement for avoidance of a policy or denial of a claim during the initial two-year period; or

(2) limit the application of Section 1201.219, 1201.220, or 1201.221 in a case of a misstatement regarding age, occupation, or other insurance.

(c) For a policy that provides that the insured is entitled to continue the policy in force by the timely payment of premiums until the insured reaches at least 50 years of age or, if the policy was issued after the insured reached 44 years of age, until at least the fifth anniversary of the policy's date of issuance, an insurer may use the following clause instead of Clause (a) of the provision required by Subsection (a):

"After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestible as to the statements contained in the application."

(d) The provision provided by Subsection (c) must be under the caption "Incontestable." An insurer that uses the provision may omit the parenthetical clause. (V.T.I.C. Art. 3.70-3, Sec. (A)

(part).)

Sec. 1201.209. POLICY PROVISION: GRACE PERIOD. (a) An individual accident and health insurance policy must contain the following provision:

"Grace Period: A grace period of ____ (insert appropriate number) days will be granted for the payment of each premium due after the first premium. During the grace period, the policy continues in force."

(b) The number of days of the grace period may not be less than:

(1) 7 for a weekly premium policy;

(2) 10 for a monthly premium policy; or

(3) 31 for any other policy.

(c) A policy that contains a cancellation provision may add, at the end of the provision required by Subsection (a): "subject to the right of the insurer to cancel the policy in accordance with the policy's cancellation provision."

(d) A policy in which the insurer reserves the right to refuse any renewal must include the following provision at the beginning of the provision required by Subsection (a):

"Unless, not less than five days before the premium due date, the insurer has delivered to the insured, or has mailed to the insured's last address as shown by the insurer's records, a written notice of the insurer's intention not to renew this policy beyond the period for which the premium has been accepted, ..." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Sec. 1201.210. POLICY PROVISION: REINSTATEMENT. (a)

Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Reinstatement: If a renewal premium is not paid before the expiration of the period granted for the insured to make the payment, a subsequent acceptance of the premium by the insurer or any agent authorized by the insurer to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the policy. However, if the insurer or authorized agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated on approval of the application by the insurer or, if the application is not approved, on the 45th day after the date of the conditional receipt unless the insurer before that date has notified the insured in writing of the insurer's disapproval of the application. The reinstated policy covers only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness that begins more than 10 days after the date of reinstatement. In all other respects the insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the policy or attached to the policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement."

(b) The insurer may omit the last sentence of the provision required by Subsection (a) in a policy that provides that the

insured is entitled to continue the policy in force by the timely payment of premiums until the insured reaches at least 50 years of age or, if the policy was issued after the insured reached 44 years of age, until at least the fifth anniversary of the policy's date of issuance. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Sec. 1201.211. POLICY PROVISION: NOTICE OF CLAIM. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Notice of Claim: A written notice of claim must be given to the insurer before the 21st day after the date of the occurrence or beginning of any loss covered by the policy, or as soon after that date as is reasonably possible. A notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of any office the insurer designates for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, constitutes notice to the insurer."

(b) In a policy that provides a loss of time benefit that may be payable for at least two years, an insurer may insert, between the first and second sentences of the provision required by Subsection (a), the following provision:

"Subject to the qualifications below, and except in the event of a legal incapacity, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every _____ (insert appropriate number) months after having given notice of claim, give to the insurer notice of continuance of the disability. In applying this provision, the period of _____ (insert

appropriate number) months following a filing of proof by the insured or any payment by the insurer on account of the claim or any denial of liability in whole or in part by the insurer shall be excluded. Delay in giving the notice does not impair the insured's right to any indemnity that would otherwise have accrued during the period of _____ (insert appropriate number) months preceding the date on which the notice is actually given."

(c) The number of months inserted in the clause permitted by Subsection (b) may not be less than one or greater than six. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Sec. 1201.212. POLICY PROVISION: CLAIM FORMS. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Claim Forms: The insurer, on receipt of a notice of claim, will provide to the claimant the forms usually provided by the insurer for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this policy as to proof of loss on submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made."

(b) The provision required by this section is not required to be contained in a policy issued by a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Sec. 1201.213. POLICY PROVISION: PROOF OF LOSS. An individual accident and health insurance policy must contain the

following provision:

"Proof of Loss: For a claim for loss for which this policy provides any periodic payment contingent on continuing loss, a written proof of loss must be provided to the insurer at the insurer's designated office before the 91st day after the termination of the period for which the insurer is liable. For a claim for any other loss, a written proof of loss must be provided to the insurer at the insurer's designated office before the 91st day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Sec. 1201.214. POLICY PROVISION: TIME OF PAYMENT OF CLAIMS. (a) Except as provided by Subsection (c), an individual accident and health insurance policy must contain the following provision:

"Time of Payment of Claims: Indemnities payable under this policy for any loss, other than a loss for which this policy provides any periodic payment, will be paid immediately on receipt of due written proof of the loss. Subject to due written proof of loss, all accrued indemnities for a loss for which this policy provides periodic payment will be paid _____ (insert period for payment) and any balance remaining unpaid on termination of liability will be paid immediately on receipt of due written proof

of loss."

(b) The period for payment to be inserted in the clause required by Subsection (a) may not be less frequent than monthly.

(c) The provision required by this section is not required to be contained in a policy issued by a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Sec. 1201.215. POLICY PROVISION: PAYMENT OF CLAIMS. (a) Except as provided by Subsection (d), an individual accident and health insurance policy must contain the following provision:

"Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting indemnity payments that may be prescribed in this policy and effective at the time of payment. If such a designation or provision is not then effective, the indemnity will be payable to the insured's estate. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either in accordance with the beneficiary designation or to the insured's estate. All other indemnities will be payable to the insured."

(b) An insurer may include with the provision required by Subsection (a) one or both of the following provisions:

"If any indemnity of this policy is payable to the insured's estate, or to an insured or beneficiary who is a minor or is otherwise not competent to give a valid release, the insurer may pay the indemnity, up to an amount not exceeding $_____ (insert amount), to any relative by blood or connection by marriage of the insured or beneficiary who is considered by the insurer to be

equitably entitled to the indemnity. Any payment made by the insurer in good faith in accordance with this provision fully discharges the insurer to the extent of the payment."

"Subject to any written direction of the insured, in the application or otherwise, all or a portion of any indemnity provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proof of the loss, be paid directly to the hospital or person providing the services. It is not required that the service be provided by a particular hospital or person."

(c) The amount to be inserted in the clause permitted by Subsection (b) may not exceed $1,000.

(d) The provision required by Subsection (a) is not required to be contained in a policy issued by a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Sec. 1201.216. POLICY PROVISION: PHYSICAL EXAMINATIONS AND AUTOPSY. An individual accident and health insurance policy must contain the following provision:

"Physical Examinations and Autopsy: The insurer at its own expense has the right and opportunity to conduct a physical examination of the insured when and as often as the insurer reasonably requires while a claim under the policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Sec. 1201.217. POLICY PROVISION: LEGAL ACTIONS. An individual accident and health insurance policy must contain the

following provision:

"Legal Actions: An action at law or in equity may not be brought to recover on this policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Sec. 1201.218. POLICY PROVISION: CHANGE OF BENEFICIARY. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved for the insured, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this policy, for any change of beneficiary or beneficiaries, or for any other changes in this policy."

(b) An insurer may omit the first clause of the provision required by Subsection (a) relating to an irrevocable designation of beneficiary. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Sec. 1201.219. POLICY PROVISION: CHANGE OF OCCUPATION. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Change of Occupation: If the insured is injured or contracts a sickness after the insured changes the insured's occupation to one classified by the insurer as more hazardous than

the occupation stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only the portion of the indemnity provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured changes the insured's occupation to one classified by the insurer as less hazardous than the occupation stated in this policy, the insurer, on receipt of proof of the change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding the receipt of the proof, whichever date is more recent. In applying this provision, the classification of occupational risk and the premium rates are the classification and rates that, before the occurrence of the loss for which the insurer is liable or before the date of proof of change in occupation, were:

(1) last filed by the insurer with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; or

(2) if filing was not required, last made effective by the insurer in the state where the insured resided at the time this policy was issued." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Sec. 1201.220. POLICY PROVISION: MISSTATEMENT OF AGE. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Misstatement of Age: If the age of the insured has been

misstated, the amounts payable under this policy are the amounts the premium paid would have purchased at the correct age." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Sec. 1201.221. POLICY PROVISION: EXCESS INSURANCE. An individual accident and health insurance policy must contain one of the following provisions if the policy addresses the subject matter of the provision:

"Other Insurance With This Insurer: If an accident or health or accident and health policy or policies previously issued by the insurer to the insured is in force concurrently with this policy, making the aggregate indemnity for _____ (insert types of coverages) in excess of $_____ (insert maximum limit of indemnity or indemnities), the excess insurance is void and all premiums paid for the excess shall be returned to the insured or to the insured's estate."

"Other Insurance With This Insurer: Insurance effective at any one time on the insured under the same type of policy or policies with this insurer is limited to the one policy elected by the insured, the insured's beneficiary, or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other policies of the same type." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Sec. 1201.222. POLICY PROVISION: RELATION OF EARNINGS TO INSURANCE. (a) Subject to Subsection (b), an individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Relation of Earnings to Insurance: If the total monthly

amount of loss of time benefits promised for the same loss under all valid loss of time coverage on the insured, regardless of whether the benefits are payable on a weekly or monthly basis, exceeds the amount of monthly earnings of the insured at the time the insured's disability began or the insured's average amount of monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever amount is greater, the insurer will be liable only for the proportionate amount of loss of time benefits under this policy as the amount of the insured's monthly earnings or average monthly earnings bears to the total amount of monthly benefits for the same loss under all loss of time coverage on the insured at the time the disability begins and for the return of the part of the premiums paid during the immediately preceding two years that exceeds the pro rata amount of the premiums for the benefits actually paid under this policy. This provision does not reduce the total monthly amount of benefits payable under all loss of time coverage on the insured to less than $200 or the sum of the monthly benefits specified in the loss of time coverages, whichever amount is less, and does not reduce benefits other than loss of time benefits."

(b) The provision described by Subsection (a) may be included only in a policy that provides that the insured is entitled to continue the policy in force subject to its terms by the timely payment of premiums until the insured reaches at least 50 years of age or, if the policy was issued after the insured reached 44 years of age, until at least the fifth anniversary of the policy's date of issuance.

(c) An insurer may include in the provision described by Subsection (a) a definition of "valid loss of time coverage." The form of the definition must be approved by the commissioner. The subject matter of the definition must be limited to:

(1) coverage provided by:

(A) governmental agencies; or

(B) organizations subject to regulation by insurance laws or by insurance authorities of this or any other state or any province of Canada;

(2) any other coverage the inclusion of which is approved by the commissioner; or

(3) any combination of coverages described by Subdivisions (1) and (2).

(d) In the absence of a definition authorized under Subsection (c), "valid loss of time coverage" does not include:

(1) coverage provided for the insured under a compulsory benefit statute, including a workers' compensation or employer's liability statute; or

(2) benefits provided by:

(A) a union welfare plan;

(B) an employer benefit organization; or

(C) an employee benefit organization. (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Sec. 1201.223. POLICY PROVISION: UNPAID PREMIUM. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Unpaid Premium: At the time of payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted from the payment." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Sec. 1201.224. POLICY PROVISION: CANCELLATION. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Cancellation: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to the insured's last address as shown by the records of the insurer, stating when the cancellation is effective, which may not be earlier than five days after the date the notice is delivered or mailed. After this policy has been continued beyond its original term, the insured may cancel the policy at any time by written notice delivered or mailed to the insurer, effective on receipt or on a later date specified in the notice. In the event of cancellation, the insurer will promptly return the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation is without prejudice to any claim originating before the effective date of cancellation." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Sec. 1201.225. POLICY PROVISION: CONFORMITY WITH STATE

STATUTES. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Conformity With State Statutes: Any provision of this policy that, on its effective date, conflicts with the statutes of the state in which the insured resides on the effective date is by this clause effectively amended to conform to the minimum requirements of that state's statutes." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Sec. 1201.226. POLICY PROVISION: ILLEGAL OCCUPATION. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Illegal Occupation: The insurer is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Sec. 1201.227. POLICY PROVISION: INTOXICANTS AND NARCOTICS. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Intoxicants and Narcotics: The insurer is not liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless the narcotic is administered on the advice of a physician." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

[Sections 1201.228-1201.270 reserved for expansion]

SUBCHAPTER F. APPLICATION FOR POLICY

Sec. 1201.271. ALTERATION OF POLICY APPLICATION. (a) A person may not alter a written application for an individual accident and health insurance policy unless the person has the written consent of the applicant.

(b) Notwithstanding Subsection (a), an insurer may make an insertion to an application solely for administrative purposes in a manner that indicates clearly that the insertion is not attributed to the applicant. (V.T.I.C. Art. 3.70-5, Sec. (B).)

Sec. 1201.272. FALSE STATEMENTS. The falsity of a statement in an application for an individual accident and health insurance policy does not bar a right to recovery under the policy unless the statement materially affected the acceptance of the risk or the hazard assumed by the insurer. (V.T.I.C. Art. 3.70-5, Sec. (C).)

Sec. 1201.273. BINDING STATEMENTS. An insured may not be bound by a statement made in an application for an individual accident and health insurance policy unless a copy of the application is attached to or endorsed on the policy as a part of the policy when issued. (V.T.I.C. Art. 3.70-5, Sec. (A) (part).)

Sec. 1201.274. INSURER'S EVIDENTIARY USE OF APPLICATION FOR REINSTATEMENT OR RENEWAL. (a) If an individual accident and health insurance policy is reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes a written request for a copy of the application for reinstatement or renewal, the insurer shall, not later than the 15th day after the date the insurer

receives the request at its home or branch office, deliver or mail a copy of the application to the person who made the request.

(b) An insurer that fails to comply with this section may not introduce the application for reinstatement or renewal as evidence in any action or proceeding based on or involving the policy or its reinstatement or renewal. (V.T.I.C. Art. 3.70-5, Sec. (A) (part).)

[Sections 1201.275-1201.700 reserved for expansion]

SUBCHAPTER O. ENFORCEMENT

Sec. 1201.701. CIVIL PENALTY. A person, partnership, or corporation that wilfully violates this chapter or an order of the commissioner made under this chapter is liable to the state for a civil penalty in an amount not to exceed $5,000 for each violation. The penalty may be recovered through a civil action. (V.T.I.C. Art. 3.70-9 (part).)

Sec. 1201.702. ACTION AGAINST CERTIFICATE OF AUTHORITY OR LICENSE. The commissioner may suspend or revoke the certificate of authority or license of an insurer or agent who wilfully violates this chapter or an order of the commissioner made under this chapter. (V.T.I.C. Art. 3.70-9 (part).)

CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES

IN GENERAL

SUBCHAPTER A. CONTINUOUS POLICIES

Sec. 1202.001. CONTINUOUS POLICIES

[Sections 1202.002-1202.050 reserved for expansion]

SUBCHAPTER B. INDIVIDUAL HEALTH INSURANCE POLICIES

Sec. 1202.051. RENEWABILITY AND CONTINUATION OF INDIVIDUAL

HEALTH INSURANCE POLICIES

Sec. 1202.052. CANCELLATION PROHIBITED FOR AIDS OR HIV

CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES

IN GENERAL

SUBCHAPTER A. CONTINUOUS POLICIES

Sec. 1202.001. CONTINUOUS POLICIES. (a) A guaranteed renewable insurance policy or a noncancellable insurance policy is considered to be a continuous policy, subject only to the policy terms and conditions, including payment of the policy premium.

(b) A guaranteed renewable insurance policy or a noncancellable insurance policy:

(1) is continued in effect by the payment of the policy premium in accordance with the policy terms and conditions; and

(2) may not be considered or treated as a renewed policy by the payment of the policy premium.

(c) This section does not apply to a small employer health benefit plan adopted in accordance with Chapter 1501. (V.T.I.C. Art. 3.70-13.)

[Sections 1202.002-1202.050 reserved for expansion]

SUBCHAPTER B. INDIVIDUAL HEALTH INSURANCE POLICIES

Sec. 1202.051. RENEWABILITY AND CONTINUATION OF INDIVIDUAL HEALTH INSURANCE POLICIES. (a) This section applies only to an individual health insurance policy that provides benefits for medical care under a hospital, medical, or surgical policy.

(b) Except as provided by Subsection (c), an insurer shall renew or continue an individual health insurance policy at the option of the individual.

(c) An insurer may decline to renew or continue an individual health insurance policy:

(1) for failure to pay a premium or contribution in accordance with the terms of the policy;

(2) for fraud or intentional misrepresentation;

(3) because the insurer is ceasing to offer coverage in the individual market in accordance with rules adopted by the commissioner;

(4) because an individual no longer resides, lives, or works in an area in which the insurer is authorized to provide coverage, but only if all policies are not renewed or not continued under this subdivision uniformly without regard to any health-status related factor of covered individuals; or

(5) in accordance with federal law, including regulations.

(d) The commissioner shall adopt rules necessary to:

(1) implement this section; and

(2) meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 3.70-1A.)

Sec. 1202.052. CANCELLATION PROHIBITED FOR AIDS OR HIV. (a) In this section, "AIDS" and "HIV" have the meanings assigned by Section 81.101, Health and Safety Code.

(b) Except as provided by Subsection (c), an insurer that delivers or issues for delivery an individual accident and health insurance policy in this state may not cancel that policy during its term because the insured:

(1) has been diagnosed as having AIDS or HIV;

(2) has been treated for AIDS or HIV; or

(3) is being treated for AIDS or HIV.

(c) The insurer may cancel the policy for:

(1) failure to pay a premium when due; or

(2) fraud or misrepresentation in obtaining coverage by not disclosing a diagnosis of an AIDS or HIV-related condition.

(d) The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this section. (V.T.I.C. Art. 3.70-3A; New.)

CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS

CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS

Sec. 1203.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to:

(1) a policy of group accident and health insurance as described by Chapter 1251;

(2) a policy of blanket accident and health insurance as described by Chapter 1251;

(3) a policy of individual accident and health insurance as defined by Section 1201.001; or

(4) an evidence of coverage as defined by Section

843.002.

(b) This chapter does not apply to an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible. (V.T.I.C. Art. 3.51-6B, Sec. 1(a) (part).)

Sec. 1203.002. CERTAIN COORDINATION OF BENEFITS PROVISIONS PROHIBITED. (a) An accident and health insurance policy or evidence of coverage may not be delivered, issued for delivery, or renewed in this state if:

(1) a provision of the policy or evidence of coverage excludes or reduces the payment of benefits to or on behalf of an insured or enrollee;

(2) the reason for the exclusion or reduction is that benefits are also payable or have been paid to or on behalf of the insured or enrollee under a supplemental policy of accident and health insurance; and

(3) the supplemental policy is individually underwritten and individually issued as a plan of coverage for:

(A) hospital confinement indemnity;

(B) a specified disease; or

(C) a limited benefit.

(b) Application of Subsection (a) to a provision of an accident and health insurance policy or evidence of coverage is not affected by:

(1) the mode or channel by which the premium for a supplemental policy of accident and health insurance is paid to the insurer; or

(2) a reduction in the premium for a supplemental policy of accident and health insurance because of the insured's membership in an organization or status as an employee. (V.T.I.C. Art. 3.51-6B, Secs. 1(a) (part), (b).)

Sec. 1203.003. CERTAIN COORDINATION OF BENEFITS PROVISIONS VOID. A provision of an accident and health insurance policy or evidence of coverage that violates Section 1203.002 is void. (V.T.I.C. Art. 3.51-6B, Sec. 2.)

CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH AND ACCIDENT INSURANCE POLICY OR PLAN BENEFITS

SUBCHAPTER A. PAYMENTS TO CERTAIN PUBLIC HOSPITALS

Sec. 1204.001. NONAPPLICABILITY TO CERTAIN FACILITIES

Sec. 1204.002. BENEFITS PAYABLE FOR TREATMENT PROVIDED BY HOSPITAL OWNED BY STATE OR UNIT OF LOCAL GOVERNMENT

[Sections 1204.003-1204.050 reserved for expansion]

SUBCHAPTER B. ASSIGNMENT OF BENEFIT PAYMENTS

Sec. 1204.051. DEFINITIONS

Sec. 1204.052. APPLICABILITY TO CERTAIN PLANS OR PROGRAMS

Sec. 1204.053. ASSIGNMENT OF BENEFITS

Sec. 1204.054. PAYMENT OF BENEFITS ACCORDING TO ASSIGNMENT

Sec. 1204.055. CONTRACTUAL RESPONSIBILITY FOR DEDUCTIBLES AND COPAYMENTS

[Sections 1204.056-1204.100 reserved for expansion]

SUBCHAPTER C. UNIFORM CLAIM BILLING FORMS

Sec. 1204.101. DEFINITIONS

CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH AND ACCIDENT INSURANCE POLICY OR PLAN BENEFITS

SUBCHAPTER A. PAYMENTS TO CERTAIN PUBLIC HOSPITALS

Sec. 1204.001. NONAPPLICABILITY TO CERTAIN FACILITIES. This subchapter does not apply to indigent care or chronic disease care provided in or by an eleemosynary institution, sanitarium, sanitorium, mental health treatment facility, tuberculosis treatment facility, or cancer treatment facility that is owned or

controlled by the state or by a unit of local government. (V.T.I.C. Art. 3.42B (part).)

Sec. 1204.002. BENEFITS PAYABLE FOR TREATMENT PROVIDED BY HOSPITAL OWNED BY STATE OR UNIT OF LOCAL GOVERNMENT. An insurance policy providing hospital, nursing, medical, or surgical coverage that is issued or delivered in this state after August 27, 1973, may not include a provision that prevents the payment of benefits for expenses of a nonindigent patient incurred in a hospital facility that:

(1) is owned or controlled by the state or by a unit of local government; and

(2) regularly and customarily demands and collects from nonindigent persons payment for those expenses. (V.T.I.C. Art. 3.42B (part).)

[Sections 1204.003-1204.050 reserved for expansion]

SUBCHAPTER B. ASSIGNMENT OF BENEFIT PAYMENTS

Sec. 1204.051. DEFINITIONS. In this subchapter:

(1) "Covered person" means a person who is insured or covered by a health insurance policy or is a participant in an employee benefit plan. The term includes:

(A) a person covered by a health insurance policy because the person is an eligible dependent; and

(B) an eligible dependent of a participant in an employee benefit plan.

(2) "Employee benefit plan" or "plan" means a plan, fund, or program established or maintained by an employer, an employee organization, or both, to the extent that it provides,

through the purchase of insurance or otherwise, health care services to employees, participants, or the dependents of employees or participants.

(3) "Health care provider" means a person who provides health care services under a license, certificate, registration, or other similar evidence of regulation issued by this or another state of the United States.

(4) "Health care service" means a service to diagnose, prevent, alleviate, cure, or heal a human illness or injury that is provided to a covered person by a physician or other health care provider.

(5) "Health insurance policy" means an individual, group, blanket, or franchise insurance policy, or an insurance agreement, that provides reimbursement or indemnity for health care expenses incurred as a result of an accident or sickness.

(6) "Insurer" means an insurance company, association, or organization authorized to engage in business in this state under Chapter 841, 861, 881, 882, 883, 884, 885, 886, 887, 888, 941, 942, or 982.

(7) "Person" means an individual, association, partnership, corporation, or other legal entity.

(8) "Physician" means an individual licensed to practice medicine in this or another state of the United States. (V.T.I.C. Art. 21.24-1, Sec. 1; New.)

Sec. 1204.052. APPLICABILITY TO CERTAIN PLANS OR PROGRAMS. This subchapter applies to:

(1) an employee benefit plan, to the extent not

preempted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(2) benefit programs under Chapters 1551 and 1601, to the extent that the benefit programs are self-insuring; and

(3) insurance coverage provided under Chapter 1575. (V.T.I.C. Art. 21.24-1, Sec. 2.)

Sec. 1204.053. ASSIGNMENT OF BENEFITS. (a) An insurer may not deliver, renew, or issue for delivery in this state a health insurance policy that prohibits or restricts a covered person from making a written assignment of benefits to a physician or other health care provider who provides health care services to the person.

(b) This section does not:

(1) provide a coverage or benefit that is not otherwise available under the health insurance policy;

(2) allow assignment of a benefit to:

(A) a person who is not legally entitled to receive such a direct payment; or

(B) another person if, under the health insurance policy or plan, the benefit must be provided to the covered person by a physician or other health care provider who is a contractor or preferred provider under the policy; or

(3) prohibit an insurer from verifying, through the insurer's normal process, the health care services the physician or other health care provider provides to the covered person. (V.T.I.C. Art. 21.24-1, Sec. 3.)

Sec. 1204.054. PAYMENT OF BENEFITS ACCORDING TO ASSIGNMENT.

An insurer shall pay benefits directly to a physician or other health care provider, and the insurer is relieved of the obligation to pay, and of any liability for paying, those benefits to the covered person if:

(1) the covered person makes a written assignment of those benefits payable to the physician or other health care provider; and

(2) the assignment is obtained by or delivered to the insurer with the claim for benefits. (V.T.I.C. Art. 21.24-1, Secs. 4(a), (b).)

Sec. 1204.055. CONTRACTUAL RESPONSIBILITY FOR DEDUCTIBLES AND COPAYMENTS. (a) The payment of benefits under an assignment does not relieve a covered person of a contractual obligation to pay a deductible or copayment.

(b) A physician or other health care provider may not waive a deductible or copayment by the acceptance of an assignment. (V.T.I.C. Art. 21.24-1, Sec. 4(c).)

[Sections 1204.056-1204.100 reserved for expansion]

SUBCHAPTER C. UNIFORM CLAIM BILLING FORMS

Sec. 1204.101. DEFINITIONS. In this subchapter:

(1) "Health benefit plan" means a group, blanket, or franchise insurance policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization, that provides benefits for health care services.

(2) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state

that provides health insurance or health benefits in this state, including:

(A) an insurance company;

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

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

(3) "Provider" means a person who provides health care under a license issued by this state. The term includes a health care practitioner listed in Section 1451.001 and a nurse first assistant, as defined by Section 1451.101. (V.T.I.C. Art. 21.52C, Sec. (a).)

Sec. 1204.102. REQUIRED CLAIM BILLING FORMS. A provider who seeks payment or reimbursement under a health benefit plan and the health benefit plan issuer that issued the plan shall use uniform claim billing form UB-82/HCFA or HCFA 1500, or a successor to one of those forms, as developed by the National Uniform Billing Committee or its successor. (V.T.I.C. Art. 21.52C, Sec. (b).)

[Sections 1204.103-1204.150 reserved for expansion]

SUBCHAPTER D. PAYMENTS FOR CERTAIN PUBLICLY PROVIDED SERVICES

Sec. 1204.151. DEFINITION. In this subchapter, "policy" means an individual or group policy of accident and health insurance, including a policy issued by a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.76, Sec. 1 (part); Art. 21.49-10 (part).)

Sec. 1204.152. PAYMENT FOR CERTAIN EXPENSES INCURRED BY TEXAS DEPARTMENT OF HUMAN SERVICES. Each policy delivered or issued for delivery in this state must provide for the repayment of the actual costs of medical expenses the Texas Department of Human Services pays through medical assistance for an insured person if, under the policy, the insured person is entitled to payment for the medical expenses. (V.T.I.C. Art. 21.49-10 (part).)

Sec. 1204.153. PAYMENTS TO TEXAS DEPARTMENT OF HUMAN SERVICES FOR CERTAIN CHILDREN. (a) This section applies only to a policy that is delivered, issued for delivery, or renewed in this state and that provides coverage for a child whose parent:

(1) purchased the policy; or

(2) is a member of the group covered under the policy.

(b) Each policy must include a requirement that, after written notice to the insurer or group hospital service corporation at the insurer's or group hospital service corporation's home office, benefits payable on behalf of a child must be paid to the Texas Department of Human Services if:

(1) the parent who purchased the policy or who is a group member is required to pay child support by a court order or court-approved agreement and:

(A) is a possessory conservator of the child under a court order issued in this state; or

(B) is not entitled to possession of or access to the child;

(2) the Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or 32, Human

Resources Code; and

(3) the insurer or group hospital service corporation is notified, through an attachment to the claim for benefits at the time the claim is first submitted to the insurer or group hospital service corporation, that the benefits must be paid directly to the Texas Department of Human Services.

(c) The commissioner and the Texas Department of Human Services may consult regarding implementation of this section. (V.T.I.C. Art. 3.76, Secs. 1 (part), 2.)

Sec. 1204.154. UNIFORM PROVISIONS. (a) The commissioner shall adopt uniform policy provisions, riders, and endorsements for the policy requirement of Section 1204.153.

(b) Before the commissioner adopts or makes a change to a provision, rider, or endorsement under Subsection (a), the commissioner shall present each provision, rider, or endorsement, and any amendment to a provision, rider, or endorsement, to the Texas Department of Human Services for comment. (V.T.I.C. Art. 3.76, Sec. 3.)

[Sections 1204.155-1204.200 reserved for expansion]

SUBCHAPTER E. EXCLUSIONARY CLAUSES

Sec. 1204.201. PROHIBITION OF EXCLUSION OF CERTAIN MEDICAL ASSISTANCE BENEFITS. An individual or group accident and health insurance policy delivered or issued for delivery in this state, including a policy issued by a group hospital service corporation operating under Chapter 842, may not include a provision that excludes or limits the insurer's or group hospital service corporation's coverage from paying benefits covered by Chapter 32,

Human Resources Code. (V.T.I.C. Art. 21.49-9.)

[Sections 1204.202-1204.250 reserved for expansion]

SUBCHAPTER F. PAYMENT OF BENEFITS TO CONSERVATOR OF MINOR

Sec. 1204.251. PAYMENT TO CONSERVATOR OTHER THAN GROUP MEMBER. (a) An insurer or group hospital service corporation operating under Chapter 842 that delivers, issues for delivery, or renews in this state a group accident and health insurance policy that provides coverage for a minor child who qualifies as a dependent of a group member may pay benefits on the child's behalf to a person who is not a group member if an order providing for the appointment of a possessory or managing conservator of the child has been issued by a court in this or another state.

(b) A person who is not a group member is entitled to be paid benefits under this section only if the person presents to the insurer or group hospital service corporation, with the claim application:

(1) written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made; and

(2) a certified copy of a court order designating the person as possessory or managing conservator of the child or other evidence designated by rule of the commissioner that the person is eligible for the benefits as this section provides. (V.T.I.C. Art. 3.51-13, Secs. 1, 3.)

Sec. 1204.252. PRECONDITIONS FOR PAYMENT; EXCEPTIONS. (a) In accordance with the terms of the policy and this subchapter, an insurer or group hospital service corporation may be required to

pay benefits under a group accident and health insurance policy to a person who is not a group member and who complies with:

(1) Section 1204.251;

(2) the insurer's or group hospital service corporation's claim application procedures; and

(3) department rules.

(b) Any requirement imposed on a possessory or managing conservator of a child under this subchapter does not apply with regard to:

(1) an unpaid medical bill for which an assignment of benefits has been exercised, whether in accordance with policy provisions or otherwise; or

(2) a claim presented by a group member for which the group member paid any portion of a medical bill that is covered under the policy's terms. (V.T.I.C. Art. 3.51-13, Sec. 2.)

Sec. 1204.253. RULES. The commissioner may adopt rules to ensure the effective implementation of this subchapter. (V.T.I.C. Art. 3.51-13, Sec. 4.)

CHAPTER 1205. CERTIFICATION OF CREDITABLE COVERAGE

CHAPTER 1205. CERTIFICATION OF CREDITABLE COVERAGE

Sec. 1205.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses

incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act and operating under Chapter 846; or

(ii) an analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) is offered by any other entity that:

(A) is not authorized under this code or another

insurance law of this state; and

(B) contracts directly for health care services on a risk-sharing basis, including a capitation basis. (V.T.I.C. Art. 21.52G, Sec. 2, as added Acts 75th Leg., R.S., Ch. 955.)

Sec. 1205.002. CERTIFICATION OF COVERAGE. (a) A health benefit plan issuer shall provide a certification of coverage as necessary to determine the period of applicable creditable coverage under that health benefit plan.

(b) The certification required under this section must be provided in accordance with the standards adopted by rule by the commissioner. (V.T.I.C. Art. 21.52G, Sec. 4, as added Acts 75th Leg., R.S., Ch. 955.)

Sec. 1205.003. RULES. The commissioner shall adopt rules as necessary to:

(1) implement this chapter and related provisions of this code; and

(2) meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.52G, Sec. 5, as added Acts 75th Leg., R.S., Ch. 955.)

Sec. 1205.004. CREDITABLE COVERAGE. (a) An individual's coverage is creditable coverage for purposes of this chapter if the coverage is provided under:

(1) a self-funded or self-insured employee welfare benefit plan that:

(A) provides health benefits; and

(B) is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section

1001 et seq.);

(2) a group health benefit plan provided by a health insurer or health maintenance organization;

(3) an individual health insurance policy or evidence of coverage;

(4) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);

(5) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that act (42 U.S.C. Section 1396s);

(6) 10 U.S.C. Section 1071 et seq.;

(7) a medical care program of the Indian Health Service or of a tribal organization;

(8) a state health benefits risk pool;

(9) a health plan offered under 5 U.S.C. Section 8901 et seq.;

(10) a public health plan as defined by federal regulations; or

(11) a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)).

(b) For purposes of this chapter, creditable coverage does not include:

(1) accident-only or disability income insurance or a combination of accident-only and disability income insurance;

(2) coverage issued as a supplement to liability insurance;

(3) liability insurance, including general liability

insurance and automobile liability insurance;

(4) workers' compensation insurance or other similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

(8) other coverage that is:

(A) similar to the coverage described by this subsection under which benefits for medical care are secondary or incidental to other insurance benefits; and

(B) specified by federal regulations;

(9) coverage that provides limited-scope dental or vision benefits;

(10) long-term care, nursing home care, home health care, or community-based care coverage or benefits or any combination of those coverages or benefits;

(11) coverage that provides other limited benefits specified by federal regulations;

(12) coverage for a specified disease or illness;

(13) hospital indemnity or other fixed indemnity insurance; or

(14) Medicare supplemental health insurance, as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under 10 U.S.C. Section 1071 et seq., or other similar supplemental coverage provided under a group plan. (V.T.I.C. Art. 21.52G, Sec. 3, as added Acts 75th Leg., R.S., Ch. 955.)

CHAPTER 1206. DENIAL OF HEALTH BENEFIT PLAN ENROLLMENT BASED ON EXISTING COVERAGE PROHIBITED

CHAPTER 1206. DENIAL OF HEALTH BENEFIT PLAN ENROLLMENT BASED ON EXISTING COVERAGE PROHIBITED

Sec. 1206.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.52L, Secs. 1(a), (b), as added Acts 77th Leg., R.S., Ch. 1074.)

Sec. 1206.002. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses;

(H) only for indemnity for hospital confinement; or

(I) in accordance with Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.);

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under

a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1206.001. (V.T.I.C. Art. 21.52L, Sec. 1(c), as added Acts 77th Leg., R.S., Ch. 1074.)

Sec. 1206.003. DENIAL OF ENROLLMENT PROHIBITED. A health benefit plan issuer may not refuse to enroll an individual in the plan solely because the individual is enrolled in another health benefit plan at the time the individual applies for coverage under the plan. (V.T.I.C. Art. 21.52L, Sec. 2, as added Acts 77th Leg., R.S., Ch. 1074.)

Sec. 1206.004. VIOLATION OF CHAPTER: UNFAIR DISCRIMINATION. A health benefit plan issuer who violates this chapter engages in unfair discrimination under Subchapter B, Chapter 544. (V.T.I.C. Art. 21.52L, Sec. 3, as added Acts 77th Leg., R.S., Ch. 1074.)

CHAPTER 1207. ENROLLMENT OF MEDICAL ASSISTANCE RECIPIENTS AND CHILDREN ELIGIBLE FOR STATE CHILD HEALTH PLAN

CHAPTER 1207. ENROLLMENT OF MEDICAL ASSISTANCE RECIPIENTS AND CHILDREN ELIGIBLE FOR STATE CHILD HEALTH PLAN

Sec. 1207.001. APPLICABILITY OF CHAPTER. This chapter

applies only to a group health benefit plan, including a small employer health benefit plan written under Chapter 1501 or a plan provided under Chapter 1551, 1575, or 1601, or a successor to a plan provided under one of those chapters, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage or similar group coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.52K, Sec. 1.)

Sec. 1207.002. ENROLLMENT REQUIRED. (a) A group health benefit plan issuer shall permit an individual who is otherwise eligible for enrollment in the plan to enroll in the plan, without

regard to any enrollment period restriction, on receipt of written notice from the Texas Department of Health or a designee of that department stating that the individual is:

(1) a recipient of medical assistance under the state Medicaid program and is a participant in the health insurance premium payment reimbursement program under Section 32.0422, Human Resources Code; or

(2) a child enrolled in the state child health plan under Chapter 62, Health and Safety Code, and is a participant in the health insurance premium payment reimbursement program under Section 62.059, Health and Safety Code.

(b) If an individual described by Subsection (a)(1) or (2) is not eligible to enroll in the group health benefit plan unless a family member of the individual is also enrolled in the plan, the plan issuer, on receipt of written notice under Subsection (a), shall enroll both the individual and the family member in the plan. (V.T.I.C. Art. 21.52K, Secs. 2(a), (b), (c).)

Sec. 1207.003. EFFECTIVE DATE OF ENROLLMENT. Unless enrollment occurs during an established enrollment period, enrollment in a group health benefit plan under Section 1207.002 takes effect on the first day of the calendar month that begins at least 30 days after the date written notice is received by the plan issuer under Section 1207.002(a). (V.T.I.C. Art. 21.52K, Sec. 2(d).)

Sec. 1207.004. TERMINATION OF ENROLLMENT. (a) Notwithstanding any other requirement of a group health benefit plan, the plan issuer shall permit an individual who is enrolled in

the plan under Section 1207.002(a)(1), and any family member of the individual enrolled under Section 1207.002(b), to terminate enrollment in the plan not later than the 60th day after the date on which the individual provides satisfactory proof to the issuer that the individual is no longer:

(1) a recipient of medical assistance under the state Medicaid program; or

(2) a participant in the health insurance premium payment reimbursement program under Section 32.0422, Human Resources Code.

(b) Notwithstanding any other requirement of a group health benefit plan, the plan issuer shall permit an individual who is enrolled in the plan under Section 1207.002(a)(2), and any family member of the individual enrolled under Section 1207.002(b), to terminate enrollment in the plan not later than the 60th day after the date on which the individual provides satisfactory proof to the issuer that the child is no longer a participant in the health insurance premium payment reimbursement program under Section 62.059, Health and Safety Code. (V.T.I.C. Art. 21.52K, Secs. 2(e), (f).)

CHAPTER 1208. IDENTITY OF AVAILABLE EMPLOYEE OF HEALTH BENEFIT PLAN ISSUER

Sec. 1208.001. APPLICABILITY OF CHAPTER

Sec. 1208.002. DISCLOSURE REQUIRED

CHAPTER 1208. IDENTITY OF AVAILABLE EMPLOYEE OF HEALTH BENEFIT PLAN ISSUER

Sec. 1208.001. APPLICABILITY OF CHAPTER. This chapter

applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.24-3, Sec. 1.)

Sec. 1208.002. DISCLOSURE REQUIRED. After an oral or written request by an insured or enrollee of a health benefit plan, the plan issuer shall provide to the insured or enrollee the name or employee identifier of the issuer's employee who is available to respond to questions or other communication from the insured or enrollee relating to coverage and benefits provided under the plan

to the insured or enrollee. The issuer shall also provide:

(1) the employee's mailing address;

(2) the municipality and state of the employee's business location; and

(3) the employee's job title. (V.T.I.C. Art. 21.24-3, Sec. 2.)

CHAPTER 1209. HEALTH BENEFIT CLAIMS COST INFORMATION REQUIRED TO BE PROVIDED TO EMPLOYER

Sec. 1209.001. APPLICABILITY OF CHAPTER

Sec. 1209.002. CLAIMS COST INFORMATION

Sec. 1209.003. CONFIDENTIALITY

CHAPTER 1209. HEALTH BENEFIT CLAIMS COST INFORMATION REQUIRED TO BE PROVIDED TO EMPLOYER

Sec. 1209.001. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan, including a small employer health benefit plan written under Chapter 1501, that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage or similar group coverage document that is offered by:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885;

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

(E) a reciprocal exchange operating under Chapter 942;

(F) a health maintenance organization operating under Chapter 843;

(G) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(H) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; and

(2) provides health benefits to the employees of one or more employers that sponsor the plan. (V.T.I.C. Art. 21.49-19, Secs. 1, 2.)

Sec. 1209.002. CLAIMS COST INFORMATION. (a) On the request of an employer sponsoring a group health benefit plan, the plan issuer shall provide to the employer the claims cost information for employees covered by the plan during the preceding calendar year.

(b) Claims cost information provided under this section:

(1) may be provided in the aggregate or on a detailed basis;

(2) must be provided separately for each month during which the group health benefit plan was in effect; and

(3) may not include information, including diagnosis code information, that may be used to identify a specific individual enrolled in the plan or a diagnosis of that individual. (V.T.I.C. Art. 21.49-19, Secs. 3(a), (b).)

Sec. 1209.003. CONFIDENTIALITY. Information obtained by an employer under this chapter is confidential and may be used by the employer only for purposes relating to obtaining or maintaining group health benefit plan coverage for the employer's employees. (V.T.I.C. Art. 21.49-19, Sec. 3(c).)

CHAPTER 1210. NOTICE OF CERTAIN POLICY PROVISIONS

Sec. 1210.001. NOTICE REQUIRED

CHAPTER 1210. NOTICE OF CERTAIN POLICY PROVISIONS

Sec. 1210.001. NOTICE REQUIRED. A policy, contract, or certificate of insurance that insures against loss resulting from sickness or accidental bodily injury and that is subject to an increase in the premium at time of renewal or to nonrenewal on the insured attaining a certain age may not be delivered, issued, or used in this state unless the document contains on the first page above the policy provisions a printed notice in 10-point type that states that the policy, contract, or certificate is subject to either or both conditions. (V.T.I.C. Art. 3.42-1, Secs. (a), (b).)

[Chapters 1211-1250 reserved for expansion]

SUBTITLE B. GROUP HEALTH COVERAGE

CHAPTER 1251. GROUP AND BLANKET HEALTH INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

CHAPTER 1251. GROUP AND BLANKET HEALTH INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1251.001. DEFINITIONS. In this chapter:

(1) "Blanket accident and health insurance" means accident, health, or accident and health insurance covering a group described by Subchapter H.

(2) "Group accident and health insurance" means accident, health, or accident and health insurance covering a group described by Subchapter B.

(3) "Group hospital service corporation" means a corporation operating under Chapter 842. (V.T.I.C. Art. 3.51-6, Secs. 1(a) (part), 2(a) (part).)

Sec. 1251.002. CERTAIN GROUP HEALTH INSURANCE AUTHORIZED. A group policy of accident, health, or accident and health insurance, including a group contract issued by a group hospital service corporation, may be delivered or issued for delivery in this state only if the policy:

(1) covers a group described by Subchapter B; and

(2) meets the requirements adopted under this chapter for a group policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(1).)

Sec. 1251.003. CERTAIN BLANKET HEALTH INSURANCE AUTHORIZED. A blanket policy of accident, health, or accident and health insurance may be delivered or issued for delivery in this state only if the policy:

(1) covers a group described by Subchapter H; and

(2) meets the requirements adopted under this chapter for a blanket policy. (V.T.I.C. Art. 3.51-6, Sec. 2(d).)

Sec. 1251.004. CERTAIN PAYMENTS BY INSURERS PROHIBITED. (a) Except as reimbursement for the cost of services that otherwise would have been provided by the insurer, an insurer may not pay to any individual, firm, corporation, or group entity a fee or allowance for services related to:

(1) a group accident and health insurance policy; or

(2) a blanket accident and health insurance policy.

(b) Subsection (a) does not limit an insurer's right to:

(1) pay dividends;

(2) return a premium to a group or a combination of groups;

(3) provide for a rate stabilization fund with combinations of groups; or

(4) pay compensation, including a commission, to a licensed agent. (V.T.I.C. Art. 3.51-6, Secs. 1(e), 2(e).)

Sec. 1251.005. PAYMENT OF BENEFITS. (a) Except as otherwise provided by this section or Section 1251.113, benefits under a group accident and health insurance policy or blanket accident and health insurance policy must be paid to:

(1) the insured;

(2) the insured's designated beneficiary;

(3) the insured's estate; or

(4) if the insured is a minor or is otherwise not competent to give a valid release, the insured's parent, guardian, or other person actually supporting the insured.

(b) A group accident and health insurance policy or blanket accident and health insurance policy may provide that all or a

portion of any indemnity provided by the policy because of hospital, nursing, medical, or surgical services may, at the option of the insurer and unless the insured requests otherwise in writing not later than the time of filing a proof of the loss, be paid directly to the hospital or person providing the services. A payment made as provided by this subsection discharges the obligation of the insurer with respect to the amount paid.

(c) A group accident and health insurance policy or blanket accident and health insurance policy must provide that all or a portion of any benefits provided by the policy for dental care services may, at the option of the insured, be assigned to the dentist providing the services. In the case of an assignment under this subsection, payment must be made directly to the dentist designated. A payment made pursuant to an assignment under this subsection discharges the obligation of the insurer with respect to the amount paid. (V.T.I.C. Art. 3.51-6, Sec. 3 (part).)

Sec. 1251.006. POLICY MAY NOT SPECIFY SERVICE PROVIDER. A group accident and health insurance policy or blanket accident and health insurance policy may not require that a covered service be provided by a particular hospital or person. (V.T.I.C. Art. 3.51-6, Sec. 3 (part).)

Sec. 1251.007. EXCEPTIONS. This subchapter and Subchapters B-I do not apply to:

(1) a credit accident and health insurance policy subject to Chapter 1153;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State

Board of Insurance before April 1, 1975;

(3) accident or health coverage that is incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the commissioner; or

(4) any policy or contract of insurance with a state agency, department, or board providing health services:

(A) to eligible individuals under Chapter 32, Human Resources Code; or

(B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

Sec. 1251.008. RULES. The commissioner may adopt rules necessary to administer this chapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C. Art. 3.51-6, Sec. 5.)

[Sections 1251.009-1251.050 reserved for expansion]

SUBCHAPTER B. GROUP ACCIDENT AND HEALTH INSURANCE: ELIGIBLE POLICYHOLDERS

Sec. 1251.051. EMPLOYERS. (a) For purposes of this section, "employee" includes:

(1) an officer, manager, or employee of the employer;

(2) an individual proprietor or partner, if the employer is an individual proprietorship or partnership;

(3) an officer, manager, or employee of a subsidiary or affiliated corporation; and

(4) an individual proprietor, partner, or employee of an individual or firm, if the business of the employer and the individual or firm is under common control through stock ownership, contract, or otherwise.

(b) A policy issued to insure employees of a public body may provide that the term "employee" includes an elected or appointed officer of the body.

(c) A policy issued to the trustees of a fund established by an employer may provide that the term "employee" includes a trustee, an employee of the trustees, or both, if the person's duties are principally connected with the trusteeship.

(d) A group accident and health insurance policy may be issued to an employer or trustees of a fund established by an employer to insure the employer's active and retired employees for the benefit of persons other than the employer.

(e) The employer or the trustees of a fund established by an employer are the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

Sec. 1251.052. ASSOCIATIONS. (a) A group accident and health insurance policy may be issued to an association, including a labor union or an organization of labor unions, a membership corporation organized or holding a certificate of authority under the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes), and a cooperative or corporation subject to the supervision and control of the Farm Credit Administration, to insure the association's active and retired members, employees, or employees of members for the benefit of

persons other than the association or its officers or trustees.

(b) To be eligible to obtain a group accident and health insurance policy, an association must:

(1) have a constitution and bylaws;

(2) have been organized and have actively existed for at least two years; and

(3) be maintained in good faith for purposes other than that of obtaining insurance. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

Sec. 1251.053. FUNDS ESTABLISHED BY EMPLOYERS, LABOR UNIONS, OR ASSOCIATIONS. (a) A group accident and health insurance policy may be issued to the trustees of a fund established by two or more employers in the same or related industry, by one or more labor unions, by one or more employers and one or more labor unions, or by an association described by Section 1251.052 to insure the active and retired employees of the employers, members of the union or association, or employees of the association for the benefit of persons other than the employers, union, or association.

(b) A policy issued to the trustees of a fund established by employers or a labor union or association may provide that the term "employee" includes:

(1) an officer or manager of the employer;

(2) an individual proprietor or partner, if the employer is an individual proprietorship or partnership; or

(3) a trustee, an employee of the trustees, or both, if the person's duties are principally connected with the trusteeship.

(c) The trustees of a fund established by employers or a

labor union or association are the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

Sec. 1251.054. ELIGIBILITY FOR GROUP LIFE INSURANCE. A group accident and health insurance policy may be issued to any individual or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under the group life policy. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

Sec. 1251.055. FUND FOR FORMER EMPLOYEES AND MEMBERS. (a) An insurer may issue a group accident and health insurance policy to a trustee of a fund to insure former employees, former members, and the spouses, former spouses, and dependents of former employees and members who were previously insured by the insurer under a policy issued to any entity described by this subchapter.

(b) The trustee of a fund is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

Sec. 1251.056. OTHER GROUPS. (a) Under the requirements prescribed by this section, a group accident and health insurance policy may be issued to cover a group other than a group described by Sections 1251.051-1251.055 if the commissioner determines that:

(1) the issuance of the policy is not contrary to the best interest of the public;

(2) the issuance of the policy would result in economies of acquisition or administration; and

(3) the benefits are reasonable in relation to the

premiums charged.

(b) Group accident and health insurance coverage may not be offered to a group in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those prescribed by Subsections (a)(1)-(3) has determined that those requirements have been met.

(c) The premium for the policy must be paid from the policyholder's funds, funds contributed by the covered persons, or both. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

[Sections 1251.057-1251.100 reserved for expansion]

SUBCHAPTER C. GROUP ACCIDENT AND HEALTH INSURANCE: REQUIRED PROVISIONS

Sec. 1251.101. REQUIRED PROVISIONS. (a) A group accident and health insurance policy, including a group contract issued by a group hospital service corporation, may not be delivered in this state unless the policy contains in substance the provisions prescribed by this subchapter or provisions in relation to provisions prescribed by this subchapter that, in the opinion of the commissioner, are:

(1) more favorable to the insureds under the policy; or

(2) at least as favorable to the insureds under the policy and more favorable to the policyholder.

(b) The standard provisions required for individual health insurance policies do not apply to group health insurance policies.

(c) If any provision of this subchapter is wholly or partly

inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall:

(1) omit the inapplicable provision or part from the policy; or

(2) modify the inconsistent provision in a manner that makes the provision as contained in the policy consistent with the coverage provided by the policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.102. PAYMENT OF PREMIUMS. A group accident and health insurance policy must provide that premiums due under the policy must be remitted by the premium payor as designated in the policy:

(1) on or before the due date; or

(2) within any grace period specified in the policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.103. INCONTESTABILITY OF POLICY. (a) A group accident and health insurance policy must provide that:

(1) the validity of the policy may not be contested after the policy has been in force for two years after its date of issue; and

(2) in the absence of fraud, a statement made by any individual covered by the policy relating to the individual's insurability may not be used in contesting the validity of the insurance with respect to which the statement was made:

(A) after the insurance has been in force before the contest for two years during the individual's lifetime; and

(B) unless the statement is contained in a written instrument signed by the individual making the statement.

(b) Subsection (a)(1) does not apply to a contest based on nonpayment of premiums.

(c) The provisions required by this section do not preclude the assertion at any time of a defense based on:

(1) a provision in the policy that relates to eligibility for coverage;

(2) a provision in a group accident and health insurance policy or disability insurance policy that relates to overinsurance;

(3) a provision in a disability policy that relates to the relation of earnings to insurance; or

(4) another similar provision in a group accident and health insurance policy or disability insurance policy that limits the amounts of recovery from all sources to not more than 100 percent of the total actual losses or expenses incurred. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.104. ENTIRE CONTRACT. A group accident and health insurance policy must provide that the policy and any application attached to the policy constitute the entire contract between the parties. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.105. STATEMENT MADE BY POLICYHOLDER OR INSURED. A group accident and health insurance policy must provide that:

(1) in the absence of fraud, a statement made by the policyholder or an insured is considered a representation and not a warranty; and

(2) a statement made by the policyholder or an insured may not be used in any contest under the policy, unless a copy of the written instrument containing the statement is or has been provided to:

(A) the person making the statement; or

(B) if the statement was made by the insured and the insured has died or become incapacitated, the insured's beneficiary or personal representative. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.106. DISTINCTION BASED ON MARITAL STATUS PROHIBITED. A group accident and health insurance policy must include a provision that prohibits a distinction on the basis of the marital status or lack of marital status between an insured and the other parent in the determination of the dependents or the beneficiaries of the insured, or both. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.107. EVIDENCE OF INSURABILITY. A group accident and health insurance policy must state the conditions, if any, under which the insurer reserves the right to require an individual eligible for insurance to provide evidence of individual insurability satisfactory to the insurer as a condition of obtaining part or all of the coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.108. EXCLUSION OR LIMITATION OF COVERAGE FOR PREEXISTING CONDITIONS. (a) A group accident and health insurance policy must specify the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or

physical condition of an insured, not otherwise excluded from the insured's coverage by name or specific description effective on the date of the insured's loss, that existed before the effective date of the insured's coverage under the policy.

(b) An exclusion or limitation described by Subsection (a) may apply only to a disease or physical condition for which the insured received medical advice or treatment during the 12 months before the effective date of the insured's coverage.

(c) An exclusion or limitation described by Subsection (a) may not apply to a loss incurred or disability beginning after the earlier of:

(1) the end of 12 consecutive months, beginning on or after the effective date of the insured's coverage, during which the insured has not received medical advice or treatment in connection with the disease or physical condition; or

(2) the second anniversary of the effective date of the insured's coverage.

(d) This section does not apply to:

(1) a credit accident and health insurance policy; or

(2) a group accident and health insurance policy subject to Chapter 1501. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.109. ADJUSTMENT OF PREMIUMS OR BENEFITS IF AGE OF INSURED IS MISSTATED. (a) A group accident and health insurance policy under which the premiums or benefits vary by age must specify an equitable adjustment of premiums or benefits, or both, to be made if the age of an insured has been misstated.

(b) The provision required by Subsection (a) must contain a clear statement of the method of adjustment to be used. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.110. DEADLINE FOR NOTICE OF CLAIM. (a) A group accident and health insurance policy must provide that written notice of a claim must be given to the insurer not later than the 20th day after the date of the occurrence or beginning of any loss covered by the policy.

(b) Failure to give notice within the time prescribed by Subsection (a) does not invalidate or reduce any claim if it is shown that:

(1) it was not reasonably possible to give the notice within that time; and

(2) notice was given as soon as was reasonably possible. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.111. CLAIM FORMS. (a) A group accident and health insurance policy must provide that the insurer will furnish to the person making a claim or to the policyholder for delivery to a person making a claim the forms usually provided by the insurer for filing a proof of loss.

(b) If the forms for a proof of loss are not provided before the 16th day after the date the insurer received notice of a claim under the policy, the person making the claim is considered to have complied with the requirements of the policy as to proof of loss on submitting, within the time set in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made. (V.T.I.C. Art. 3.51-6,

Sec. 1(d)(2) (part).)

Sec. 1251.112. DEADLINE FOR CLAIM. (a) A group accident and health insurance policy must provide that:

(1) in the case of a claim for a loss other than a claim for a loss of time for disability, written proof of the loss must be provided to the insurer not later than the 90th day after the date of the loss; and

(2) in the case of a claim for loss of time for disability:

(A) written proof of the loss must be provided to the insurer not later than the 90th day after the beginning of the period for which the insurer is liable; and

(B) subsequent written proofs of the continuance of the disability must be provided to the insurer at intervals as reasonably required by the insurer.

(b) Failure to provide written proof of a loss within the time prescribed by Subsection (a) does not invalidate or reduce a claim if:

(1) it was not reasonably possible to provide written proof of the loss within that time;

(2) written proof of the loss is provided as soon as reasonably possible; and

(3) unless the claimant does not have the legal capacity to provide proof of loss, proof of loss is provided not later than the first anniversary of the date the proof of loss is otherwise required. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.113. PROMPT PAYMENT OF BENEFITS REQUIRED. A

group accident and health insurance policy must provide that:

(1) all benefits payable under the policy, other than benefits for loss of time, must be paid not later than the 60th day after the date the proof of loss is received; and

(2) subject to written proof of loss, all accrued benefits payable under the policy for loss of time must be paid at least monthly during the period for which the insurer is liable, and that any balance remaining unpaid at the end of that period must be paid as soon as possible after the proof of loss is received. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.114. PAYMENT OF BENEFITS. (a) A group accident and health insurance policy must provide that all benefits of the policy, other than benefits for loss of life, must be paid to the insured or the insured's assignee.

(b) A group accident and health insurance policy must provide that, subject to the provisions of the policy, benefits for loss of life of an insured must be paid to:

(1) the beneficiary designated by the insured or the beneficiary's assignee;

(2) the family member specified by the policy terms, if the policy contains conditions relating to family status; or

(3) the estate of the insured, if the designated or specified beneficiary is not living at the time the insured dies.

(c) A group accident and health insurance policy may provide that if any benefits are payable to the estate of an individual or to an individual who is a minor or is otherwise not competent to give a valid release, the insurer may pay the benefits, up to an

amount established by the commissioner, to any individual related by consanguinity or affinity to the individual who is considered by the insurer to be equitably entitled to the benefits.

(d) This section does not apply to:

(1) a credit accident and health insurance policy; or

(2) a group contract issued by a group hospital service corporation. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.115. RIGHT TO CONDUCT PHYSICAL EXAMINATION OR AUTOPSY. A group accident and health insurance policy must provide that the insurer has the right and opportunity to:

(1) conduct a physical examination of an individual for whom a claim is made when and as often as the insurer reasonably requires during the pendency of the claim under the policy; and

(2) in the case of a death, require that an autopsy be conducted, unless the autopsy is prohibited by law. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.116. LEGAL OR EQUITABLE ACTIONS; LIMITATIONS. A group accident and health insurance policy must provide that an action at law or in equity may not be brought to recover on the policy:

(1) before the 61st day after the date written proof of loss is filed as required under the policy; or

(2) after the third anniversary of the date on which written proof of loss is required under the policy to be filed. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Sec. 1251.117. CONTINUATION OR CONVERSION OF COVERAGE. (a) A group accident and health insurance policy must describe the

continuation of group coverage and any conversion coverage provided in accordance with Subchapter F.

(b) Subsection (a) does not apply to a credit accident and health insurance policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

[Sections 1251.118-1251.150 reserved for expansion]

SUBCHAPTER D. GROUP ACCIDENT AND HEALTH INSURANCE: COVERAGE FOR DEPENDENTS

Sec. 1251.151. COVERAGE FOR CERTAIN GRANDCHILDREN. (a) A group policy or contract of insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness, including a group contract issued by a group hospital service corporation, that provides coverage under the policy or contract for a child of an insured must, on payment of a premium, provide coverage for any grandchild of the insured if the grandchild is:

(1) unmarried;

(2) younger than 25 years of age; and

(3) a dependent of the insured for federal income tax purposes at the time the application for coverage of the grandchild is made.

(b) Coverage for a grandchild of the insured under this section may not be terminated solely because the covered grandchild is no longer a dependent of the insured for federal income tax purposes. (V.T.I.C. Art. 3.51-6, Sec. 3E, as amended Acts 77th Leg., R.S., Chs. 396 and 1027.)

Sec. 1251.152. OPTIONAL COVERAGE FOR SPOUSES AND DEPENDENTS. (a) For purposes of this section, "dependent"

includes:

(1) a child of an employee or member who is:

(A) unmarried; and

(B) younger than 25 years of age; and

(2) a grandchild of an employee or member who is:

(A) unmarried;

(B) younger than 25 years of age; and

(C) a dependent of the insured for federal income tax purposes at the time the application for coverage of the grandchild is made.

(b) A group accident and health insurance policy may provide coverage for the spouse or a dependent of an employee or member. (V.T.I.C. Art. 3.51-6, Sec. 1(b), as amended Acts 77th Leg., R.S., Chs. 396 and 1027.)

Sec. 1251.153. OPTIONAL CONTINUATION OF DEPENDENTS' BENEFITS ON DEATH OF INSURED. (a) A group accident and health insurance policy that provides for the payment by the insurer of benefits for members of the family or dependents of an insured may provide for a continuation of all or part of those benefits after the death of the insured.

(b) Insurance provided by benefits described by Subsection (a) is not life insurance under Title 7.

(c) Coverage described by Subsection (a) may continue for any period subject to any other policy provisions relating to the termination of a dependent's coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(f).)

Sec. 1251.154. COVERAGE FOR ADOPTED CHILDREN. A group

policy or contract of insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness, including a group contract issued by a group hospital service corporation, that provides coverage for the immediate family or a child of an insured may not exclude from coverage or limit coverage of a child of the insured solely because the child is adopted. A child is considered to be the child of an insured if the insured is a party to a suit in which the insured seeks to adopt the child. (V.T.I.C. Art. 3.51-6, Sec. 3D.)

[Sections 1251.155-1251.200 reserved for expansion]

SUBCHAPTER E. GROUP ACCIDENT AND HEALTH INSURANCE: GENERAL PROVISIONS

Sec. 1251.201. CERTIFICATE OF INSURANCE. (a) An insurer issuing a group policy under this chapter shall provide to the policyholder for delivery to each employee or member of the insured group a certificate of insurance that:

(1) summarizes the essential features of the insurance coverage of the employee or member; and

(2) states the person to whom benefits are payable.

(b) If dependents are included in the coverage, an insurer is not required to provide more than one certificate for each family unit. (V.T.I.C. Art. 3.51-6, Sec. 1(c).)

[Sections 1251.202-1251.250 reserved for expansion]

SUBCHAPTER F. CONTINUATION OR CONVERSION PRIVILEGE ON TERMINATION OF COVERAGE UNDER GROUP POLICY

Sec. 1251.251. CONTINUATION OF GROUP COVERAGE REQUIRED; EXCEPTION. (a) An insurer or group hospital service corporation

that issues policies that provide hospital, surgical, or major medical expense insurance coverage or any combination of those coverages on an expense incurred basis shall, as required by this subchapter, provide continuation of group coverage for employees or members and their eligible dependents, subject to the eligibility provisions prescribed by Section 1251.252.

(b) This subchapter does not apply to an insurance policy that provides benefits only for expenses incurred because of a specified disease or an accident. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3) (part), (3)(A)(i).)

Sec. 1251.252. ELIGIBILITY FOR CONTINUATION OF GROUP COVERAGE. (a) An employee, member, or dependent is entitled to continuation of group coverage if:

(1) the individual's coverage under the group policy is terminated for any reason other than involuntary termination for cause, including discontinuance of the group policy in its entirety or with respect to an insured class; and

(2) the individual has been continuously insured under the group policy, or under any group policy providing similar benefits that the policy replaces, for at least three consecutive months immediately before termination.

(b) For purposes of Subsection (a), involuntary termination for cause does not include termination for any health-related cause. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3) (part).)

Sec. 1251.253. REQUEST FOR CONTINUATION OF GROUP COVERAGE. An employee, member, or dependent must request in writing the continuation of group coverage not later than the 31st day after the

later of:

(1) the date the group coverage would otherwise terminate; or

(2) the date the individual is given, in a format prescribed by the commissioner, notice by either the employer or the group policyholder of the right to continuation of group coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3)(A)(ii).)

Sec. 1251.254. PAYMENT OF CONTRIBUTIONS. (a) An employee, member, or dependent who elects to continue group coverage under this subchapter must pay to the employer or group policyholder, each month in advance, the amount of contribution required by the employer or policyholder, plus two percent of the group rate for the coverage being continued under the group policy on the due date of each payment.

(b) The employee's, member's, or dependent's written election for continuation of group coverage, together with the first contribution required to establish advance monthly contributions, must be given to the employer or policyholder not later than the later of:

(1) the 31st day after the date coverage would otherwise terminate; or

(2) the date the individual is given notice by either the employer or the group policyholder of the right to continuation of group coverage. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3)(A)(iii), (iv).)

Sec. 1251.255. TERMINATION OF CONTINUED COVERAGE. (a) Group coverage continued under this subchapter may not terminate

until the earliest of:

(1) six months after the date the employee, member, or dependent elects to continue the group coverage;

(2) the date failure to make timely payments would terminate the group coverage;

(3) the date the group coverage terminates in its entirety;

(4) the date the insured is or could be covered under Medicare;

(5) the date the insured is covered for similar benefits by another plan or program, including:

(A) a hospital, surgical, medical, or major medical expense insurance policy;

(B) a hospital or medical service subscriber contract; or

(C) a medical practice or other prepayment plan;

(6) the date the insured is eligible for similar benefits, whether or not covered for those benefits, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(7) the date similar benefits are provided or available to the insured under any state or federal law.

(b) Not later than the 30th day before the end of the six months after the date the employee, member, or dependent elects to continue group coverage under the policy, the insurer shall:

(1) notify the individual that the individual may be eligible for coverage under the Texas Health Insurance Risk Pool as

provided by Chapter 1506; and

(2) provide to the individual the address for applying to that pool. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3)(A)(v), (vi).)

Sec. 1251.256. CONVERSION OF GROUP POLICY. (a) An insurer may offer a conversion policy to each employee, member, or dependent who is covered under a group accident and health insurance policy that is terminating.

(b) If offered, an issuer shall issue a conversion policy without evidence of insurability if a written application for the policy and payment of the first premium are made not later than the 31st day after the date of termination.

(c) Any conversion policy must meet the minimum standards for benefits for conversion policies.

(d) The insurer may provide the conversion coverage on an individual or group basis. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3)(B)(i), (iii).)

Sec. 1251.257. PREMIUM FOR CONVERTED POLICY. (a) An insurer shall determine the premium for a converted policy issued under this subchapter in accordance with the insurer's table of premium rates for coverage that was provided under the group policy. The premium:

(1) must be based on the type of converted policy and the coverage provided by the policy; and

(2) may be based on the age and geographic location of each individual to be covered.

(b) The premium for the same coverage and benefits under a converted policy may not exceed 200 percent of the premium

determined for the group policy in accordance with Subsection (a). (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3) (part).)

Sec. 1251.258. BENEFITS UNDER CONVERTED POLICY. The commissioner by rule shall establish minimum standards for benefits under converted policies issued under this subchapter. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3)(B)(ii) (part).)

Sec. 1251.259. TERMINATION OF CONVERTED POLICY. Conversion coverage under this subchapter for an insured may not terminate until the earlier of:

(1) the date failure to make timely payments would terminate coverage; or

(2) the date of an event specified by Section 1251.255(a)(4), (5), (6), or (7) for termination of continued group coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3)(B)(ii) (part).)

Sec. 1251.260. NOTICE OF CONTINUATION AND CONVERSION PRIVILEGES. (a) An employer that provides to its employees group accident and health insurance coverage that includes a group continuation or conversion privilege on termination of coverage shall give written notice of the continuation or conversion privileges under the policy to each employee or dependent insured under the group and affected by the termination.

(b) The commissioner by rule shall establish minimum standards for the notice required by this section. (V.T.I.C. Art. 3.51-6, Sec. 3C, as added Acts 71st Leg., R.S., Ch. 1041, Sec. 10.)

[Sections 1251.261-1251.300 reserved for expansion]

SUBCHAPTER G. CONTINUATION OF GROUP COVERAGE FOR CERTAIN FAMILY MEMBERS AND DEPENDENTS

Sec. 1251.301. CONTINUATION OF GROUP COVERAGE. A group policy or contract delivered, issued for delivery, renewed, amended, or extended in this state, including a group contract issued by a group hospital service corporation, that provides insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness must include an option for each individual covered by the policy or contract because of a family or dependent relationship to an individual who is a member of the group for which the policy or contract is provided to continue coverage with the group if the individual's eligibility for coverage under the policy or contract ends because of:

(1) the severance of the family relationship; or

(2) the retirement or death of the group member. (V.T.I.C. Art. 3.51-6, Secs. 3B(a), (b) (part).)

Sec. 1251.302. ELIGIBILITY FOR CONTINUED COVERAGE. A family member or dependent of an insured is eligible for continued coverage under this subchapter if the family member or dependent:

(1) has been a member of the group for a period of at least one year; or

(2) is an infant under one year of age. (V.T.I.C. Art. 3.51-6, Sec. 3B(b) (part).)

Sec. 1251.303. PHYSICAL EXAMINATION NOT REQUIRED. An individual who exercises the option to continue group coverage under this subchapter may not be required to take and pass a physical examination as a condition to continuing coverage. (V.T.I.C. Art. 3.51-6, Sec. 3B(c).)

Sec. 1251.304. SCOPE OF COVERAGE. (a) An individual

covered under group continuation coverage under this subchapter is entitled to coverage that is identical in scope to the coverage provided under the group health insurance policy or contract. An exclusion that was not included in the health insurance policy or contract may not be included in the group continuation coverage.

(b) If the group policyholder or contract holder replaces the health insurance policy or contract within the period prescribed by Section 1251.310(3), an individual covered under group continuation coverage may obtain coverage identical in scope to the coverage under the replacement group policy as provided by this subchapter. (V.T.I.C. Art. 3.51-6, Sec. 3B(d).)

Sec. 1251.305. AMOUNT OF PREMIUM. Except as provided by Section 1551.064, the premium for continuation of a spouse or dependent on the group health insurance policy or contract may not be more than the premium charged under the group policy or contract for the individual had the family relationship not been severed. (V.T.I.C. Art. 3.51-6, Sec. 3B(f).)

Sec. 1251.306. PAYMENT OF PREMIUMS. (a) An individual covered under group continuation coverage under this subchapter shall pay premiums for the coverage directly to the group policyholder or contract holder.

(b) The coverage must provide the individual with the option of paying the premiums in monthly installments.

(c) The group policyholder or contract holder may require the individual to pay a monthly fee of not more than $5 for administrative costs. (V.T.I.C. Art. 3.51-6, Sec. 3B(e).)

Sec. 1251.307. NOTICE OF CONTINUATION OPTION. Except as

provided by Section 1551.064, at the time a health insurance policy or contract is issued, the group policyholder or contract holder shall give written notice to each group member and each dependent of a group member covered by the policy or contract of the continuation option under this subchapter. (V.T.I.C. Art. 3.51-6, Sec. 3B(g).)

Sec. 1251.308. NOTICE OF SEVERANCE OF FAMILY RELATIONSHIP; NOTICE OF DESIRE TO EXERCISE OPTION. (a) Except as provided by Section 1551.064, each group health insurance policy or contract must require a group member to give written notice to the group policyholder or contract holder not later than the 15th day after the date of any severance of the family relationship that might activate the continuation option under this subchapter. Written notice under this subsection may be given by the group member's dependent.

(b) On receipt of notice under Subsection (a), the group policyholder or contract holder shall immediately give written notice of the continuation option under this subchapter to each affected dependent of the group member.

(c) On receipt of notice of the death or retirement of a group member, the group policyholder or contract holder shall immediately give written notice of the continuation option under this subchapter to each dependent of the group member. The notice must state the amount of the premium to be charged and must be accompanied by any necessary enrollment forms.

(d) Not later than the 60th day after the date of the severance of the family relationship or the retirement or death of the group member, a dependent must give written notice to the group

policyholder or contract holder of the individual's desire to exercise the continuation option under this subchapter. Coverage under the health insurance policy or contract remains in effect during the period prescribed by this subsection if the policy or contract premiums are paid.

(e) If a dependent does not give written notice of the individual's desire to exercise the continuation option under this subchapter within the time prescribed by Subsection (d), the option expires. (V.T.I.C. Art. 3.51-6, Secs. 3B(h), (i).)

Sec. 1251.309. CONTINUATION OF CERTAIN COVERAGES. (a) Any period of previous coverage under the health insurance policy or contract, including a policy or contract executed under Chapter 1551, must be used in full or partial satisfaction of any required probationary or waiting periods provided in the contract for dependent coverage.

(b) If a health insurance policy or contract provides to a group member continuation rights to cover the period between the time the member retires and the time the member is eligible for coverage by Medicare, those same continuation rights must be made available to the group member's dependents. (V.T.I.C. Art. 3.51-6, Secs. 3B(j), (k).)

Sec. 1251.310. TERMINATION OF CONTINUED COVERAGE. The coverage of an individual who exercises the continuation option under this subchapter continues without interruption and may not be canceled or otherwise terminated until:

(1) the insured fails to make a premium payment within the time required to make the payment;

(2) the insured becomes eligible for substantially similar coverage under another plan or program, including a group health insurance policy or contract, hospital or medical service subscriber contract, or medical practice or other prepayment plan; or

(3) the third anniversary of:

(A) the severance of the family relationship; or

(B) the retirement or death of the group member. (V.T.I.C. Art. 3.51-6, Sec. 3B(l).)

[Sections 1251.311-1251.350 reserved for expansion]

SUBCHAPTER H. BLANKET ACCIDENT AND HEALTH INSURANCE: ELIGIBLE POLICYHOLDERS

Sec. 1251.351. COMMON CARRIER OR MOTOR VEHICLE RENTAL OR LEASING COMPANY. (a) A blanket accident and health insurance policy may be issued to:

(1) a common carrier or the operator, owner, or lessor of a means of transportation to cover a group of individuals who may become passengers defined by reference to their travel status on the common carrier or means of transportation; or

(2) an automobile or truck rental or leasing company to cover a group of individuals who may become renters, lessees, or passengers defined by their travel status on the rented or leased vehicles.

(b) The common carrier, the operator, owner, or lessor of a means of transportation, or the automobile or truck rental or leasing company is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Sec. 1251.352. EMPLOYERS. (a) A blanket accident and health insurance policy may be issued to an employer to cover any group of employees, dependents, or guests defined by reference to specified hazards incident to an activity or operation of the employer.

(b) The employer is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Sec. 1251.353. EDUCATIONAL INSTITUTIONS. (a) A blanket accident and health insurance policy may be issued to a college, school, or other institution of learning, to a school district or school jurisdictional unit, or to the head, principal, or governing board of such an educational unit to cover students, teachers, or employees.

(b) The institution, head, principal, or governing board is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Sec. 1251.354. RELIGIOUS, CHARITABLE, RECREATIONAL, EDUCATIONAL, OR CIVIC ORGANIZATION. (a) A blanket accident and health insurance policy may be issued to a religious, charitable, recreational, educational, or civic organization, or a branch of the organization, to cover any group of members or participants defined by reference to specified hazards incident to an activity or operation sponsored or supervised by the organization or branch.

(b) The organization or branch is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Sec. 1251.355. SPORTS TEAM OR CAMP. (a) A blanket accident

and health insurance policy may be issued to a sports team or camp or the sponsor of a sports team or camp to cover members, campers, employees, officials, or supervisors.

(b) The sports team, camp, or sponsor is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Sec. 1251.356. GOVERNMENTAL OR VOLUNTEER EMERGENCY SERVICES ORGANIZATION. (a) A blanket accident and health insurance policy may be issued to a governmental or volunteer fire department or fire company, first aid or civil defense organization, or similar governmental or volunteer organization to cover a group of members or participants defined by reference to specified hazards incident to an activity or operation sponsored or supervised by the organization.

(b) The governmental or volunteer organization is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Sec. 1251.357. NEWSPAPER OR OTHER PUBLISHER. (a) A blanket accident and health insurance policy may be issued to a newspaper or other publisher to cover the publisher's carriers.

(b) The publisher is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Sec. 1251.358. ASSOCIATION. (a) A blanket accident and health insurance policy may be issued to an association, including a labor union, to cover any group of members or participants defined by reference to specified hazards incident to an activity or

operation sponsored or supervised by the association.

(b) To be eligible to obtain a blanket accident and health insurance policy, an association must:

(1) have a constitution and bylaws; and

(2) have been organized and be maintained in good faith for purposes other than that of obtaining insurance.

(c) The association is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Sec. 1251.359. COVERAGE FOR OTHER RISKS. (a) A blanket accident and health insurance policy may be issued to cover any risk or class of risks other than a risk described by this subchapter that, as determined by the commissioner, is eligible for blanket accident and health insurance.

(b) The commissioner may make a determination under Subsection (a) based on an individual risk, a class of risks, or both. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

[Sections 1251.360-1251.400 reserved for expansion]

SUBCHAPTER I. BLANKET ACCIDENT AND HEALTH INSURANCE: GENERAL PROVISIONS

Sec. 1251.401. INDIVIDUAL APPLICATION AND CERTIFICATE NOT REQUIRED. (a) An individual application from an insured under a blanket accident and health insurance policy is not required.

(b) An insurer is not required to provide a certificate to each insured under a blanket accident and health insurance policy. (V.T.I.C. Art. 3.51-6, Sec. 2(b).)

Sec. 1251.402. LIABILITY OF POLICYHOLDER NOT AFFECTED.

Subchapter H and this subchapter do not affect the legal liability of a policyholder for the death of or injury to a member of a group. (V.T.I.C. Art. 3.51-6, Sec. 2(c).)

[Sections 1251.403-1251.450 reserved for expansion]

SUBCHAPTER J. REGULATION OF OUT-OF-STATE GROUP ACCIDENT AND HEALTH INSURANCE COVERAGE

Sec. 1251.451. APPLICABILITY OF CERTAIN LAWS TO OUT-OF-STATE GROUP ACCIDENT AND HEALTH INSURANCE COVERAGE. (a) Chapters 1365 and 1368 and Subchapters A and C, Chapter 1451, apply to:

(1) a certificate of insurance issued to a resident of this state under a group accident and health insurance policy delivered, issued for delivery, or renewed outside this state; or

(2) a certificate issued to a resident of this state under a policy delivered, issued for delivery, or renewed outside this state by a group hospital service corporation.

(b) Subsection (a) does not apply to a specified disease or limited benefit policy. (V.T.I.C. Art. 3.51-12.)

CHAPTER 1252. DISCONTINUATION AND REPLACEMENT OF GROUP AND GROUP-TYPE HEALTH BENEFIT PLAN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 1252.004-1252.100 reserved for expansion]

SUBCHAPTER B. DISCONTINUATION OF COVERAGE

CHAPTER 1252. DISCONTINUATION AND REPLACEMENT OF GROUP AND GROUP-TYPE HEALTH BENEFIT PLAN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1252.001. DEFINITIONS. In this chapter:

(1) "Carrier" means:

(A) an insurer; or

(B) a group hospital service corporation operating under Chapter 842.

(2) "Health benefit plan" means:

(A) any accident and health insurance policy;

(B) a subscriber contract of a group hospital

service corporation; or

(C) an accident and health benefits package of a multiple employer trust that is not exempt from regulation by this state as an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), as amended.

(3) "Previous carrier" means a carrier whose health benefit plan coverage has been replaced with health benefit plan coverage provided by a succeeding carrier.

(4) "Succeeding carrier" means a carrier that replaces the health benefit plan coverage provided by another carrier with its own health benefit plan coverage.

(5) "Total disability" or "totally disabled" means:

(A) with respect to an employee or other primary insured covered under a health benefit plan, the complete inability of that individual to perform all of the substantial and material duties and functions of the individual's occupation and any other gainful occupation in which the individual earns substantially the same compensation earned before the disability; and

(B) with respect to any other individual covered under a health benefit plan, confinement as a bed patient in a hospital. (V.T.I.C. Art. 3.51-6A, Secs. 1 (part); 2(b); 5(f); 6(b)(1), (3); New.)

Sec. 1252.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that:

(1) provides coverage on a group or group-type basis to an individual eligible for that coverage because of the

individual's status as:

(A) an employee of an employer; or

(B) a member of a labor union or a member of an association; and

(2) is delivered or issued for delivery in this state.

(b) This chapter does not apply to an entity that is not engaged in the business of insurance in this state. (V.T.I.C. Art. 3.51-6A, Sec. 1.)

Sec. 1252.003. COVERAGE ISSUED ON GROUP-TYPE BASIS. (a) For purposes of this chapter, health benefit plan coverage is provided on a group-type basis if:

(1) the plan provides coverage under an insurance policy or subscriber contract to a class of employees or a class of members of a labor union or members of an association and the class is determined by conditions relating to their employment or to their membership in the union or association;

(2) coverage under the plan is not available to the general public and can be obtained and maintained only because of the covered individual's employment status or membership in a labor union or an association;

(3) premiums or subscription charges for the plan are paid to the carrier on an aggregate or bulk-payment basis; and

(4) the plan is sponsored by:

(A) the employer of the class of employees covered by the plan; or

(B) the labor union or an association to which the class of members covered by the plan belongs.

(b) Health benefit plan coverage is not provided on a group-type basis if it is a salary-budget plan using individual insurance policies or subscriber contracts that do not meet the conditions for group-type coverage specified by Subsection (a). (V.T.I.C. Art. 3.51-6A, Sec. 2(a).)

[Sections 1252.004-1252.100 reserved for expansion]

SUBCHAPTER B. DISCONTINUATION OF COVERAGE

Sec. 1252.101. NOTICE OF DISCONTINUATION OF COVERAGE. A notice of discontinuation of a health benefit plan must include a request to the group policyholder or other entity responsible for making payments or submitting subscription charges to the carrier to notify employees or members covered by the plan of the discontinuation and the date of the discontinuation. (V.T.I.C. Art. 3.51-6A, Sec. 4.)

Sec. 1252.102. EXTENSION OF BENEFITS PROVISION; EXEMPTION. (a) A health benefit plan must contain, subject to this section and Section 1252.103, a reasonable provision providing for an extension of benefits for a total disability that exists on the date of the plan's discontinuation.

(b) A health benefit plan must contain a reasonable extension of benefits provision for coverage for hospital or medical expenses other than dental expenses. A provision is considered reasonable if it provides to an individual who is covered under the plan and who is totally disabled on the date of the plan's discontinuation an extension of benefits for expenses incurred in treating the condition causing the total disability and the extension is provided for at least the lesser of:

(1) 90 days; or

(2) the duration of the total disability.

(c) An extension of benefits provision required under this section may provide for an exclusion from coverage for an individual whose coverage is being discontinued and replaced with coverage that:

(1) is provided by a succeeding carrier; and

(2) provides a level of benefits that is at least substantially equal to the level of benefits provided under the replaced health benefit plan.

(d) An applicable extension of benefits provision must be described in the policy or contract and the group insurance certificate.

(e) Benefits payable during an extension period may be subject to the regular benefit limits of the health benefit plan.

(f) This section does not apply to a health benefit plan that was delivered or issued for delivery in this state before January 1, 1982, and whose level of benefits has not been modified after December 31, 1981. (V.T.I.C. Art. 3.51-6A, Secs. 5(a), (c), (d), (e).)

Sec. 1252.103. INDEMNITY OR BENEFITS PAYABLE FOR DISABILITY. A discontinuation of health benefit plan coverage occurring during a period of disability does not affect:

(1) any benefits payable under the plan for loss of time from work because of the disability; or

(2) any specific indemnity required to be provided under the plan during a period of hospital confinement. (V.T.I.C.

Art. 3.51-6A, Sec. 5(b).)

Sec. 1252.104. LIABILITY FOR LOSS UNDER AUTOMATICALLY DISCONTINUED COVERAGE. (a) If a health benefit plan provides for automatic discontinuation of coverage when a premium or subscription charge due under the plan is not paid before the expiration of a grace period specified in the plan for that payment, the carrier or other entity responsible for making premium payments or for submitting premiums or subscription charges to the carrier is liable, on the submission of a valid claim, for a loss that is:

(1) covered by the plan; and

(2) incurred before the expiration of the grace period.

(b) The commissioner may adopt reasonable rules necessary to implement this section. (V.T.I.C. Art. 3.51-6A, Sec. 3.)

[Sections 1252.105-1252.200 reserved for expansion]

SUBCHAPTER C. REPLACEMENT OF COVERAGE

Sec. 1252.201. TOTAL DISABILITY STATUS. In this subchapter, a reference to the total disability status of an individual means the individual's disability status immediately preceding the date on which the succeeding carrier's coverage takes effect. (V.T.I.C. Art. 3.51-6A, Sec. 6(c).)

Sec. 1252.202. EFFECTIVE DATE OF COVERAGE UNDER REPLACEMENT PLAN. (a) An individual who was covered by a previous carrier's health benefit plan on the date on which that plan was discontinued shall be provided coverage under the succeeding carrier's health benefit plan as of the replacement plan's effective date if the individual:

(1) is eligible for coverage because the individual is a member of a class eligible for coverage under the replacement plan and satisfies the replacement plan's actively at work and nonconfinement requirements; and

(2) elects to be covered under the replacement plan.

(b) An individual who would be covered by the succeeding carrier under Subsection (a) but who does not satisfy the replacement plan's actively at work and nonconfinement requirements shall be covered under the replacement plan when the individual satisfies those requirements. (V.T.I.C. Art. 3.51-6A, Sec. 6(e).)

Sec. 1252.203. EXTENSION OF BENEFITS FOR TOTAL DISABILITY. (a) With respect to providing a type of coverage for which Section 1252.102 requires an extension of benefits for an individual with a total disability, a succeeding carrier replacing a previous carrier's plan that is not subject to that section must provide, subject to Subsection (b), the lesser of:

(1) extended benefit coverage that the previous carrier would have been required to provide under Section 1252.102 if the previous carrier had been subject to that section; or

(2) extended benefit coverage that the succeeding carrier is required to provide under Section 1252.102.

(b) The extended benefit coverage may be reduced by any benefits actually payable under the previous carrier's health benefit plan. (V.T.I.C. Art. 3.51-6A, Sec. 6(f).)

Sec. 1252.204. COVERAGE FOR PREEXISTING CONDITIONS. (a) A succeeding carrier's health benefit plan that limits coverage in

accordance with a preexisting conditions provision, other than a waiting period, must provide, during the period the limitation on coverage is in effect, the level of benefits prescribed by this section to an individual covered by the succeeding carrier who:

(1) has a preexisting condition; and

(2) was covered by the previous carrier's plan on the date on which that plan was discontinued.

(b) The health benefit plan must provide a level of benefits equal to the lesser of:

(1) the level of benefits available under the succeeding carrier's plan as determined without applying the preexisting conditions provision; or

(2) the level of benefits that would have been available under the previous carrier's plan. (V.T.I.C. Art. 3.51-6A, Sec. 6(g).)

Sec. 1252.205. WAITING PERIOD. If the benefits that were available under a previous carrier's health benefit plan are similar to the benefits available under a succeeding carrier's health benefit plan, the succeeding carrier shall give credit for the satisfaction or partial satisfaction of any waiting period or similar provision that has been satisfied under the previous carrier's plan. (V.T.I.C. Art. 3.51-6A, Sec. 6(h) (part).)

Sec. 1252.206. DETERMINATION OF BENEFITS AVAILABLE UNDER REPLACED PLAN. (a) If a succeeding carrier requires a determination of the benefits available under the previous carrier's health benefit plan, the previous carrier shall provide at the request of the succeeding carrier:

(1) a statement of the benefits available under the previous carrier's plan; or

(2) pertinent information sufficient either to allow verification of those benefits or to allow the succeeding carrier to make a determination of those benefits.

(b) A determination of benefits under this section must be made using the definitions of, and in accordance with all of the conditions and covered expense provisions of, the previous carrier's plan as if that plan had not been replaced. (V.T.I.C. Art. 3.51-6A, Sec. 6(h) (part).)

Sec. 1252.207. LIABILITY OF PREVIOUS CARRIER. A carrier of a health benefit plan that is being discontinued is liable only for any accrued liabilities regarding the plan and for any extension of benefits provided under the plan, regardless of whether the group policyholder or any other entity responsible for making payments or for submitting subscription charges to the carrier:

(1) replaces the coverage provided under the discontinued plan with health benefit plan coverage provided by another carrier;

(2) self-insures a health benefit plan; or

(3) does not provide health benefit plan coverage. (V.T.I.C. Art. 3.51-6A, Sec. 6(d).)

CHAPTER 1253. CANCELLATION OF GROUP COVERAGE IN CERTAIN CIRCUMSTANCES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1253.001. LIMITATION OF SERVICES AND BENEFITS ON CONTRACT RENEGOTIATION

[Sections 1253.002-1253.050 reserved for expansion]

SUBCHAPTER B. CONTINUATION OF GROUP ACCIDENT AND HEALTH INSURANCE POLICIES DURING LABOR DISPUTE

CHAPTER 1253. CANCELLATION OF GROUP COVERAGE IN CERTAIN CIRCUMSTANCES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1253.001. LIMITATION OF SERVICES AND BENEFITS ON CONTRACT RENEGOTIATION. (a) In this section, "health benefit contract" means a contract providing group health care coverage for employees that is delivered, issued for delivery, or renewed in this state by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842; or

(3) a health maintenance organization operating under Chapter 843.

(b) Subject to Subsection (c), if an employer in this state agrees to renegotiate a health benefit contract, a change in the renegotiated contract may not operate solely to terminate eligibility with respect to any member of the group who, before the contract was renegotiated:

(1) was covered under the contract; and

(2) had a sickness or injury for which a service was being provided or a benefit was being paid under the contract.

(c) A renegotiated health benefit contract may include a different durational or dollar limit or a different deductible amount or amount of coinsurance applicable to a sickness or injury for which a service was being provided or benefit was being paid before the contract was renegotiated if that same or a similar limit or amount applies to a service provided or benefit paid for a similar sickness or a related condition or injury covered by the contract. (V.T.I.C. Art. 3.51-6C.)

[Sections 1253.002-1253.050 reserved for expansion]

SUBCHAPTER B. CONTINUATION OF GROUP ACCIDENT AND HEALTH INSURANCE POLICIES DURING LABOR DISPUTE

Sec. 1253.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group accident and health insurance policy that is delivered or issued for delivery in this state and as to which any part of the premium is paid or is to be paid by an employer under the terms of a collective bargaining agreement. (V.T.I.C. Art. 3.51-8 (part), as amended Acts 77th Leg., R.S., Ch. 1419.)

Sec. 1253.052. CONTINUATION OF GROUP ACCIDENT AND HEALTH INSURANCE DURING LABOR DISPUTE REQUIRED FOR CERTAIN POLICIES. An insurer may not deliver or issue for delivery a policy subject to this subchapter unless the policy provides that if the employees covered by the policy stop work because of a labor dispute, coverage continues under the policy, on timely payment of the premium, for each employee who:

(1) is covered under the policy on the date the work stoppage begins;

(2) continues to pay the employee's individual contribution, subject to the conditions provided by this subchapter; and

(3) assumes and pays during the work stoppage the contribution due from the employer, subject to the conditions provided by this subchapter. (V.T.I.C. Art. 3.51-8 (part), as amended Acts 77th Leg., R.S., Ch. 1419.)

Sec. 1253.053. CONTRIBUTIONS IF POLICYHOLDER IS TRUSTEE. (a) An employee's contribution for purposes of a policy as to which the policyholder is a trustee or the trustees of a fund established or maintained wholly or partly by the employer is the amount the employee and employer would have been required to contribute to the fund for the employee if:

(1) the work stoppage had not occurred; and

(2) the agreement requiring the employer to make contributions to the fund were in effect.

(b) The policy may provide that continuation of coverage is contingent on the collection of individual contributions by the

policyholder or the policyholder's agent. (V.T.I.C. Art. 3.51-8, Subdivs. (b), (c) (part).)

Sec. 1253.054. CONTRIBUTIONS IF POLICYHOLDER IS NOT TRUSTEE. (a) A policy as to which the policyholder is not a trustee or the trustees of a fund established or maintained in whole or in part by the employer must provide that the employee's individual contribution:

(1) is the policy rate applicable:

(A) on the date the work stoppage begins; and

(B) to an individual in the class to which the employee belongs as provided by the policy; or

(2) if the policy does not provide for a rate applicable to an individual, is an amount equal to the amount determined by dividing:

(A) the total monthly premium in effect under the policy on the date the work stoppage begins; by

(B) the total number of insureds under the policy on that date.

(b) The policy may provide that continuation of coverage under this subchapter is contingent on the collection of individual contributions by the union or unions representing the employees. (V.T.I.C. Art. 3.51-8, Subdivs. (a), (c) (part).)

Sec. 1253.055. PAYMENT OF CONTRIBUTION AND PREMIUM. A policy may provide that continuation of coverage for an employee under the policy is contingent on timely payment of:

(1) contributions by the employee; and

(2) the premium by the entity responsible for

collecting the individual employee contributions. (V.T.I.C. Art. 3.51-8, Subdiv. (d).)

Sec. 1253.056. PAST DUE PREMIUM. (a) A policy may provide that the continuation of coverage is contingent on payment of any premium that:

(1) is unpaid on the date the work stoppage begins; and

(2) became due before the date the work stoppage begins.

(b) A premium described by Subsection (a) must be paid before the date the next premium becomes due under the policy. (V.T.I.C. Art. 3.51-8, Subdiv. (h).)

Sec. 1253.057. INDIVIDUAL PREMIUM RATE INCREASE. (a) A policy may provide that, during the period of a work stoppage, each individual premium rate shall be increased by an amount not to exceed 20 percent of the amount shown in the policy, or a greater percentage as approved by the commissioner, to provide sufficient compensation to the insurer to cover increased:

(1) administrative costs; and

(2) mortality and morbidity.

(b) If a policy provides for a premium rate increase in accordance with this section, the amount of an employee's contribution must be increased by the same percentage. (V.T.I.C. Art. 3.51-8, Subdiv. (e).)

Sec. 1253.058. PREMIUM RATE CHANGE NOT LIMITED. (a) This subchapter does not limit any right of the insurer under a policy to increase or decrease a premium rate before, during, or after a work stoppage if the insurer would be entitled to increase the premium

rate had a work stoppage not occurred.

(b) A change in a premium rate made in accordance with this section takes effect on a date that is determined by the insurer in accordance with the terms of the policy. (V.T.I.C. Art. 3.51-8, Subdiv. (f).)

Sec. 1253.059. LIMITATIONS ON CONTINUATION OF COVERAGE. This subchapter does not require the continuation of coverage under a policy for any loss of time benefits included in the policy or the continuation of other coverage for a period:

(1) longer than six months after a work stoppage occurs;

(2) beyond the time that 75 percent of the covered employees continue the coverage; or

(3) as to an individual covered employee, beyond the time that the employee takes a full-time job with another employer. (V.T.I.C. Art. 3.51-8, Subdiv. (i).)

Sec. 1253.060. OTHER PROVISIONS; COMMISSIONER APPROVAL REQUIRED. A policy may contain any other provision relating to continuation of policy coverage during a work stoppage that the commissioner approves. (V.T.I.C. Art. 3.51-8, Subdiv. (g).)

CHAPTER 1254. NOTICE OF RATE INCREASE FOR GROUP HEALTH AND ACCIDENT COVERAGE

Sec. 1254.001. NOTICE OF RATE INCREASE

CHAPTER 1254. NOTICE OF RATE INCREASE FOR GROUP HEALTH AND ACCIDENT COVERAGE

Sec. 1254.001. NOTICE OF RATE INCREASE. (a) In this section, "insurer" means:

(1) a life insurance company;

(2) a health insurance company;

(3) an accident insurance company;

(4) a general casualty company;

(5) a mutual life insurance company or other mutual insurance company;

(6) a mutual or natural premium life insurance company;

(7) a Lloyd's plan;

(8) a reciprocal or interinsurance exchange;

(9) a fraternal benefit society;

(10) a local mutual aid association; or

(11) a group hospital service corporation.

(b) Not later than the 31st day before the date on which a premium rate increase takes effect on a group policy of health insurance, accident and health insurance, or life, health, and accident insurance delivered or issued for delivery in this state by an insurer, the insurer shall give written notice to the policyholder of:

(1) the amount of the increase; and

(2) the date on which the increase is to take effect.

(c) A health maintenance organization shall give notice of an increase in subscriber charges and service fees under a group contract or coverage in the same manner as is required of an insurer under Subsection (b).

(d) An insurer that issues a group policy described by Subsection (b) to a multiple employer trust shall give the notice

required by that subsection to the trustee or group policyholder.

(e) The notice required by this section must be based on coverage in effect on the date of the notice.

(f) This section may not be construed to prevent an insurer or health maintenance organization, at the request of a policyholder or contract holder, from negotiating a change in benefits or rates after delivery of the notice required by this section. (V.T.I.C. Art. 3.51-10, as amended Acts 77th Leg., R.S., Ch. 1419.)

[Chapters 1255-1270 reserved for expansion]

SUBTITLE C. MANAGED CARE

CHAPTER 1271. BENEFITS PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS; EVIDENCE OF COVERAGE; CHARGES

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 1271.008-1271.050 reserved for expansion]

SUBCHAPTER B. CONTENTS OF EVIDENCE OF COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1271.001. APPLICABILITY OF DEFINITIONS. In this chapter, terms defined by Section 843.002 have the meanings assigned by that section. (V.T.I.C. Art. 20A.01B, as added Acts 77th Leg., R.S., Ch. 1419.)

Sec. 1271.002. RIGHT TO EVIDENCE OF COVERAGE; ISSUANCE. (a) Each enrollee residing in this state is entitled to evidence of coverage under a health care plan.

(b) The health maintenance organization shall issue the evidence of coverage, except as provided by Subsection (c).

(c) If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation shall issue the evidence of coverage. (V.T.I.C. Art. 20A.09, Secs. (a), as amended Acts 75th Leg., R.S., Ch. 905; (a)(1), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.003. EVIDENCE OF COVERAGE NOT HEALTH INSURANCE POLICY. An evidence of coverage is not a health insurance policy as that term is defined by this code. (V.T.I.C. Art. 20A.09, Secs. (o), as amended Acts 75th Leg., R.S., Ch. 905; (g), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.004. INDIVIDUAL HEALTH CARE PLAN. (a) In this section, "individual health care plan" means a health care plan:

(1) that provides health care services for individuals and their dependents;

(2) under which an enrollee:

(A) pays the premium; and

(B) is not covered under the contract in accordance with a continuation of services or continuation of benefits requirement applicable under federal or state law; and

(3) in which the evidence of coverage meets the requirements of the definition of "basic health care services" provided by Section 843.002.

(b) A health maintenance organization may provide an individual health care plan in accordance with this section and Section 1271.307.

(c) A health maintenance organization may limit enrollment in an individual health care plan to individuals who reside or work within the service area for the plan's network.

(d) The commissioner may adopt rules necessary to implement this section and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 20A.09, Sec. (l) (part), as added Acts 75th Leg., R.S., Ch. 837.)

Sec. 1271.005. APPLICABILITY OF OTHER LAW. (a) Chapters 1368 and 1652 apply to a health maintenance organization other than a health maintenance organization that offers only a single health care service plan.

(b) Subchapter B, Chapter 1355, applies to a health maintenance organization providing benefits for mental health treatment in a residential treatment center for children and adolescents or crisis stabilization unit to the extent that:

(1) Subchapter B, Chapter 1355, does not conflict with this chapter, Chapter 843, or Subchapter A, Chapter 1452; and

(2) the residential treatment center for children and adolescents or crisis stabilization unit is located within the service area of the health maintenance organization and is subject to inspection and review as required by this chapter, Chapter 843, or Subchapter A, Chapter 1452, or rules adopted under this chapter, Chapter 843, or Subchapter A, Chapter 1452.

(c) A health maintenance organization shall comply with Subchapter B, Chapter 542, with respect to prompt payment to an enrollee.

(d) Notwithstanding any other law, Subchapter C, Chapter 1355, applies to a group contract issued by a health maintenance organization.

(e) Notwithstanding any other law, Section 1201.062 applies to an evidence of coverage issued by a health maintenance organization. (V.T.I.C. Art. 3.70-1, Sec. (F)(5) (part); Art. 3.70-2, Secs. (F) (part), (L) (part), as amended Acts 77th Leg., R.S., Chs. 396 and 1027; Art. 20A.09, Secs. (n), (p), (q), as amended Acts 75th Leg., R.S., Ch. 905; (e), (f), (h), (i), as amended Acts 75th Leg., R.S., Ch. 1026; Art. 20A.09Z.)

Sec. 1271.006. BENEFITS TO DEPENDENT CHILD AND GRANDCHILD. (a) If children are eligible for coverage under the terms of an evidence of coverage, any limiting age applicable to an unmarried child of an enrollee, including an unmarried grandchild of an enrollee, is 25 years of age. The limiting age applicable to a child must be stated in the evidence of coverage.

(b) A health maintenance organization may provide benefits under a health care plan to an enrollee's dependent grandchild who

is living with and in the household of the enrollee. (V.T.I.C. Art. 20A.09H, Sec. (a), as redesignated and amended Acts 77th Leg., R.S., Ch. 396; Art. 20A.09H, as redesignated and amended Acts 77th Leg., R.S., Ch. 1027.)

Sec. 1271.007. RELIGIOUS CONVICTIONS. (a) This chapter, Chapters 843, 1272, and 1367, and Subchapter A, Chapter 1452, do not require a health maintenance organization, physician, or provider to recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing any health care service that violates the religious convictions of the health maintenance organization, physician, or provider.

(b) A health maintenance organization that limits or denies health care services under this section shall state the limitations in the evidence of coverage as required by Section 1271.052. (V.T.I.C. Art. 20A.09, Sec. (m), as added Acts 75th Leg., R.S., Ch. 1026.)

[Sections 1271.008-1271.050 reserved for expansion]

SUBCHAPTER B. CONTENTS OF EVIDENCE OF COVERAGE

Sec. 1271.051. EVIDENCE OF COVERAGE: CONTRACT AND CERTIFICATE REQUIREMENTS. (a) An evidence of coverage that is a contract must contain a clear and complete statement of the information required by Sections 1271.052, 1271.053, and 1271.054.

(b) An evidence of coverage that is a certificate must contain a reasonably complete facsimile of the information required by Sections 1271.052, 1271.053, and 1271.054. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.052. INFORMATION ABOUT BENEFITS AND LIMITATIONS. An evidence of coverage must state:

(1) the health care services, limited health care services, or single health care service to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan;

(2) the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan; and

(3) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or copayment feature. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.053. INFORMATION ABOUT OBTAINING SERVICES. An evidence of coverage must indicate where and in what manner information is available about how to obtain services. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.054. INFORMATION ABOUT COMPLAINTS AND APPEALS. (a) An evidence of coverage must contain a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including:

(1) the enrollee's right to appeal denial of an adverse determination to an independent review organization; and

(2) the procedures for appealing to an independent review organization.

(b) A health maintenance organization may indicate a subsequent change to the methods for resolving enrollee complaints in a separate document issued to the enrollee. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.055. OUT-OF-NETWORK SERVICES. (a) An evidence of coverage must contain a provision regarding non-network physicians and providers in accordance with the requirements of this section.

(b) If medically necessary covered services are not available through network physicians or providers, the health maintenance organization, on the request of a network physician or provider and within a reasonable period, shall:

(1) allow referral to a non-network physician or provider; and

(2) fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate.

(c) Before denying a request for a referral to a non-network physician or provider, a health maintenance organization must provide for a review conducted by a specialist of the same or similar type of specialty as the physician or provider to whom the referral is requested. (V.T.I.C. Art. 20A.09, Secs. (d), (f), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.056. UNFAIR OR DECEPTIVE PROVISIONS AND STATEMENTS PROHIBITED. An evidence of coverage may not contain a provision or statement that:

(1) is unjust, unfair, inequitable, misleading, or deceptive;

(2) encourages misrepresentation; or

(3) is untrue, misleading, or deceptive within the meaning of Section 843.204. (V.T.I.C. Art. 20A.09, Secs. (c), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

[Sections 1271.057-1271.100 reserved for expansion]

SUBCHAPTER C. COMMISSIONER APPROVAL

Sec. 1271.101. APPROVAL OF FORM OF EVIDENCE OF COVERAGE OR GROUP CONTRACT. (a) An evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner.

(b) Except as provided by Subsection (c), the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of Section 1271.102.

(c) If the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. However, Subchapters B and E apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E. (V.T.I.C. Art. 20A.09, Secs. (b), (j), as amended Acts 75th Leg., R.S., Ch.

905; (a)(2), (5), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.102. PROCEDURES FOR APPROVAL OF FORM OF EVIDENCE OF COVERAGE OR GROUP CONTRACT; WITHDRAWAL OF APPROVAL. (a) The commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of this chapter.

(b) If the commissioner does not disapprove a form before the 31st day after the date the form is filed, the form is considered approved. The commissioner may, by written notice, extend the period for approval or disapproval as necessary for proper consideration of the filing for not more than an additional 30 days.

(c) If the commissioner disapproves a form, the commissioner shall notify the person who filed the form of the reason for the disapproval.

(d) A hearing on the disapproval of a form shall be granted not later than the 30th day after the date the person filing the form makes a written request for a hearing. (V.T.I.C. Art. 20A.09, Secs. (l) (part), as amended Acts 75th Leg., R.S., Ch. 905; (c) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.103. WITHDRAWAL OF APPROVAL OF FORM. (a) After notice and opportunity for hearing, the commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the commissioner determines that the form violates this chapter, Chapter 843, 1272, or 1367, or Subchapter A, Chapter 1452, or a rule adopted by the commissioner.

(b) If the commissioner withdraws approval of a form under

this section, the form may not be issued until it is approved. (V.T.I.C. Art. 20A.09, Secs. (l) (part), as amended Acts 75th Leg., R.S., Ch. 905; (c) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.104. INFORMATION REQUIRED BY COMMISSIONER. The commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under this subchapter. (V.T.I.C. Art. 20A.09, Secs. (m), as amended Acts 75th Leg., R.S., Ch. 905; (d), as amended Acts 75th Leg., R.S., Ch. 1026.)

[Sections 1271.105-1271.150 reserved for expansion]

SUBCHAPTER D. CERTAIN BENEFITS REQUIRED

Sec. 1271.151. PROVISION OF BASIC HEALTH CARE SERVICES. A health maintenance organization that offers a basic health care plan shall provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner. (V.T.I.C. Art. 20A.09, Sec. (l), as added Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.152. STANDARDS FOR BASIC HEALTH CARE SERVICES. The commissioner may adopt minimum standards relating to basic health care services. (V.T.I.C. Art. 20A.09, Sec. (n), as added Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.153. PERIODIC HEALTH EVALUATIONS. (a) The basic health care services provided under an evidence of coverage must include periodic health evaluations for each adult enrollee.

(b) The services provided under this section must include a

health risk assessment at least once every three years and, for a female enrollee, an annual well-woman examination provided in accordance with Subchapter F, Chapter 1451.

(c) This section does not apply to an evidence of coverage for a limited health care service plan or a single health care service plan. (V.T.I.C. Art. 20A.09B.)

Sec. 1271.154. WELL-CHILD CARE FROM BIRTH. (a) In this section, "well-child care from birth" has the meaning used under Section 1302, Public Health Service Act (42 U.S.C. Section 300e-1), and its subsequent amendments. The term includes newborn screening required by the Texas Department of Health.

(b) A health maintenance organization shall ensure that each health care plan provided by the health maintenance organization includes well-child care from birth that complies with:

(1) federal requirements adopted under Chapter XI, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments; and

(2) the rules adopted by the Texas Department of Health to implement those requirements. (V.T.I.C. Art. 20A.09E.)

Sec. 1271.155. EMERGENCY CARE. (a) A health maintenance organization shall pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate.

(b) A health care plan of a health maintenance organization must provide the following coverage of emergency care:

(1) a medical screening examination or other

evaluation required by state or federal law necessary to determine whether an emergency medical condition exists shall be provided to covered enrollees in a hospital emergency facility or comparable facility;

(2) necessary emergency care shall be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition; and

(3) services originated in a hospital emergency facility or comparable facility following treatment or stabilization of an emergency medical condition shall be provided to covered enrollees as approved by the health maintenance organization, subject to Subsections (c) and (d).

(c) A health maintenance organization shall approve or deny coverage of poststabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but not to exceed one hour from the time of the request.

(d) A health maintenance organization shall respond to inquiries from a treating physician or provider in compliance with this provision in the health care plan of the health maintenance organization.

(e) A health care plan of a health maintenance organization shall comply with this section regardless of whether the physician or provider furnishing the emergency care has a contractual or other arrangement with the health maintenance organization to provide items or services to covered enrollees. (V.T.I.C. Art.

20A.09Y, as added Acts 77th Leg., R.S., Ch. 1419.)

Sec. 1271.156. BENEFITS FOR REHABILITATION SERVICES AND THERAPIES. (a) If benefits are provided for rehabilitation services and therapies under an evidence of coverage, the provision of a rehabilitation service or therapy that, in the opinion of a physician, is medically necessary may not be denied, limited, or terminated if the service or therapy meets or exceeds treatment goals for the enrollee.

(b) For an enrollee with a physical disability, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration. (V.T.I.C. Art. 20A.09, Sec. (a)(4), as amended Acts 75th Leg., R.S., Ch. 1026.)

[Sections 1271.157-1271.200 reserved for expansion]

SUBCHAPTER E. CHOICE OF PRIMARY CARE PHYSICIAN FOR CERTAIN ENROLLEES

Sec. 1271.201. DESIGNATION OF SPECIALIST AS PRIMARY CARE PHYSICIAN. (a) An evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the health maintenance organization's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

(b) The application must:

(1) include information specified by the health maintenance organization, including certification of the medical need; and

(2) be signed by the enrollee and the nonprimary care physician specialist interested in serving as the enrollee's

primary care physician.

(c) To be eligible to serve as the enrollee's primary care physician, a physician specialist must:

(1) meet the health maintenance organization's requirements for primary care physician participation; and

(2) agree to accept the responsibility to coordinate all of the enrollee's health care needs. (V.T.I.C. Art. 20A.09, Secs. (d), (g), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.202. APPEAL. If a health maintenance organization denies a request under Section 1271.201, the enrollee may appeal the decision through the health maintenance organization's established complaint and appeals process. (V.T.I.C. Art. 20A.09, Secs. (h), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.203. EFFECTIVE DATE OF DESIGNATION. (a) The effective date of the designation of a nonprimary care physician specialist as an enrollee's primary care physician under Section 1271.201 may not be applied retroactively.

(b) A health maintenance organization may not reduce the amount of compensation owed to the original primary care physician for services provided before the date of the new designation. (V.T.I.C. Art. 20A.09, Secs. (i), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

[Sections 1271.204-1271.250 reserved for expansion]

SUBCHAPTER F. SCHEDULE OF CHARGES

Sec. 1271.251. APPROVAL OF FORMULA OR METHOD FOR COMPUTING

SCHEDULE OF CHARGES. (a) The formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan.

(b) The formula or method must be established in accordance with actuarial principles for the various categories of enrollees. The filing of the method or formula must contain:

(1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and

(2) supporting information that the commissioner considers adequate.

(c) The formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory. Benefits must be reasonable with respect to the rates produced by the formula or method. (V.T.I.C. Art. 20A.09, Secs. (k) (part), as amended Acts 75th Leg., R.S., Ch. 905; (b) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.252. CONSIDERATION OF INDIVIDUAL HEALTH STATUS PROHIBITED. The charges resulting from the application of a formula or method described by Section 1271.251 may not be altered for an individual enrollee based on the status of that enrollee's health. (V.T.I.C. Art. 20A.09, Secs. (k) (part), as amended Acts 75th Leg., R.S., Ch. 905; (b) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.253. INFORMATION REQUIRED BY COMMISSIONER. The commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to

approve or disapprove a filing under this subchapter. (V.T.I.C. Art. 20A.09, Secs. (m), as amended Acts 75th Leg., R.S., Ch. 905; (d), as amended Acts 75th Leg., R.S., Ch. 1026.)

[Sections 1271.254-1271.300 reserved for expansion]

SUBCHAPTER G. CONTINUATION OF COVERAGE, CONVERSION CONTRACTS, AND RENEWAL

Sec. 1271.301. ENTITLEMENT TO CONTINUATION OF GROUP COVERAGE. (a) In this section, "involuntary termination for cause" does not include termination for any health-related reason.

(b) A health maintenance organization shall provide a group coverage continuation privilege as required by and subject to the eligibility provisions of this subchapter.

(c) An enrollee is entitled to continue group coverage as provided by this subchapter if:

(1) the enrollee's coverage under a group contract is terminated for any reason except involuntary termination for cause; and

(2) the enrollee for at least three consecutive months immediately before the termination of coverage has been continuously covered under the group contract and under any previous group contract providing similar services and benefits that the current group contract replaced. (V.T.I.C. Art. 20A.09, Sec. (k)(A) (part), as added Acts 75th Leg., R.S., Ch. 837.)

Sec. 1271.302. REQUEST FOR CONTINUED COVERAGE; DEADLINE. An enrollee must make a written election to continue group coverage under this subchapter and pay the first contribution required to establish contributions on an advance monthly basis to the employer

or group contract holder not later than the 31st day after the later of:

(1) the date the group coverage would otherwise terminate; or

(2) the date the enrollee is given notice of the right of continuation by the employer or group contract holder. (V.T.I.C. Art. 20A.09, Secs. (k)(A)(1), (3), as added Acts 75th Leg., R.S., Ch. 837.)

Sec. 1271.303. PAYMENT FOR CONTINUED COVERAGE. (a) An enrollee electing continuation of group coverage must pay to the employer or group contract holder the amount of contribution required by the employer or group contract holder, plus an amount equal to two percent of the group rate for the coverage being continued under the group contract.

(b) The enrollee must make the payment in advance on a monthly basis on the due date of each payment. (V.T.I.C. Art. 20A.09, Sec. (k)(A)(2), as added Acts 75th Leg., R.S., Ch. 837.)

Sec. 1271.304. TERMINATION OF CONTINUED COVERAGE. Group continued coverage under this subchapter may not terminate until the earliest of:

(1) the end of the six-month period after the date the election to continue coverage is made;

(2) the date on which failure to make timely payments terminates coverage;

(3) the date on which the enrollee is covered for similar services and benefits by any other plan or program, including a hospital, surgical, medical, or major medical expense

insurance policy, hospital or medical service subscriber contract, or medical practice or other prepayment plan; or

(4) the date on which the group coverage terminates in its entirety. (V.T.I.C. Art. 20A.09, Sec. (k)(A)(4), as added Acts 75th Leg., R.S., Ch. 837.)

Sec. 1271.305. NOTIFICATION OF RISK POOL ELIGIBILITY. (a) At least 30 days before the end of the six-month period after the date an enrollee elects to continue group coverage, the health maintenance organization shall notify the enrollee that the enrollee may be eligible for coverage under the Texas Health Insurance Risk Pool as provided by Chapter 1506.

(b) The health maintenance organization shall provide to the enrollee the address for applying to the pool for coverage. (V.T.I.C. Art. 20A.09, Sec. (k)(A)(5), as added Acts 75th Leg., R.S., Ch. 837.)

Sec. 1271.306. CONVERSION CONTRACTS. (a) A health maintenance organization may offer to each enrollee a conversion contract.

(b) A health maintenance organization shall issue the conversion contract without evidence of insurability if written application for the contract and payment of the first premium are made not later than the 31st day after the date of termination of coverage.

(c) A conversion contract must meet the minimum standards for services and benefits for conversion contracts. The commissioner shall adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.

(d) The premium for a conversion contract shall be determined in accordance with the health maintenance organization's premium rates for coverage provided under the group contract or plan. The premium may be based on the geographic location of each person to be covered and must be based on the type of conversion contract and the coverage provided by the contract. The premium may not exceed 200 percent of the premium rates for the same coverage provided under a group contract or plan. (V.T.I.C. Art. 20A.09, Secs. (k)(B), (C), as added Acts 75th Leg., R.S., Ch. 837.)

Sec. 1271.307. RENEWABILITY OF COVERAGE: INDIVIDUAL HEALTH CARE PLANS AND CONVERSION CONTRACTS. (a) In this section, "individual health care plan" has the meaning assigned by Section 1271.004.

(b) An individual health care plan or a conversion contract that provides health care services to an enrollee is renewable at the option of the enrollee. A health maintenance organization may decline to renew an individual health care plan or conversion contract only:

(1) for failure to pay premiums or contributions in accordance with the terms of the plan or because the issuer of the plan has not received timely premium payments;

(2) for fraud or intentional misrepresentation;

(3) because the health maintenance organization ceases to offer coverage in the individual market in accordance with rules established by the commissioner;

(4) because the enrollee no longer resides or works in

the area in which the health maintenance organization is authorized to provide coverage, if coverage under the plan is terminated uniformly for this reason without regard to any factor related to the health status of a covered enrollee; or

(5) in accordance with applicable federal law, including regulations.

(c) The commissioner may adopt rules necessary to implement this section and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 20A.09, Sec. (l) (part), as added Acts 75th Leg., R.S., Ch. 837.)

CHAPTER 1272. DELEGATION OF CERTAIN FUNCTIONS BY HEALTH MAINTENANCE ORGANIZATION

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 1272.003-1272.050 reserved for expansion]

SUBCHAPTER B. DELEGATION AGREEMENTS

Sec. 1272.301. ACCESS TO OUT-OF-NETWORK SERVICES

Sec. 1272.302. CONTINUITY OF CARE

CHAPTER 1272. DELEGATION OF CERTAIN FUNCTIONS BY HEALTH MAINTENANCE ORGANIZATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1272.001. DEFINITIONS. (a) In this chapter:

(1) "Delegated entity" means an entity, other than a health maintenance organization authorized to engage in business under Chapter 843, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility for performing on behalf of the health maintenance organization a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452. The term does not include:

(A) an individual physician; or

(B) a group of employed physicians, practicing medicine under one federal tax identification number, whose total claims paid to providers not employed by the group constitute less than 20 percent of the group's total collected revenue computed on a calendar year basis.

(2) "Delegated network" means a delegated entity that assumes total financial risk for more than one of the following categories of health care services: medical care, hospital or other institutional services, or prescription drugs, as defined by Section 551.003, Occupations Code. The term does not include a delegated entity that shares risk for a category of services with a

health maintenance organization.

(3) "Delegated third party" means a third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to:

(A) accept responsibility for performing a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452; or

(B) receive, handle, or administer funds, if the receipt, handling, or administration is directly or indirectly related to a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452.

(4) "Delegation agreement" means an agreement by which a health maintenance organization assigns the responsibility for a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452.

(5) "Limited provider network" means a subnetwork within a health maintenance organization delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations, or physician groups that limits an enrollee's access to physicians and providers to those physicians and providers in the subnetwork.

(b) In this chapter, terms defined by Section 843.002 have the meanings assigned by that section. (V.T.I.C. Art. 20A.02, Secs. (dd), (ee), (ff), (gg), (hh); New.)

Sec. 1272.002. COMPLIANCE OF LIMITED PROVIDER NETWORK OR DELEGATED ENTITY WITH CERTAIN LEGAL REQUIREMENTS. A limited provider network or delegated entity shall comply with each

statutory or regulatory requirement that relates to a function assumed by or carried out by the network or entity under this chapter. (V.T.I.C. Art. 20A.18G.)

[Sections 1272.003-1272.050 reserved for expansion]

SUBCHAPTER B. DELEGATION AGREEMENTS

Sec. 1272.051. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18C, Sec. (q).)

Sec. 1272.052. DELEGATION AGREEMENT REQUIRED. (a) A health maintenance organization that delegates a function required by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452, shall execute a written delegation agreement with the entity to which the function is delegated.

(b) The health maintenance organization shall file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

(c) The parties to the delegation agreement shall determine which party bears the expense of complying with a requirement of this subchapter, including the cost of an examination required by the department under Article 1.15, if applicable. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Sec. 1272.053. MONITORING PLAN. A delegation agreement required by Section 1272.052 must establish a monitoring plan that:

(1) allows the health maintenance organization to monitor compliance with the minimum solvency requirements established under Subchapter D, if applicable; and

(2) includes:

(A) a description of financial practices that will ensure that the delegated entity tracks and reports liabilities that have been incurred but not reported;

(B) a summary of the total amount paid by the entity to physicians and providers on a monthly basis; and

(C) a summary of complaints from physicians, providers, and enrollees regarding delays in payment or nonpayment of claims, including the status of each complaint, on a monthly basis. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Sec. 1272.054. REQUIREMENTS FOR TERMINATION WITHOUT CAUSE. A delegation agreement required by Section 1272.052 must provide that the agreement cannot be terminated without cause by the delegated entity or the health maintenance organization unless the party terminating the agreement provides written notice before the 90th day before the termination date. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Sec. 1272.055. COLLECTION OF PAYMENTS. A delegation agreement required by Section 1272.052 must prohibit the delegated entity and the physicians and providers with whom the entity has contracted from billing or attempting to collect from an enrollee under any circumstance, including the insolvency of the health maintenance organization or entity, payments for covered services other than authorized copayments and deductibles. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Sec. 1272.056. COMPLIANCE WITH STATUTORY AND REGULATORY REQUIREMENTS. A delegation agreement required by Section 1272.052

must provide that:

(1) the agreement does not limit in any way the health maintenance organization's authority or responsibility, including financial responsibility, to comply with each statutory or regulatory requirement; and

(2) the delegated entity shall comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the entity. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Sec. 1272.057. EXAMINATION BY COMMISSIONER. A delegation agreement required by Section 1272.052 must require the delegated entity to permit the commissioner to examine at any time any information the commissioner reasonably believes is relevant to:

(1) the financial solvency of the entity; or

(2) the ability of the entity to meet the entity's responsibilities in connection with any function delegated to the entity by the health maintenance organization. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Sec. 1272.058. INFORMATION RELATING TO DELEGATED THIRD PARTY. A delegation agreement required by Section 1272.052 must require the delegated entity to provide the license number of a delegated third party performing a function that requires:

(1) a license as a third-party administrator under Chapter 4151 or utilization review agent under Article 21.58A; or

(2) another license under this code or another insurance law of this state. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Sec. 1272.059. CONTRACTS WITH DELEGATED THIRD PARTY. A delegation agreement required by Section 1272.052 must provide that:

(1) any agreement under which the delegated entity directly or indirectly delegates a function required by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452, including the handling of funds, if applicable, to a delegated third party must be in writing; and

(2) the delegated entity, in contracting with a delegated third party directly or through a third party, shall require the delegated third party to comply with the requirements of Section 1272.057 and any rules adopted by the commissioner implementing that section. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Sec. 1272.060. UTILIZATION REVIEW. A delegation agreement required by Section 1272.052 must provide that:

(1) enrollees shall receive notification at the time of enrollment of which entity is responsible for performing utilization review;

(2) the delegated entity or third party performing utilization review shall perform that review in accordance with Article 21.58A; and

(3) the delegated entity or third party shall forward utilization review decisions made by the entity or third party to the health maintenance organization on a monthly basis. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Sec. 1272.061. RIGHTS AND DUTIES OF DELEGATED ENTITY AND

HEALTH MAINTENANCE ORGANIZATION. A delegation agreement required by Section 1272.052 must provide that the delegated entity acknowledges and agrees that:

(1) the health maintenance organization:

(A) is required to establish, operate, and maintain a health care delivery system, quality assurance system, provider credentialing system, and other systems and programs that meet statutory and regulatory standards;

(B) is directly accountable for compliance with those standards; and

(C) is not precluded from contractually requesting that the delegated entity provide proof of financial viability;

(2) the role of another delegated entity with which the delegated entity subcontracts through a delegated third party is limited to performing certain delegated functions of the health maintenance organization, using standards that are approved by the health maintenance organization and that are in compliance with applicable statutes and rules and subject to the health maintenance organization's oversight and monitoring of the entity's performance; and

(3) if the delegated entity fails to meet monitoring standards established to ensure that functions delegated or assigned to the entity under the delegation agreement are in full compliance with all statutory and regulatory requirements, the health maintenance organization may cancel delegation of any or all delegated functions. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Sec. 1272.062. INFORMATION TO BE PROVIDED BY DELEGATED ENTITY TO HEALTH MAINTENANCE ORGANIZATION. (a) A delegation agreement required by Section 1272.052 must provide that:

(1) except as provided by Subsection (b), the delegated entity shall make available to the health maintenance organization samples of contracts with physicians and providers to ensure compliance with the contractual requirements described by Sections 1272.054 and 1272.055; and

(2) the delegated entity shall provide to the health maintenance organization, in a format usable for audit purposes and not more frequently than quarterly unless otherwise specified in the delegation agreement, the data necessary for the health maintenance organization to comply with the department's reporting requirements with respect to any delegated functions performed under the delegation agreement, including:

(A) a summary describing the methods, including capitation, fee-for-service, or other risk arrangements, that the delegated entity used to pay the entity's physicians and providers, and including the percentage of physicians and providers paid for each payment category;

(B) the period that claims and debts for medical services owed by the delegated entity have been pending and the aggregate dollar amount of those claims and debts;

(C) information to enable the health maintenance organization to file claims for reinsurance, coordination of benefits, and subrogation, if required by the delegation agreement; and

(D) documentation, except for information, documents, and deliberations related to peer review that are confidential or privileged under Subchapter A, Chapter 160, Occupations Code, that relates to:

(i) a regulatory agency's inquiry or investigation of the delegated entity or an individual physician or provider with whom the entity contracts that relates to an enrollee of the health maintenance organization; and

(ii) the final resolution of a regulatory agency's inquiry or investigation.

(b) A delegation agreement may not require a delegated entity to make available to the health maintenance organization contractual provisions relating to financial arrangements with the entity's physicians and providers. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Sec. 1272.063. ENROLLEE COMPLAINTS. (a) A delegation agreement required by Section 1272.052 must provide that:

(1) if the delegated entity receives a complaint that does not involve emergency care, the entity shall report the complaint to the health maintenance organization not later than the second business day after the date the entity receives the complaint; and

(2) if the delegated entity receives a complaint involving emergency care, the entity shall immediately forward the complaint to the health maintenance organization.

(b) Subsection (a) does not prohibit a delegated entity from attempting to resolve a complaint. (V.T.I.C. Art. 20A.18C, Sec.

(a) (part).)

Sec. 1272.064. RULES. The commissioner may adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C, Sec. (r).)

[Sections 1272.065-1272.100 reserved for expansion]

SUBCHAPTER C. INFORMATION REPORTING TO DELEGATED ENTITY

Sec. 1272.101. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18C, Sec. (q).)

Sec. 1272.102. REPORTING REQUIRED. (a) The commissioner shall determine the information a health maintenance organization shall provide to a delegated entity with which the health maintenance organization has entered into a delegation agreement.

(b) The information must include:

(1) for each enrollee who is eligible or assigned to receive services from the delegated entity:

(A) the enrollee's name, birth date or social security number, age, and sex;

(B) the benefit plan and any riders to that plan that are applicable to the enrollee; and

(C) the enrollee's employer;

(2) the name and birth date or social security number of each enrollee added or terminated since the health maintenance organization last provided the information;

(3) if the health maintenance organization pays any claims on behalf of the delegated entity, a summary of the number

and amount of:

(A) claims paid during the previous reporting period; and

(B) pharmacy prescriptions paid for each enrollee during the previous reporting period for which the delegated entity has taken partial risk;

(4) information that enables the delegated entity to file claims for reinsurance, coordination of benefits, and subrogation;

(5) patient complaint data that relates to the delegated entity;

(6) detailed risk-pool data, reported quarterly and on settlement;

(7) if hospital or facility costs impact the delegated entity's costs, the percent of premium attributable to hospital or facility costs, reported quarterly; and

(8) if there are changes in hospital or facility contracts with the health maintenance organization, the projected impact of those changes on the percent of premium attributable to hospital and facility costs during the 30-day period following those changes.

(c) Notwithstanding Subsection (b)(3), a delegated entity may, on request, receive additional nonproprietary information regarding claims paid by a health maintenance organization on behalf of the entity.

(d) A health maintenance organization shall provide information required under Subsections (b)(1)-(5) in standard

electronic format at least monthly unless the delegation agreement provides otherwise. (V.T.I.C. Art. 20A.18C, Secs. (b), (c).)

Sec. 1272.103. RULES. The commissioner may adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C, Sec. (r).)

[Sections 1272.104-1272.150 reserved for expansion]

SUBCHAPTER D. RESERVE REQUIREMENTS

Sec. 1272.151. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18D, Sec. (h), as added Acts 77th Leg., R.S., Ch. 550.)

Sec. 1272.152. GENERAL RESERVE REQUIREMENTS. (a) A delegated network shall maintain reserves adequate for the liabilities and risks assumed by the network, as computed in accordance with accepted standards, practices, and procedures relating to the liabilities and risks for which the reserves are maintained, including known and unknown components and anticipated expenses of providing benefits or services.

(b) Except as provided by Sections 1272.153 and 1272.154, a delegated network shall maintain reserves as described by Subsection (c) only with respect to the portion of services assumed under the delegation agreement that is outside the scope of the network's license for medical care or hospital or other institutional services, as applicable.

(c) A delegated network shall maintain financial reserves equal to the greater of:

(1) 80 percent of the amount of liabilities and risks

for which reserves must be maintained under this subchapter and that have been incurred but not paid by the network; or

(2) an amount equal to two months of the premium amount assumed by the network for services with respect to which reserves must be maintained under this subchapter. (V.T.I.C. Art. 20A.18D, Secs. (a), (b), (e), as added Acts 77th Leg., R.S., Ch. 550.)

Sec. 1272.153. RESERVE REQUIREMENTS FOR MEDICAL CARE AND HOSPITAL OR INSTITUTIONAL SERVICES. A delegated network that assumes under a delegation agreement both medical care and hospital or institutional services shall maintain reserves adequate to cover the liabilities and risks associated with medical care or hospital or institutional services, whichever category of services is allocated the largest portion of the premium by the health maintenance organization. (V.T.I.C. Art. 20A.18D, Sec. (c), as added Acts 77th Leg., R.S., Ch. 550.)

Sec. 1272.154. RESERVE REQUIREMENTS FOR PRESCRIPTION DRUGS. A delegated network that assumes financial risk for medical care or hospital or institutional services and for prescription drugs, as defined by Section 551.003, Occupations Code, shall maintain, in addition to any other reserves required under this subchapter, reserves adequate to cover the liabilities and risks associated with the prescription drug benefits. (V.T.I.C. Art. 20A.18D, Sec. (d), as added Acts 77th Leg., R.S., Ch. 550.)

Sec. 1272.155. FORM OF RESERVES. The reserves required under this subchapter must be:

(1) secured by and consist only of United States legal tender or bonds of the United States or this state;

(2) held at a financial institution in this state that is chartered by the United States or this state; and

(3) held in trust for, for the benefit of, or to provide health care services to enrollees under the delegation agreement. (V.T.I.C. Art. 20A.18D, Sec. (f), as added Acts 77th Leg., R.S., Ch. 550.)

Sec. 1272.156. ESCROW ACCOUNT. (a) A delegated network required to maintain reserves under this subchapter shall establish an escrow account to pay claims and deposit the reserves into the escrow account on:

(1) notification of the network's intent to terminate or refuse to renew a contract under which the network assumed liabilities and risks from a health maintenance organization; or

(2) modification of a contract under which the network assumed liabilities and risks from a health maintenance organization if the modified contract eliminates those liabilities and risks.

(b) The delegated network shall notify the commissioner on establishing an escrow account under this section.

(c) On the 271st day after the date the reserves are deposited into the escrow account, the delegated network is entitled to the release of funds remaining in escrow. Funds released from the escrow account shall be distributed to each individual who contributed to the reserves deposited into the account in proportion to the individual's total contribution.

(d) The commissioner shall take any action necessary to ensure the release of funds remaining in escrow after the date

specified by Subsection (c). (V.T.I.C. Art. 20A.18D, Sec. (g), as added Acts 77th Leg., R.S., Ch. 550.)

[Sections 1272.157-1272.200 reserved for expansion]

SUBCHAPTER E. COMPLIANCE

Sec. 1272.201. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18C, Sec. (q).)

Sec. 1272.202. NOTICE OF NONCOMPLIANCE OR HAZARDOUS OPERATING CONDITION. (a) If a health maintenance organization becomes aware of information that indicates a delegated entity with which the health maintenance organization has entered into a delegation agreement is not operating in accordance with the agreement or is operating in a condition that renders continuing the entity's business hazardous to the enrollees, the health maintenance organization shall in writing:

(1) notify the entity of those findings; and

(2) request a written explanation and documentation supporting that explanation of the entity's apparent noncompliance or the existence of the hazardous condition.

(b) A health maintenance organization shall provide to the commissioner a copy of each notice and request submitted to a delegated entity under this section and each response or other documentation the health maintenance organization receives or generates in response to the notice and request. (V.T.I.C. Art. 20A.18C, Sec. (d).)

Sec. 1272.203. RESPONSE TO NOTICE. A delegated entity

shall respond in writing to a request from a health maintenance organization under Section 1272.202 not later than the 30th day after the date the entity receives the request. (V.T.I.C. Art. 20A.18C, Sec. (e).)

Sec. 1272.204. COOPERATION OF HEALTH MAINTENANCE ORGANIZATION. A health maintenance organization shall cooperate with a delegated entity to correct a failure by the entity to comply with the department's regulatory requirements relating to:

(1) a function delegated to the entity by the health maintenance organization; or

(2) a matter necessary for the health maintenance organization to ensure compliance with each statutory or regulatory requirement. (V.T.I.C. Art. 20A.18C, Sec. (f).)

Sec. 1272.205. EXAMINATION BY DEPARTMENT; REPORT. (a) On receipt of a notice under Section 1272.202 or if complaints are filed with the department, the department may conduct an examination regarding:

(1) any matter contained in the notice; and

(2) any other matter relating to the financial solvency of the delegated entity or the entity's ability to meet the entity's responsibilities in connection with a function delegated to the entity by the health maintenance organization.

(b) Except as provided by Subsection (c), the department, on completion of an examination under this section, shall report to the delegated entity and the health maintenance organization:

(1) the results of the examination; and

(2) any action the department determines is necessary

to ensure that:

(A) the health maintenance organization meets the health maintenance organization's responsibilities under this code, any other insurance laws of this state, and rules adopted by the commissioner; and

(B) the entity is able to meet the entity's responsibilities in connection with a function delegated to the entity by the health maintenance organization.

(c) The department may not report to the health maintenance organization information relating to fee schedules, prices, or cost of care or other information not relevant to the monitoring plan. (V.T.I.C. Art. 20A.18C, Secs. (g), (h).)

Sec. 1272.206. RESPONSE TO DEPARTMENT REPORT; CORRECTIVE PLAN. The delegated entity and health maintenance organization shall respond to the department's report under Section 1272.205(b) and submit a corrective plan to the department not later than the 30th day after the date of receipt of the report. (V.T.I.C. Art. 20A.18C, Sec. (i).)

Sec. 1272.207. REQUEST FOR CORRECTIVE ACTION. The department may request at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that:

(1) relate to a function delegated by the health maintenance organization to the entity; or

(2) are necessary to ensure the health maintenance organization's compliance with each statutory or regulatory requirement. (V.T.I.C. Art. 20A.18C, Sec. (k).)

Sec. 1272.208. AUTHORITY OF COMMISSIONER TO ISSUE ORDER. (a) Regardless of whether a delegated entity complies with a request for corrective action under Section 1272.207, the commissioner may order a health maintenance organization with which the entity has entered into a delegation agreement to take any action the commissioner determines is necessary to ensure that the health maintenance organization is complying with this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452.

(b) Actions the commissioner may order a health maintenance organization to take under this section include:

(1) reassuming the functions delegated to the delegated entity, including claims payments for services previously provided to enrollees;

(2) temporarily or permanently ceasing assignment of new enrollees to the entity;

(3) temporarily or permanently transferring enrollees to alternative delivery systems to receive services; or

(4) terminating the delegation agreement with the entity. (V.T.I.C. Art. 20A.18C, Sec. (l).)

Sec. 1272.209. PUBLIC DOCUMENTS. (a) Except as provided by Subsection (b), a report required under Section 1272.205(b) or corrective plan required under Section 1272.206 is a public document.

(b) Health care provider fee schedules, prices, costs of care, or other information that is not relevant to the monitoring plan or is confidential by law is not a public document under this section. (V.T.I.C. Art. 20A.18C, Sec. (j).)

Sec. 1272.210. RECORD OF COMPLAINTS; REPORT. (a) The department shall:

(1) maintain enrollee and provider complaints in a manner that identifies complaints made about limited provider networks and delegated entities; and

(2) periodically issue a report on the complaints that includes a list of complaints organized by:

(A) category;

(B) action taken on the complaint; and

(C) entity or network name and type.

(b) The department shall make available to the public the report and information to assist the public in evaluating the information contained in the report. (V.T.I.C. Art. 20A.18C, Sec. (m).)

Sec. 1272.211. RULES. The commissioner may adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C, Sec. (r).)

[Sections 1272.212-1272.250 reserved for expansion]

SUBCHAPTER F. PENALTIES

Sec. 1272.251. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18C, Sec. (q).)

Sec. 1272.252. SUSPENSION OR REVOCATION OF LICENSE OF THIRD-PARTY ADMINISTRATOR OR UTILIZATION REVIEW AGENT. Notwithstanding any other provision of this code or another insurance law of this state, the commissioner may suspend or revoke

the license of a third-party administrator or utilization review agent that fails to comply with Subchapter B, C, or E. (V.T.I.C. Art. 20A.18C, Sec. (n).)

Sec. 1272.253. SANCTIONS AND PENALTIES AGAINST HEALTH MAINTENANCE ORGANIZATION. The commissioner may impose sanctions or penalties under Chapters 82, 83, and 84 on a health maintenance organization that does not provide in a timely manner information required by Subchapter C. (V.T.I.C. Art. 20A.18C, Sec. (o).)

Sec. 1272.254. CONTRACTUAL PENALTIES REQUIRED. A health maintenance organization by contract shall establish penalties for a delegated entity that does not provide in a timely manner information required under a monitoring plan established under Section 1272.053. (V.T.I.C. Art. 20A.18C, Sec. (p).)

Sec. 1272.255. RULES. The commissioner may adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C, Sec. (r).)

[Sections 1272.256-1272.300 reserved for expansion]

SUBCHAPTER G. PROVISION OF SERVICES BY LIMITED PROVIDER NETWORK OR DELEGATED ENTITY

Sec. 1272.301. ACCESS TO OUT-OF-NETWORK SERVICES. (a) A contract between a health maintenance organization and a limited provider network or delegated entity must provide that:

(1) if medically necessary covered services are not available through network physicians or providers, the limited provider network or delegated entity, on the request of a network physician or provider, shall:

(A) allow a referral to a non-network physician

or provider; and

(B) fully reimburse the non-network physician or provider at the usual and customary rate or an agreed rate; and

(2) before the limited provider network or delegated entity may deny a referral to a non-network physician or provider, a specialist of the same or similar specialty as the type of physician or provider to whom the referral is requested must conduct a review of the request.

(b) The limited provider network or delegated entity shall allow the referral within the time appropriate to the circumstances relating to the delivery of the services and the condition of the enrollee who is a patient, but not later than the fifth business day after the date the network or entity receives any reasonably requested documentation.

(c) An enrollee may not be required to change the enrollee's primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network or through the delegated entity.

(d) A denial of out-of-network services under this section is subject to appeal under Article 21.58A. (V.T.I.C. Art. 20A.18F.)

Sec. 1272.302. CONTINUITY OF CARE. (a) In this section, "special circumstance" means a condition regarding which a treating physician or provider reasonably believes that discontinuing care by that physician or provider could cause harm to an enrollee who is a patient. Examples of an enrollee who has a special circumstance include an enrollee with a disability, acute condition, or

life-threatening illness and an enrollee who is past the 24th week of pregnancy.

(b) A contract between a health maintenance organization and a limited provider network or delegated entity must require that each contract between the network or entity and a physician or provider must:

(1) require that reasonable advance notice be given to an enrollee of an impending termination from the network or entity of a physician or provider who is currently treating the enrollee; and

(2) provide that the termination of the physician's or provider's contract, except for reason of medical competence or professional behavior, does not release the network or entity from the obligation to reimburse the physician or provider for treatment of an enrollee who has a special circumstance at a rate that is not less than the contract rate for that enrollee's care in exchange for continuity of ongoing treatment of the enrollee then receiving medically necessary treatment in accordance with the dictates of medical prudence.

(c) The treating physician or provider shall identify a special circumstance. That physician or provider must:

(1) request that the enrollee be permitted to continue treatment under the physician's or provider's care; and

(2) agree not to seek payment from the enrollee who is a patient of any amount for which the enrollee would not be responsible if the physician or provider continued to be included in the limited provider network or delegated entity.

(d) Except as provided by Subsection (e), this section does not extend the obligation of a limited provider network or delegated entity to reimburse a terminated physician or provider for ongoing treatment of an enrollee after:

(1) the 90th day after the effective date of the termination; or

(2) if the enrollee has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination.

(e) If an enrollee is past the 24th week of pregnancy at the time of termination, the obligation of the limited provider network or delegated entity to reimburse the terminated physician or provider or, if applicable, the enrollee extends through delivery of the child, immediate postpartum care, and a follow-up checkup within the six-week period after delivery.

(f) A contract between a limited provider network or delegated entity and a physician or provider must provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider. (V.T.I.C. Art. 20A.18E.)

CHAPTER 1273. POINT-OF-SERVICE PLANS

SUBCHAPTER A. BLENDED CONTRACTS

CHAPTER 1273. POINT-OF-SERVICE PLANS

SUBCHAPTER A. BLENDED CONTRACTS

Sec. 1273.001. DEFINITIONS. In this subchapter:

(1) "Blended contract" means a single document, including a single contract policy, certificate, or evidence of coverage, that provides a combination of indemnity and health maintenance organization benefits.

(2) "Health maintenance organization" has the meaning assigned by Section 843.002.

(3) "Insurer" means an insurance company, association, or organization authorized to engage in business in this state under Chapter 841, 842, 861, 881, 882, 883, 884, 885, 886, 887, 888, 941, 942, or 982.

(4) "Point-of-service plan" means an arrangement under which:

(A) an enrollee chooses to obtain benefits or

services through:

(i) a health maintenance organization delivery network, including a limited provider network; or

(ii) a non-network delivery system outside the health maintenance organization delivery network, including a limited provider network, that is administered under an indemnity benefit arrangement for the cost of health care services; or

(B) indemnity benefits for the cost of health care services are provided by an insurer or group hospital service corporation in conjunction with network benefits arranged or provided by a health maintenance organization. (V.T.I.C. Art. 3.64, Sec. (a).)

Sec. 1273.002. POINT-OF-SERVICE PLAN. An insurer may contract with a health maintenance organization to provide benefits under a point-of-service plan, including optional coverage for out-of-area services or out-of-network care. (V.T.I.C. Art. 3.64, Sec. (b).)

Sec. 1273.003. BLENDED CONTRACT. (a) A health maintenance organization and an insurer may offer a blended contract. The use of a blended contract is limited to point-of-service arrangements between a health maintenance organization and an insurer.

(b) A blended contract delivered, issued, or used in this state is subject to, and must be filed with the department for approval as provided by, Chapter 1701 and Section 1271.101. (V.T.I.C. Art. 3.64, Secs. (c), (d).)

Sec. 1273.004. LIMITED BENEFITS AND SERVICES; COST-SHARING PROVISIONS. Indemnity benefits and services provided under a

point-of-service plan may be limited to those services described by the blended contract and may be subject to different cost-sharing provisions. The cost-sharing provisions for indemnity benefits may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For an enrollee in a limited provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the health maintenance organization delivery network. (V.T.I.C. Art. 3.64, Sec. (e).)

Sec. 1273.005. RULES. The commissioner may adopt rules to implement this subchapter. (V.T.I.C. Art. 3.64, Sec. (f).)

[Sections 1273.006-1273.050 reserved for expansion]

SUBCHAPTER B. AVAILABILITY OF HEALTH BENEFIT COVERAGE OPTIONS

Sec. 1273.051. DEFINITIONS. In this subchapter:

(1) "Employee" means an individual employed by an employer.

(2) "Health benefit plan" has the meaning assigned by Section 1501.002.

(3) "Non-network plan" means health benefit coverage that provides an enrollee an opportunity to obtain health care services through a health delivery system other than a health maintenance organization delivery network, as defined by Section 843.002.

(4) "Point-of-service plan" means an arrangement under which an enrollee chooses to obtain benefits or services through:

(A) a health maintenance organization delivery

network, including a limited provider network; or

(B) a non-network delivery system outside the health maintenance organization delivery network, including a limited provider network, that is administered under an indemnity benefit arrangement for the cost of health care services.

(5) "Preferred provider benefit plan" means an insurance policy issued under Chapter 1301.

(6) "Small employer health benefit plan" has the meaning assigned by Section 1501.002. (V.T.I.C. Art. 26.02, Subdivs. (10), (11), (31), as amended Acts 77th Leg., R.S., Ch. 608, (32), as amended Acts 77th Leg., R.S., Ch. 823; Art. 26.09, Sec. (a).)

Sec. 1273.052. OFFER OF COVERAGE THROUGH NON-NETWORK PLAN REQUIRED. (a) Except as provided by Subsection (b), if the only health benefit coverage offered under an employer's health benefit plan is a network-based delivery system of coverage offered by one or more health maintenance organizations, each health maintenance organization offering coverage must offer to all eligible employees, at the time of enrollment and at least annually, the opportunity to obtain coverage through a non-network plan.

(b) Each health maintenance organization to which Subsection (a) applies may enter into an agreement designating one or more of those health maintenance organizations to offer the coverage required by Subsection (a) for eligible employees of the employer. (V.T.I.C. Art. 26.09, Sec. (b) (part).)

Sec. 1273.053. COVERAGE OPTIONS. The coverage required to be offered under this subchapter may be provided through:

(1) a point-of-service plan;

(2) a preferred provider benefit plan; or

(3) any coverage arrangement that provides an enrollee with access to services outside the health maintenance organization's or limited provider network's delivery network. (V.T.I.C. Art. 26.09, Sec. (b) (part).)

Sec. 1273.054. PREMIUM FOR COVERAGE OPTIONS. The premium for coverage required to be offered under this subchapter must be based on the actuarial value of that coverage and may be different from the premium for coverage otherwise offered by the health maintenance organization. (V.T.I.C. Art. 26.09, Sec. (c).)

Sec. 1273.055. COST-SHARING PROVISIONS. (a) Different cost-sharing provisions may be imposed for a point-of-service plan offered under this subchapter, and those provisions may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For an enrollee in a limited provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the health maintenance organization delivery network.

(b) An employee who chooses the non-network plan is responsible for any additional costs for the non-network plan, and the employer may impose a reasonable administrative fee for providing the non-network plan. (V.T.I.C. Art. 26.09, Secs. (d), (e).)

Sec. 1273.056. EXCEPTIONS. This subchapter does not apply to:

(1) a small employer health benefit plan; or

(2) a group model health maintenance organization that is a nonprofit, state-certified health maintenance organization that:

(A) provides the majority of its professional services through a single group medical practice that is governed by a board composed entirely of physicians; and

(B) educates medical students or resident physicians through a contract with the medical school component of a Texas state-supported college or university accredited by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association. (V.T.I.C. Art. 26.09, Sec. (f).)

Sec. 1273.057. RULES. The commissioner shall adopt rules necessary to administer this subchapter. (V.T.I.C. Art. 26.04 (part).)

[Chapters 1274-1300 reserved for expansion]

SUBTITLE D. PREFERRED PROVIDER BENEFIT PLANS

CHAPTER 1301. PREFERRED PROVIDER BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 1301.008-1301.050 reserved for expansion]

CHAPTER 1301. PREFERRED PROVIDER BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1301.001. DEFINITIONS. In this chapter:

(1) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term does not include a physician.

(2) "Health insurance policy" means a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.

(3) "Hospital" means a licensed public or private institution as defined by Chapter 241, Health and Safety Code, or

Subtitle C, Title 7, Health and Safety Code.

(4) "Institutional provider" means a hospital, nursing home, or other medical or health-related service facility that provides care for the sick or injured or other care that may be covered in a health insurance policy.

(5) "Insurer" means a life, health, and accident insurance company, health and accident insurance company, health insurance company, or other company operating under Chapter 841, 842, 884, 885, 982, or 1501, that is authorized to issue, deliver, or issue for delivery in this state health insurance policies.

(6) "Physician" means a person licensed to practice medicine in this state.

(7) "Practitioner" means a person who practices a healing art and is a practitioner described by Section 1451.001 or 1451.101.

(8) "Preferred provider" means a physician or health care provider, or an organization of physicians or health care providers, who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy.

(9) "Preferred provider benefit plan" means a benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider.

(10) "Service area" means a geographic area or areas specified in a health insurance policy or preferred provider contract in which a network of preferred providers is offered and

available. (V.T.I.C. Art. 3.70-3C, Secs. 1(2), (3), (4), (5), (6), (8), (9), (10), (13), 2 (part), as added Acts 75th Leg., R.S., Ch. 1024; Art. 3.70-3C, Sec. 1, as added Acts 75th Leg., R.S., Ch. 1260.)

Sec. 1301.002. NONAPPLICABILITY TO DENTAL CARE BENEFITS. This chapter does not apply to a provision for dental care benefits in a health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 2 (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.003. PREFERRED PROVIDER BENEFIT PLANS PERMITTED. A health insurance policy that provides different benefits from the basic level of coverage for the use of preferred providers and that meets the requirements of this chapter is not:

(1) unjust under Chapter 1701;

(2) unfair discrimination under Subchapter A or B, Chapter 544; or

(3) a violation of Subchapter B or C, Chapter 1451. (V.T.I.C. Art. 3.70-3C, Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.004. COMPLIANCE WITH CHAPTER REQUIRED. Each preferred provider benefit plan offered in this state must comply with this chapter. (V.T.I.C. Art. 3.70-3C, Sec. 3(l) (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.005. AVAILABILITY OF PREFERRED PROVIDERS. (a) An insurer offering a preferred provider benefit plan shall ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area.

(b) If services are not available through a preferred provider within the service area, an insurer shall reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider.

(c) Subsection (b) does not require reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from a provider other than a preferred provider for the insured's own convenience. (V.T.I.C. Art. 3.70-3C, Sec. 8, as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.006. AVAILABILITY OF AND ACCESSIBILITY TO HEALTH CARE SERVICES. An insurer that markets a preferred provider benefit plan shall contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities. (V.T.I.C. Art. 3.70-3C, Sec. 3(d), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.007. RULES. The commissioner shall adopt rules as necessary to:

(1) implement this chapter; and

(2) ensure reasonable accessibility and availability of preferred provider benefits and basic level benefits to

residents of this state. (V.T.I.C. Art. 3.70-3C, Sec. 9, as added Acts 75th Leg., R.S., Ch. 1024.)

[Sections 1301.008-1301.050 reserved for expansion]

SUBCHAPTER B. RELATIONS WITH PHYSICIANS OR HEALTH CARE PROVIDERS

Sec. 1301.051. DESIGNATION AS PREFERRED PROVIDER. (a) An insurer shall afford a fair, reasonable, and equivalent opportunity to apply to be and to be designated as a preferred provider to practitioners and institutional providers and to health care providers other than practitioners and institutional providers, if those other health care providers are included by the insurer as preferred providers, provided that the practitioners, institutional providers, or health care providers:

(1) are licensed to treat injuries or illnesses or to provide services covered by a health insurance policy; and

(2) comply with the terms established by the insurer for designation as preferred providers.

(b) An insurer may not unreasonably withhold a designation as a preferred provider.

(c) An insurer shall give a physician or health care provider who, on the person's initial application, is not designated as a preferred provider written reasons for denial of the designation.

(d) Unless otherwise limited by this code, this section does not prohibit an insurer from rejecting a physician's or health care provider's application for designation based on a determination that the preferred provider benefit plan has sufficient qualified providers. (V.T.I.C. Art. 3.70-3C, Secs. 3(b)(1), (4), as added

Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.052. DESIGNATION OF ADVANCED PRACTICE NURSE OR PHYSICIAN ASSISTANT AS PREFERRED PROVIDER. An insurer offering a preferred provider benefit plan may not refuse a request made by a physician participating as a preferred provider under the plan and an advanced practice nurse or physician assistant to have the advanced practice nurse or physician assistant included as a preferred provider under the plan if:

(1) the advanced practice nurse or physician assistant is authorized by the physician to provide care under Subchapter B, Chapter 157, Occupations Code; and

(2) the advanced practice nurse or physician assistant meets the quality of care standards previously established by the insurer for participation in the plan by advanced practice nurses and physician assistants. (V.T.I.C. Art. 3.70-3C, Sec. 2, as added Acts 75th Leg., R.S., Ch. 1260.)

Sec. 1301.053. APPEAL RELATING TO DESIGNATION AS PREFERRED PROVIDER. (a) An insurer that does not designate a practitioner as a preferred provider shall provide a reasonable mechanism for reviewing that action. The review mechanism must incorporate, in an advisory role only, a review panel.

(b) A review panel must be composed of at least three individuals selected by the insurer from a list of participating practitioners and must include one member who is a practitioner in the same or similar specialty as the affected practitioner, if available. The practitioners contracting with the insurer in the applicable service area shall provide the list of practitioners to

the insurer.

(c) On request, the insurer shall provide to the affected practitioner:

(1) the panel's recommendation, if any; and

(2) a written explanation of the insurer's determination, if that determination is contrary to the panel's recommendation. (V.T.I.C. Art. 3.70-3C, Secs. 3(b)(2), (3), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.054. NOTICE TO PRACTITIONERS OF PREFERRED PROVIDER BENEFIT PLAN. (a) When sponsoring a preferred provider benefit plan, an insurer shall immediately notify each practitioner in the plan's service area of the insurer's intent to offer the plan and of the opportunity to participate. The notification must be made by publication or in writing to each practitioner.

(b) After establishing a preferred provider benefit plan, an insurer shall annually provide notice of and an opportunity to participate in the plan to practitioners in the plan's service area who do not participate in the plan.

(c) On request, an insurer shall provide to any physician or health care provider information concerning the application process and qualification requirements for participation as a preferred provider in the plan. (V.T.I.C. Art. 3.70-3C, Sec. 3(c), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.055. COMPLAINT RESOLUTION. (a) Each contract under a preferred provider benefit plan between an insurer and a physician or other practitioner or a physicians' group must have a mechanism for resolving complaints initiated by an insured, a

physician or other practitioner, or a physicians' group.

(b) A complaint resolution mechanism must provide for reasonable due process that includes, in an advisory role only, a review panel selected in the manner described by Section 1301.053(b). (V.T.I.C. Art. 3.70-3C, Sec. 3(f), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.056. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT. (a) An insurer or third-party administrator may not reimburse a physician or other practitioner, institutional provider, or organization of physicians and health care providers on a discounted fee basis for covered services that are provided to an insured unless:

(1) the insurer or third-party administrator has contracted with either:

(A) the physician or other practitioner, institutional provider, or organization of physicians and health care providers; or

(B) a preferred provider organization that has a network of preferred providers and that has contracted with the physician or other practitioner, institutional provider, or organization of physicians and health care providers;

(2) the physician or other practitioner, institutional provider, or organization of physicians and health care providers has agreed to the contract and has agreed to provide health care services under the terms of the contract; and

(3) the insurer or third-party administrator has agreed to provide coverage for those health care services under the

health insurance policy.

(b) A party to a preferred provider contract, including a contract with a preferred provider organization, may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other contracting parties. This subsection does not affect the authority of the commissioner or the Texas Workers' Compensation Commission under this code to request and obtain information.

(c) An insurer or third-party administrator who violates this section:

(1) commits an unfair claim settlement practice in violation of Subchapter A, Chapter 542; and

(2) is subject to administrative penalties under Chapters 82 and 84. (V.T.I.C. Art. 3.70-3C, Sec. 7A, as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.057. TERMINATION OF PARTICIPATION; EXPEDITED REVIEW PROCESS. (a) Before terminating a contract with a preferred provider, an insurer shall:

(1) provide written reasons for the termination; and

(2) if the affected provider is a practitioner, provide, on request, a reasonable review mechanism, except in a case involving:

(A) imminent harm to a patient's health;

(B) an action by a state medical or other physician licensing board or other government agency that effectively impairs the practitioner's ability to practice

medicine; or

(C) fraud or malfeasance.

(b) The review mechanism described by Subsection (a)(2) must incorporate, in an advisory role only, a review panel selected in the manner described by Section 1301.053(b) and must be completed within a period not to exceed 60 days.

(c) The insurer shall provide to the affected practitioner:

(1) the panel's recommendation, if any; and

(2) on request, a written explanation of the insurer's determination, if that determination is contrary to the panel's recommendation.

(d) On request, an insurer shall make an expedited review available to a practitioner whose participation in a preferred provider benefit plan is being terminated. The expedited review process must comply with rules established by the commissioner. (V.T.I.C. Art. 3.70-3C, Sec. 3(g), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.058. ECONOMIC PROFILING. An insurer that conducts, uses, or relies on economic profiling to admit or terminate the participation of physicians or health care providers in a preferred provider benefit plan shall make available to a physician or health care provider on request the economic profile of that physician or health care provider, including the written criteria by which the physician or health care provider's performance is to be measured. An economic profile must be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected

costs. (V.T.I.C. Art. 3.70-3C, Sec. 3(h), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.059. QUALITY ASSESSMENT. (a) In this section, "quality assessment" means a mechanism used by an insurer to evaluate, monitor, or improve the quality and effectiveness of the medical care delivered by physicians or health care providers to persons covered by a health insurance policy to ensure that the care delivered is consistent with the care delivered by an ordinary, reasonable, and prudent physician or health care provider under the same or similar circumstances.

(b) An insurer may not engage in quality assessment except through a panel of at least three physicians selected by the insurer from among a list of physicians contracting with the insurer. The physicians contracting with the insurer in the applicable service area shall provide the list of physicians to the insurer. (V.T.I.C. Art. 3.70-3C, Secs. 1(12), 3(i), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.060. COMPENSATION ON DISCOUNTED FEE BASIS. A preferred provider contract must include a provision by which the physician or health care provider agrees that if the preferred provider is compensated on a discounted fee basis, the insured may be billed only on the discounted fee and not the full charge. (V.T.I.C. Art. 3.70-3C, Sec. 3(k), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.061. PREFERRED PROVIDER NETWORKS. (a) An insurer may enter into an agreement with a preferred provider organization for the purposes of offering a network of preferred

providers. The agreement may provide that either the insurer or the preferred provider organization on the insurer's behalf will comply with the notice requirements and other requirements imposed on the insurer by this subchapter.

(b) An insurer that enters into an agreement with a preferred provider organization under this section shall meet the requirements of this chapter or ensure that those requirements are met. (V.T.I.C. Art. 3.70-3C, Sec. 3(l) (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.062. PREFERRED PROVIDER CONTRACTS BETWEEN INSURERS AND PODIATRISTS. A preferred provider contract between an insurer and a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners must provide that:

(1) the podiatrist may request a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;

(2) the insurer shall provide a copy of the coding guidelines and payment schedules not later than the 30th day after the date of the podiatrist's request;

(3) the insurer may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

(4) the podiatrist may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by the health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3(n), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.063. CONTRACT PROVISIONS RELATING TO USE OF

HOSPITALIST. (a) In this section, "hospitalist" means a physician who:

(1) serves as physician of record at a hospital for a hospitalized patient of another physician; and

(2) returns the care of the patient to that other physician at the end of the patient's hospitalization.

(b) A preferred provider contract between an insurer and a physician may not require the physician to use a hospitalist for a hospitalized patient. (V.T.I.C. Art. 3.70-3C, Sec. 3B, as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.064. CONTRACT PROVISIONS RELATING TO PAYMENT OF CLAIMS. Subject to Subchapter C, a preferred provider contract must provide for payment to a physician or health care provider for health care services and benefits provided to an insured under the contract and to which the insured is entitled under the terms of the contract not later than:

(1) the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to process the claim; or

(2) if applicable, within the number of calendar days specified by written agreement between the physician or health care provider and the insurer. (V.T.I.C. Art. 3.70-3C, Sec. 3(m) (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.065. SHIFTING OF INSURER'S TORT LIABILITY PROHIBITED. A preferred provider contract may not require any physician, health care provider, or physicians' group to execute a hold harmless clause to shift the insurer's tort liability

resulting from the insurer's acts or omissions to the preferred provider. (V.T.I.C. Art. 3.70-3C, Sec. 3(j), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.066. RETALIATION AGAINST PREFERRED PROVIDER PROHIBITED. An insurer may not engage in any retaliatory action against a physician or health care provider, including terminating the physician's or provider's participation in the preferred provider benefit plan or refusing to renew the physician's or provider's contract, because the physician or provider has:

(1) on behalf of an insured, reasonably filed a complaint against the insurer; or

(2) appealed a decision of the insurer. (V.T.I.C. Art. 3.70-3C, Sec. 7(b), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.067. INTERFERENCE WITH RELATIONSHIP BETWEEN PATIENT AND PHYSICIAN OR HEALTH CARE PROVIDER PROHIBITED. (a) An insurer may not, as a condition of a preferred provider contract with a physician or health care provider or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from discussing with or communicating to a current, prospective, or former patient, or a person designated by a patient, information or an opinion:

(1) regarding the patient's health care, including the patient's medical condition or treatment options; or

(2) in good faith regarding the provisions, terms, requirements, or services of the health insurance policy as they relate to the patient's medical needs.

(b) An insurer may not in any way penalize, terminate the

participation of, or refuse to compensate for covered services a physician or health care provider for discussing or communicating with a current, prospective, or former patient, or a person designated by a patient, pursuant to this section. (V.T.I.C. Art. 3.70-3C, Sec. 7(c), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.068. INDUCEMENT TO LIMIT MEDICALLY NECESSARY SERVICES PROHIBITED. (a) An insurer may not use any financial incentive or make payment to a physician or health care provider that acts directly or indirectly as an inducement to limit medically necessary services.

(b) This section does not prohibit the use of capitation as a method of payment. (V.T.I.C. Art. 3.70-3C, Sec. 7(d), as added Acts 75th Leg., R.S., Ch. 1024.)

[Sections 1301.069-1301.100 reserved for expansion]

SUBCHAPTER C. PAYMENT OF CLAIMS TO PROVIDERS

Sec. 1301.101. DEFINITION. In this subchapter, "clean claim" means a completed claim, as determined under department rules, submitted by a preferred provider for medical care or health care services under a health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3A(a), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.102. ACKNOWLEDGMENT OF RECEIPT OF CLAIM. (a) A preferred provider may obtain acknowledgment of receipt of a claim for medical care or health care services under a health insurance policy by submitting the claim by United States mail, return receipt requested.

(b) An insurer or the contracted clearinghouse of an insurer that receives a claim electronically shall acknowledge receipt of

the claim by an electronic transmission to the preferred provider and is not required to acknowledge receipt of the claim in writing. (V.T.I.C. Art. 3.70-3C, Sec. 3A(b), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. Not later than the 45th day after the date on which an insurer receives a clean claim from a preferred provider, the insurer shall:

(1) pay the total amount of the claim in accordance with the contract between the preferred provider and the insurer;

(2) pay the portion of the claim that is not in dispute and notify the preferred provider in writing why the remaining portion of the claim will not be paid; or

(3) notify the preferred provider in writing why the claim will not be paid. (V.T.I.C. Art. 3.70-3C, Sec. 3A(c), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.104. DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION BENEFIT CLAIMS. If a preferred provider or its designated agent authorizes treatment, a prescription benefit claim that is electronically adjudicated and electronically paid shall be paid not later than the 21st day after the date on which the treatment is authorized. (V.T.I.C. Art. 3.70-3C, Sec. 3A(d), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.105. AUDITED CLAIMS. An insurer that acknowledges coverage of an insured under a health insurance policy but intends to audit a claim submitted by a preferred provider shall pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date on which the

insurer receives the claim from the preferred provider. Following completion of the audit, any additional payment due a preferred provider or any refund due the insurer shall be made not later than the 30th day after the later of the date that:

(1) the preferred provider receives notice of the audit results; or

(2) any appeal rights of the insured are exhausted. (V.T.I.C. Art. 3.70-3C, Sec. 3A(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.106. CLAIMS PROCESSING PROCEDURES. (a) An insurer shall provide a preferred provider with copies of all applicable utilization review policies and claim processing policies or procedures, including required data elements and claim formats.

(b) An insurer may, by contract with a preferred provider, add or change the data elements that must be submitted with a claim.

(c) Not later than the 60th day before the date of an addition or change in the data elements that must be submitted with a claim or any other change in an insurer's claim processing and payment procedures, the insurer shall provide written notice of the addition or change to each preferred provider. (V.T.I.C. Art. 3.70-3C, Secs. 3A(i), (j), (k), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.107. VIOLATION OF CLAIMS PAYMENT PROVISIONS; ADMINISTRATIVE PENALTY. (a) An insurer that violates Section 1301.103 or 1301.105 is liable to a preferred provider for the full amount of billed charges submitted on the claim or the amount

payable under the contracted penalty rate, less any amount previously paid or any charge for a service that is not covered by the health insurance policy.

(b) In addition to any other penalty or remedy authorized by this code or another insurance law of this state, an insurer that violates Section 1301.103 or 1301.105 is subject to an administrative penalty under Chapter 84. The administrative penalty imposed under that chapter may not exceed $1,000 for each day the claim remains unpaid in violation of Section 1301.103 or 1301.105. (V.T.I.C. Art. 3.70-3C, Secs. 3A(f), (h), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.108. ATTORNEY'S FEES. A preferred provider may recover reasonable attorney's fees in an action to recover payment under this subchapter. (V.T.I.C. Art. 3.70-3C, Sec. 3A(g), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.109. APPLICABILITY TO ENTITIES CONTRACTING WITH INSURER. This subchapter applies to a person with whom an insurer contracts to:

(1) process claims; or

(2) obtain the services of a preferred provider to provide medical care or health care to an insured under a health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3A(m), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.110. EXCEPTION. This subchapter does not apply to a claim submitted by a preferred provider who is a member of the legislature. (V.T.I.C. Art. 3.70-3C, Sec. 3A(l), as added Acts 75th Leg., R.S., Ch. 1024.)

[Sections 1301.111-1301.150 reserved for expansion]

SUBCHAPTER D. RELATIONS BETWEEN INSUREDS AND PREFERRED PROVIDERS

Sec. 1301.151. INSURED'S RIGHT TO TREATMENT. Each insured is entitled to treatment and diagnostic techniques that are prescribed by the physician or health care provider included in the preferred provider benefit plan. (V.T.I.C. Art. 3.70-3C, Sec. 3(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.152. CONTINUING CARE IN GENERAL. (a) An insurer shall establish reasonable procedures for ensuring a transition of insureds to physicians or health care providers and for continuity of treatment.

(b) An insurer shall:

(1) provide, subject to Section 1301.160, reasonable advance notice to an insured of the impending termination of the participation in the plan of a physician or health care provider who is currently treating the insured; and

(2) in the event of termination of a preferred provider's participation in the plan, make available to the insured a current listing of preferred providers.

(c) A contract between an insurer and a physician or health care provider must include a procedure for resolving disputes regarding the necessity for continued treatment by the physician or provider. (V.T.I.C. Art. 3.70-3C, Secs. 4(a), (d), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.153. CONTINUITY OF CARE. (a) In this section:

(1) "Life-threatening" means a disease or condition

for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(2) "Special circumstances" means a condition regarding which the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the insured. Examples of an insured who has a special circumstance include an insured with a disability, acute condition, or life-threatening illness or an insured who is past the 24th week of pregnancy.

(b) Each contract between an insurer and a physician or health care provider must provide that the termination of the physician's or provider's participation in a preferred provider benefit plan, except for reason of medical competence or professional behavior, does not:

(1) release the physician or health care provider from the generally recognized obligation to:

(A) treat an insured whom the physician or provider is currently treating; and

(B) cooperate in arranging for appropriate referrals; or

(2) release the insurer from the obligation to reimburse the physician or health care provider or, if applicable, the insured, at the same preferred provider rate if, at the time a physician's or provider's participation is terminated, an insured whom the physician or provider is currently treating has special circumstances in accordance with the dictates of medical prudence.

(c) The treating physician or health care provider shall

identify a special circumstance. The treating physician or health care provider shall:

(1) request that the insured be permitted to continue treatment under the physician's or provider's care; and

(2) agree not to seek payment from the insured of any amount for which the insured would not be responsible if the physician or provider were still a preferred provider. (V.T.I.C. Art. 3.70-3C, Secs. 1(7), 4(b), (c), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.154. OBLIGATION FOR CONTINUITY OF CARE OF INSURER. (a) Except as provided by Subsection (b), Sections 1301.152 and 1301.153 do not extend an insurer's obligation to reimburse the terminated physician or provider or, if applicable, the insured at the preferred provider level of coverage for ongoing treatment of an insured after:

(1) the 90th day after the effective date of the termination; or

(2) if the insured has been diagnosed as having a terminal illness at the time of the termination, the expiration of the nine-month period after the effective date of the termination.

(b) If an insured is past the 24th week of pregnancy at the time of termination, an insurer's obligation to reimburse, at the preferred provider level of coverage, the physician or provider or, if applicable, the insured, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the six-week period after delivery. (V.T.I.C. Art. 3.70-3C, Sec. 4(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.155. EMERGENCY CARE. (a) In this section, "emergency care" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(1) placing the person's health in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of a bodily organ or part;

(4) serious disfigurement; or

(5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(b) If an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider:

(1) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists;

(2) necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and

(3) services originating in a hospital emergency facility following treatment or stabilization of an emergency

medical condition. (V.T.I.C. Art. 3.70-3C, Secs. 1(1), 5, as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.156. PAYMENT OF CLAIMS TO INSURED. An insurer shall comply with Subchapter B, Chapter 542, with respect to prompt payment to insureds. (V.T.I.C. Art. 3.70-3C, Sec. 3(m) (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.157. PLAIN LANGUAGE REQUIREMENTS. Each health insurance policy, health benefit plan certificate, endorsement, amendment, application, or rider must:

(1) be written in plain language;

(2) be in a readable and understandable format; and

(3) comply with all applicable requirements relating to minimum readability requirements. (V.T.I.C. Art. 3.70-3C, Sec. 6(a), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.158. INFORMATION CONCERNING PREFERRED PROVIDER BENEFIT PLANS. (a) In this section, "prospective insured" means:

(1) for group coverage, an individual or an individual's dependent who is eligible for coverage under a health insurance policy issued to the group; or

(2) for individual coverage, an individual or an individual's dependent who is eligible for coverage and who has expressed an interest in purchasing an individual health insurance policy.

(b) An insurer shall provide to a current or prospective group contract holder or current or prospective insured on request an accurate written description of the terms of the health insurance policy to allow the current or prospective group contract

holder or current or prospective insured to make comparisons and an informed decision before selecting among health care plans. The description must be in a readable and understandable format as prescribed by the commissioner and must include a current list of preferred providers. The insurer may satisfy this requirement by providing its handbook if:

(1) the handbook's content is substantively similar to and achieves the same level of disclosure as the written description prescribed by the commissioner; and

(2) the current list of preferred providers is provided.

(c) An insurer or an agent or representative of an insurer may not use or distribute, or permit the use or distribution of, information for prospective insureds that is untrue or misleading. (V.T.I.C. Art. 3.70-3C, Secs. 1(11), 6(b), (d), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.159. ANNUAL LIST OF PREFERRED PROVIDERS. A current list of preferred providers shall be provided to each insured at least annually. (V.T.I.C. Art. 3.70-3C, Sec. 6(c), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.160. NOTIFICATION OF TERMINATION OF PARTICIPATION OF PREFERRED PROVIDER. (a) If a practitioner's participation in a preferred provider benefit plan is terminated for a reason other than at the practitioner's request, an insurer may not notify insureds of the termination until the later of:

(1) the effective date of the termination; or

(2) the time at which a review panel makes a formal

recommendation regarding the termination.

(b) A physician or health care provider that voluntarily terminates the physician's or provider's participation in a preferred provider benefit plan shall provide reasonable notice to each insured under the physician's or provider's care. The insurer shall provide assistance to the physician or provider in ensuring that the notice requirements of this subsection are met.

(c) If a practitioner's participation in a preferred provider benefit plan is terminated for reasons related to imminent harm, an insurer may notify insureds immediately. (V.T.I.C. Art. 3.70-3C, Sec. 6(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.161. RETALIATION AGAINST INSURED PROHIBITED. An insurer may not engage in any retaliatory action against an insured, including canceling or refusing to renew a health insurance policy, because the insured or a person acting on the insured's behalf has:

(1) filed a complaint against the insurer or against a preferred provider; or

(2) appealed a decision of the insurer. (V.T.I.C. Art. 3.70-3C, Sec. 7(a), as added Acts 75th Leg., R.S., Ch. 1024.)

[Sections 1301.162-1301.200 reserved for expansion]

SUBCHAPTER E. CERTAIN HEALTH CARE PROVIDERS

Sec. 1301.201. CONTRACTS WITH AND REIMBURSEMENT FOR NURSE FIRST ASSISTANTS. A preferred provider may not refuse to:

(1) contract with a nurse first assistant, as defined by Section 301.1525, Occupations Code, to be included in the provider's network; or

(2) reimburse the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform. (V.T.I.C. Art. 3.70-3C, Sec. 3(o), as added Acts 75th Leg., R.S., Ch. 1024.)

[Chapters 1302-1350 reserved for expansion]

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1351. HOME HEALTH SERVICES

CHAPTER 1351. HOME HEALTH SERVICES

Sec. 1351.001. DEFINITIONS. In this chapter:

(1) "Health services" includes:

(A) skilled nursing by a registered nurse or a licensed vocational nurse under the supervision of at least one registered nurse and at least one physician;

(B) physical, occupational, speech, or

respiratory therapy;

(C) the services of a home health aide under the supervision of a registered nurse; and

(D) the furnishing of medical equipment and supplies other than drugs or medicines.

(2) "Home health agency" means a business that:

(A) provides home health services; and

(B) is licensed by the Texas Department of Human Services under Chapter 142, Health and Safety Code.

(3) "Home health services" means the provision of health services for payment or other consideration in a patient's residence under a plan of care that is:

(A) established, approved in writing, and reviewed at least every two months by the attending physician; and

(B) certified by the attending physician as necessary for medical purposes. (V.T.I.C. Art. 3.70-3B, Sec. 1.)

Sec. 1351.002. APPLICABILITY OF CHAPTER. (a) This chapter applies to a group health benefit plan that is delivered or issued for delivery in this state and that is a group policy of accident and health insurance, including a policy issued by a group hospital service corporation operating under Chapter 842.

(b) This chapter applies to an accident and health insurance policy issued by a stipulated premium company subject to Chapter 884. (V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part); Art. 3.70-8, Secs. (a) (part), (b).)

Sec. 1351.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating

to the applicability, purpose, and enforcement of that chapter, the construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this chapter. (New.)

Sec. 1351.004. EXCEPTION. This chapter does not apply to:

(1) a group policy of accident and health insurance that provides coverage only for:

(A) a specified disease or diseases;

(B) vision care;

(C) dental care;

(D) hospital indemnity;

(E) prescription drugs; or

(F) other limited benefits;

(2) a blanket insurance policy, as described by Chapter 1251;

(3) a short-term travel insurance policy;

(4) an accident-only insurance policy;

(5) a hospital indemnity insurance policy;

(6) a limited or specified disease insurance policy;

(7) an insurance policy or contract issued under a right of conversion; or

(8) an insurance policy or contract designed for issuance to a person eligible for Medicare coverage. (V.T.I.C. Art. 3.70-3B, Sec. 2(c).)

Sec. 1351.005. COVERAGE REQUIRED. Except as provided by Section 1351.008, a group health benefit plan must provide coverage for home health services provided by a home health agency.

(V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part).)

Sec. 1351.006. REIMBURSEMENT FOR HOME HEALTH SERVICES: PHYSICIAN CERTIFICATION REQUIRED. A group health benefit plan issuer may not provide reimbursement for home health services provided under the plan unless the attending physician certifies that hospitalization or confinement in a skilled facility would be required if a treatment plan for home health care were not provided. (V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part).)

Sec. 1351.007. LIMITATIONS AND EXCLUSIONS ON COVERAGE PERMITTED. (a) A group health benefit plan may include:

(1) a limitation on the number of visits for home health services for which benefits are payable, subject to Subsection (b);

(2) an exclusion for home health services coverage for:

(A) custodial care;

(B) services provided by an individual who:

(i) resides in the covered individual's home; or

(ii) is a member of the covered individual's family; or

(C) services provided to a covered individual who is eligible for Medicare coverage;

(3) annual deductible and coinsurance provisions for home health services coverage that are not less favorable than the deductible or coinsurance provisions applicable to hospital services coverage under the plan; and

(4) other coverage limitations or exclusions consistent with the remaining provisions of the plan.

(b) A limitation under Subsection (a)(1) may not limit each individual covered under the plan to fewer than 60 visits in any calendar year or continuous 12-month period.

(c) For purposes of this section, each of the following is considered to be one visit for home health services:

(1) a visit by a representative of a home health agency;

(2) four hours of home health aide service; and

(3) if home health aide service extends beyond four hours, each additional four hours or portion of that four-hour period. (V.T.I.C. Art. 3.70-3B, Secs. 3(a), (b), (c).)

Sec. 1351.008. REJECTION OF COVERAGE BY PLAN HOLDER; NEGOTIATION OF ALTERNATIVE COVERAGE. (a) If the holder of a group health benefit plan rejects in writing the coverage required under this chapter, the plan issuer:

(1) may not include the coverage in the plan; and

(2) is not required to:

(A) offer the coverage to the plan holder; or

(B) provide the coverage under the plan.

(b) If a plan holder rejects in writing the coverage required under this chapter, the plan holder and the plan issuer may negotiate coverage for home health services other than the coverage required under this chapter. (V.T.I.C. Art. 3.70-3B, Sec. 2(b).)

Sec. 1351.009. ADDITIONAL COVERAGE NOT PRECLUDED. This chapter does not preclude a group health benefit plan issuer from

providing coverage for home health services that exceeds the coverage required under this chapter. (V.T.I.C. Art. 3.70-3B, Sec. 3(d).)

CHAPTER 1352. BRAIN INJURY

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Sec. 1352.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

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

(7) a health maintenance organization operating under Chapter 843;

(8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53Q, Secs. 1(a), (b).)

Sec. 1352.002. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit other than an accident policy;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1352.001. (V.T.I.C. Art. 21.53Q, Sec. 1(c).)

Sec. 1352.003. EXCLUSION OF COVERAGE PROHIBITED. (a) A health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, or psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

(b) Coverage required under this chapter may be subject to deductibles, copayments, coinsurance, or annual or maximum payment limits that are consistent with the deductibles, copayments, coinsurance, or annual or maximum payment limits applicable to other similar coverage provided under the health benefit plan.

(c) The commissioner shall adopt rules as necessary to implement this section. (V.T.I.C. Art. 21.53Q, Sec. 2.)

Sec. 1352.004. TRAINING FOR CERTAIN PERSONNEL REQUIRED. (a) In this section, "preauthorization" means the provision of a reliable representation to a physician or health care provider of whether a health benefit plan issuer will pay the physician or provider for proposed medical or health care services if the physician or provider provides those services to the patient for

whom the services are proposed. The term includes precertification, certification, recertification, or any other activity that involves providing a reliable representation by the issuer to a physician or health care provider.

(b) The commissioner by rule shall require a health benefit plan issuer to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan. The purpose of the training is to prevent denial of coverage in violation of Section 1352.003 and to avoid confusion of medical benefits with mental health benefits. (V.T.I.C. Art. 21.53Q, Sec. 3.)

CHAPTER 1353. IMMUNIZATION OR VACCINATION PROTOCOLS UNDER MANAGED CARE PLANS

CHAPTER 1353. IMMUNIZATION OR VACCINATION PROTOCOLS UNDER MANAGED CARE PLANS

Sec. 1353.001. PROHIBITED CONDUCT. A managed care entity may not:

(1) require a physician participating in a managed care plan to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee in the plan;

(2) limit an enrollee's benefits for immunizations or vaccinations to circumstances in which an immunization or vaccination protocol is issued;

(3) provide a financial incentive to a physician to

issue an immunization or vaccination protocol; or

(4) impose a financial or other penalty on a physician who refuses to issue an immunization or vaccination protocol. (V.T.I.C. Art. 21.53K, Sec. 1.)

Sec. 1353.002. RULES. The commissioner may adopt rules to implement this chapter. (V.T.I.C. Art. 21.53K, Sec. 2.)

CHAPTER 1354. ELIGIBILITY FOR BENEFITS FOR ALZHEIMER'S DISEASE

CHAPTER 1354. ELIGIBILITY FOR BENEFITS FOR ALZHEIMER'S DISEASE

Sec. 1354.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides coverage for Alzheimer's disease; and

(2) is an individual or group policy, contract, certificate, or evidence of coverage that is delivered or issued for delivery in this state by an insurer or a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.78 (part).)

Sec. 1354.002. PROOF OF ORGANIC DISEASE. If a health benefit plan requires demonstrable proof of organic disease or other proof before the health benefit plan issuer will authorize payment of benefits for Alzheimer's disease, that proof requirement is satisfied by a clinical diagnosis of Alzheimer's disease made by a physician licensed in this state, including a history and physical, neurological, and psychological or psychiatric evaluations, and laboratory studies. (V.T.I.C. Art. 3.78 (part).)

CHAPTER 1355. BENEFITS FOR CERTAIN MENTAL DISORDERS

CHAPTER 1355. BENEFITS FOR CERTAIN MENTAL DISORDERS

SUBCHAPTER A. GROUP HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN SERIOUS MENTAL ILLNESSES

Sec. 1355.001. DEFINITIONS. In this subchapter:

(1) "Serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

(A) bipolar disorders (hypomanic, manic, depressive, and mixed);

(B) depression in childhood and adolescence;

(C) major depressive disorders (single episode or recurrent);

(D) obsessive-compulsive disorders;

(E) paranoid and other psychotic disorders;

(F) pervasive developmental disorders;

(G) schizo-affective disorders (bipolar or depressive); and

(H) schizophrenia.

(2) "Small employer" has the meaning assigned by Section 1501.002. (V.T.I.C. Art. 3.51-14, Secs. 1(1), (3).)

Sec. 1355.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) a group insurance policy, group insurance agreement, group hospital service contract, or group evidence of coverage that is offered by:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884; or

(E) a health maintenance organization operating under Chapter 843; and

(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a plan offered under:

(A) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(B) another analogous benefit arrangement. (V.T.I.C. Art. 3.51-14, Sec. 2(a).)

Sec. 1355.003. EXCEPTION. (a) This subchapter does not apply to coverage under:

(1) a blanket accident and health insurance policy, as described by Chapter 1251;

(2) a short-term travel policy;

(3) an accident-only policy;

(4) a limited or specified-disease policy that does not provide benefits for mental health care or similar services;

(5) except as provided by Subsection (b), a plan offered under Chapter 1551 or Chapter 1601;

(6) a plan offered in accordance with Section 1355.151; or

(7) a Medicare supplement benefit plan, as defined by Section 1652.002.

(b) For the purposes of a plan described by Subsection (a)(5), "serious mental illness" has the meaning assigned by Section 1355.001. (V.T.I.C. Art. 3.51-14, Sec. 2(b).)

Sec. 1355.004. REQUIRED COVERAGE FOR SERIOUS MENTAL ILLNESS. (a) A group health benefit plan:

(1) must provide coverage, based on medical necessity, for not less than the following treatments of serious mental illness in each calendar year:

(A) 45 days of inpatient treatment; and

(B) 60 visits for outpatient treatment, including group and individual outpatient treatment;

(2) may not include a lifetime limitation on the number of days of inpatient treatment or the number of visits for outpatient treatment covered under the plan; and

(3) must include the same amount limitations, deductibles, copayments, and coinsurance factors for serious mental illness as the plan includes for physical illness.

(b) A group health benefit plan issuer:

(1) may not count an outpatient visit for medication management against the number of outpatient visits required to be covered under Subsection (a)(1)(B); and

(2) must provide coverage for an outpatient visit described by Subsection (a)(1)(B) under the same terms as the coverage the issuer provides for an outpatient visit for the treatment of physical illness. (V.T.I.C. Art. 3.51-14, Secs. 3(a),

(b).)

Sec. 1355.005. MANAGED CARE PLAN AUTHORIZED. A group health benefit plan issuer may provide or offer coverage required by Section 1355.004 through a managed care plan. (V.T.I.C. Art. 3.51-14, Sec. 3(c).)

Sec. 1355.006. COVERAGE FOR CERTAIN CONDITIONS RELATED TO CONTROLLED SUBSTANCE OR MARIHUANA NOT REQUIRED. (a) In this section, "controlled substance" and "marihuana" have the meanings assigned by Section 481.002, Health and Safety Code.

(b) This subchapter does not require a group health benefit plan to provide coverage for the treatment of:

(1) addiction to a controlled substance or marihuana that is used in violation of law; or

(2) mental illness that results from the use of a controlled substance or marihuana in violation of law. (V.T.I.C. Art. 3.51-14, Sec. 5.)

Sec. 1355.007. SMALL EMPLOYER COVERAGE. An issuer of a group health benefit plan to a small employer must offer the coverage described by Section 1355.004 to the employer but is not required to provide the coverage if the employer rejects the coverage. (V.T.I.C. Art. 3.51-14, Sec. 4.)

[Sections 1355.008-1355.050 reserved for expansion]

SUBCHAPTER B. ALTERNATIVE MENTAL HEALTH TREATMENT BENEFITS

Sec. 1355.051. DEFINITIONS. In this subchapter:

(1) "Crisis stabilization unit" means a 24-hour residential program that provides, usually for a short term,

intensive supervision and highly structured activities to individuals who demonstrate a moderate to severe acute psychiatric crisis.

(2) "Individual treatment plan" means a treatment plan with specific attainable goals and objectives that are appropriate to:

(A) the patient; and

(B) the program's treatment modality.

(3) "Residential treatment center for children and adolescents" means a child-care institution that:

(A) is accredited as a residential treatment center by:

(i) the Council on Accreditation;

(ii) the Joint Commission on Accreditation of Healthcare Organizations; or

(iii) the American Association of Psychiatric Services for Children; and

(B) provides residential care and treatment for emotionally disturbed children and adolescents. (V.T.I.C. Art. 3.72, Subsec. (a).)

Sec. 1355.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group health benefit plan that is delivered or issued for delivery in this state and that is:

(1) an accident and health insurance group policy;

(2) a group policy issued by a group hospital service corporation operating under Chapter 842; or

(3) a group health care plan provided by a health

maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.72, Subsec. (b) (part).)

Sec. 1355.053. REQUIRED COVERAGE FOR CERTAIN ILLNESSES AND DISORDERS. A group health benefit plan that provides coverage for treatment of mental or emotional illness or disorder for a covered individual when the individual is confined in a hospital must also provide coverage for treatment in a residential treatment center for children and adolescents or a crisis stabilization unit that is at least as favorable as the coverage the plan provides for treatment of mental or emotional illness or disorder in a hospital. (V.T.I.C. Art. 3.72, Subsec. (b) (part).)

Sec. 1355.054. CONDITIONS FOR COVERAGE. (a) Benefits of coverage provided under this subchapter may be used only in a situation in which:

(1) the covered individual has a serious mental illness that requires confinement of the individual in a hospital unless treatment is available through a residential treatment center for children and adolescents or a crisis stabilization unit; and

(2) the covered individual's mental illness:

(A) substantially impairs the individual's thought, perception of reality, emotional process, or judgment; or

(B) as manifested by the individual's recent disturbed behavior, grossly impairs the individual's behavior.

(b) The service for which benefits are to be paid from coverage provided under this subchapter must be:

(1) based on an individual treatment plan for the

covered individual; and

(2) provided by a service provider licensed or operated by the appropriate state agency to provide those services.

(c) Benefits under coverage provided under this subchapter are subject to the same benefit maximums, durational limitations, deductibles, and coinsurance factors that apply to inpatient psychiatric treatment under the coverage. (V.T.I.C. Art. 3.72, Subsec. (c).)

Sec. 1355.055. DETERMINATIONS FOR TREATMENT IN A RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS. (a) Treatment in a residential treatment center for children and adolescents must be determined as if necessary care and treatment were inpatient care and treatment in a hospital.

(b) For the purposes of determining policy benefits and benefit maximums, each two days of treatment in a residential treatment center for children and adolescents is the equivalent of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program. (V.T.I.C. Art. 3.72, Subsec. (d).)

Sec. 1355.056. DETERMINATIONS FOR TREATMENT BY A CRISIS STABILIZATION UNIT. (a) Treatment by a crisis stabilization unit must be determined as if necessary care and treatment were inpatient care and treatment in a hospital.

(b) For the purposes of determining plan benefits and benefit maximums, each two days of treatment in a crisis stabilization unit is the equivalent of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program.

(c) Treatment provided to an individual by a crisis stabilization unit licensed or certified by the Texas Department of Mental Health and Mental Retardation shall be reimbursed. (V.T.I.C. Art. 3.72, Subsec. (e).)

Sec. 1355.057. REVIEW AND ADJUSTMENT OF MINIMUM RATIOS OF REIMBURSEMENT. (a) The commissioner shall monitor and review the minimum ratios of reimbursement for alternative treatments required by Sections 1355.055 and 1355.056.

(b) If the commissioner finds that the limits provided by this subchapter are creating an artificial increase in the costs of services, the commissioner by rule may adjust the ratios to the extent necessary to prevent the artificial increase.

(c) Before the commissioner adjusts a ratio under Subsection (b), the commissioner must give notice and hold a hearing to:

(1) consider information related to the adjustment; and

(2) determine whether the information justifies the adjustment.

(d) The department shall review the reimbursement ratios at least every two years. (V.T.I.C. Art. 3.72, Subsec. (f) (part).)

Sec. 1355.058. ASSISTANCE OF THE TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION. (a) The Texas Department of Mental Health and Mental Retardation shall assist the department in carrying out the department's responsibilities under this subchapter.

(b) The department and the Texas Department of Mental Health

and Mental Retardation by rule may adopt a memorandum of understanding to carry out this subchapter. (V.T.I.C. Art. 3.72, Subsec. (g).)

[Sections 1355.059-1355.100 reserved for expansion]

SUBCHAPTER C. PSYCHIATRIC DAY TREATMENT FACILITIES

Sec. 1355.101. DEFINITION. In this subchapter, "psychiatric day treatment facility" means a mental health facility that:

(1) provides treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program using individualized treatment plans with specific attainable goals and objectives that are appropriate to the patient and the program's treatment modality; and

(2) is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

Sec. 1355.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group policy of accident and health insurance delivered or issued for delivery in this state, including a group policy issued by a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

Sec. 1355.103. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply

to this subchapter. (New.)

Sec. 1355.104. REQUIRED COVERAGE FOR TREATMENT IN PSYCHIATRIC DAY TREATMENT FACILITY. (a) A group insurance policy that provides coverage for treatment of mental or emotional illness or disorder when an individual is confined in a hospital must also provide coverage for treatment obtained under the direction and continued medical supervision of a doctor of medicine or doctor of osteopathy in a psychiatric day treatment facility that provides organizational structure and individualized treatment plans separate from an inpatient program.

(b) The psychiatric day treatment facility coverage required by this section may not be less favorable than the hospital coverage and must be subject to the same durational limits, deductibles, and coinsurance factors.

(c) A group insurance policy subject to this section may require that:

(1) the treatment obtained in a psychiatric day treatment facility be provided by a facility that treats a patient for not more than 8 hours in any 24-hour period;

(2) the attending physician certify that the treatment is in lieu of hospitalization; and

(3) the psychiatric day treatment facility be accredited by the Program for Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Healthcare Organizations. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

Sec. 1355.105. DETERMINATIONS FOR TREATMENT IN PSYCHIATRIC DAY TREATMENT FACILITY. (a) Benefits provided under this

subchapter shall be determined as if necessary care and treatment in a psychiatric day treatment facility were inpatient care and treatment in a hospital.

(b) For the purpose of determining policy benefits and benefit maximums, each full day of treatment in a psychiatric day treatment facility is the equivalent of one-half of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

Sec. 1355.106. OFFER OF COVERAGE REQUIRED; ALTERNATIVE BENEFITS. (a) An insurer shall offer, and a policyholder is entitled to reject, coverage under a group insurance policy for treatment of mental or emotional illness or disorder when confined in a hospital or in a psychiatric day treatment facility.

(b) A policyholder may select an alternative level of benefits under the group insurance policy if the alternative level is offered by or negotiated with the insurer.

(c) The alternative level of benefits must provide policy benefits and benefit maximums for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for treatment in a hospital, except that benefits for treatment in a psychiatric day treatment facility may not exceed the usual and customary charges of the facility. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

[Sections 1355.107-1355.150 reserved for expansion]

SUBCHAPTER D. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

Sec. 1355.151. PROHIBITION ON EXCLUSION OR LIMITATION OF CERTAIN COVERAGES. (a) In this section, "serious mental illness"

has the meaning assigned by Section 1355.001.

(b) A political subdivision that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to the political subdivision's officers or employees may not contract for or provide coverage that is less extensive for serious mental illness than the coverage provided for any other physical illness. (V.T.I.C. Art. 3.51-5A, Subsecs. (a) (part), (b).)

[Sections 1355.152-1355.200 reserved for expansion]

SUBCHAPTER E. BENEFITS FOR TREATMENT BY TAX-SUPPORTED INSTITUTION

Sec. 1355.201. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

Sec. 1355.202. PROHIBITION OF EXCLUSION OF MENTAL HEALTH OR MENTAL RETARDATION BENEFITS FOR TREATMENT BY TAX-SUPPORTED INSTITUTION. (a) An individual or group accident and health insurance policy delivered or issued for delivery to a person in this state that provides coverage for mental illness or mental retardation may not exclude benefits under that coverage for support, maintenance, and treatment provided by a tax-supported institution of this state, or by a community center for mental health or mental retardation services, that regularly and customarily charges patients who are not indigent for those services.

(b) In determining whether a patient is not indigent, as provided by Subchapter B, Chapter 552, Health and Safety Code, a tax-supported institution of this state or a community center for mental health or mental retardation services shall consider any insurance policy or policies that provide coverage to the patient for mental illness or mental retardation. (V.T.I.C. Art. 3.70-2, Sec. (D).)

CHAPTER 1356. LOW-DOSE MAMMOGRAPHY

CHAPTER 1356. LOW-DOSE MAMMOGRAPHY

Sec. 1356.001. DEFINITION. In this chapter, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Sec. 1356.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that is delivered, issued for delivery, or renewed in this state and that is an individual or group accident and health insurance policy, including a policy issued by a group hospital service corporation operating under

Chapter 842. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Sec. 1356.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this chapter. (New.)

Sec. 1356.004. EXCEPTION. This chapter does not apply to a plan that provides coverage only for a specified disease or for another limited benefit. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Sec. 1356.005. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage to a female who is 35 years of age or older must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer.

(b) Coverage required by this section:

(1) may not be less favorable than coverage for other radiological examinations under the plan; and

(2) must be subject to the same dollar limits, deductibles, and coinsurance factors as coverage for other radiological examinations under the plan. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

CHAPTER 1357. MASTECTOMY

SUBCHAPTER A. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

Sec. 1357.001. DEFINITIONS

CHAPTER 1357. MASTECTOMY

SUBCHAPTER A. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

Sec. 1357.001. DEFINITIONS. In this subchapter:

(1) "Breast reconstruction" means reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy has been performed and surgical reconstruction of a breast on which mastectomy has not been performed.

(2) "Enrollee" means an individual entitled to coverage under a health benefit plan. (V.T.I.C. Art. 21.53I, Secs.

1(2), (3).)

Sec. 1357.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53I, Sec. 2(a).)

Sec. 1357.003. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or another limited benefit, other than benefits for cancer;

(B) only for accidental death or dismemberment;

(C) only for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) only for credit insurance;

(E) only for dental or vision care;

(F) only for indemnity for hospital confinement; or

(G) as a supplement to a liability insurance policy;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1357.002. (V.T.I.C. Art. 21.53I, Sec. 2(b).)

Sec. 1357.004. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for mastectomy must provide coverage for:

(1) reconstruction of the breast on which the

mastectomy has been performed;

(2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

(3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

(b) Coverage required under this section:

(1) shall be provided in a manner determined to be appropriate in consultation with the attending physician and the enrollee;

(2) may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan; and

(3) may not be subject to dollar limits other than the lifetime maximum benefits under the plan. (V.T.I.C. Art. 21.53I, Sec. 3.)

Sec. 1357.005. PROHIBITED CONDUCT. (a) An issuer of a health benefit plan may not:

(1) offer a financial incentive for an enrollee to not receive breast reconstruction or to waive the coverage required under this subchapter;

(2) condition, limit, or deny the eligibility of a person to enroll in the plan or to renew coverage under the terms of the plan solely to avoid the requirements of this subchapter; or

(3) reduce or limit the reimbursement or amount paid to, or otherwise penalize, an attending physician or provider or provide a financial incentive or other benefit to an attending

physician or provider to induce the physician or provider to provide care to an enrollee in a manner that is inconsistent with this subchapter.

(b) This section does not prevent an issuer of a health benefit plan from negotiating with a physician or provider the level and type of reimbursement that the physician or provider will receive for care provided in accordance with this subchapter. (V.T.I.C. Art. 21.53I, Sec. 4.)

Sec. 1357.006. NOTICE OF COVERAGE. (a) An issuer of a health benefit plan that provides coverage under this subchapter shall provide to each enrollee notice of the availability of the coverage.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.53I, Sec. 5.)

Sec. 1357.007. RULES. The commissioner may adopt rules to implement this subchapter and to meet the minimum requirements of federal law. (V.T.I.C. Art. 21.53I, Sec. 7.)

[Sections 1357.008-1357.050 reserved for expansion]

SUBCHAPTER B. HOSPITAL STAY FOLLOWING MASTECTOMY AND CERTAIN RELATED PROCEDURES

Sec. 1357.051. DEFINITION. In this subchapter, "enrollee" means an individual entitled to coverage under a health benefit plan. (V.T.I.C. Art. 21.52G, Sec. 1(1), as added Acts 75th Leg., R.S., Ch. 725.)

Sec. 1357.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses

incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides coverage only for a specific disease or condition or for hospitalization. (V.T.I.C. Art. 21.52G, Secs.

2(a), (b), as added Acts 75th Leg., R.S., Ch. 725.)

Sec. 1357.053. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for accidental death or dismemberment;

(B) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(C) as a supplement to a liability insurance policy;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1357.052. (V.T.I.C. Art. 21.52G, Sec. 2(c), as added Acts 75th Leg., R.S., Ch. 725.)

Sec. 1357.054. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for the treatment of breast cancer must provide to each enrollee coverage for inpatient care for a minimum of:

(1) 48 hours following a mastectomy; and

(2) 24 hours following a lymph node dissection for the treatment of breast cancer.

(b) A health benefit plan is not required to provide the minimum hours of coverage of inpatient care required under Subsection (a) if the enrollee and the enrollee's attending physician determine that a shorter period of inpatient care is appropriate. (V.T.I.C. Art. 21.52G, Sec. 3, as added Acts 75th Leg., R.S., Ch. 725.)

Sec. 1357.055. PROHIBITED CONDUCT. An issuer of a health benefit plan may not:

(1) deny the eligibility or continued eligibility of an individual to enroll in the plan or renew coverage under the plan solely to avoid the requirements of this subchapter;

(2) provide money payments or rebates to an enrollee to encourage the enrollee to accept less than the minimum coverage required under this subchapter;

(3) reduce or limit the amount paid to an attending physician, or otherwise penalize the physician, because the physician provided care to an enrollee in accordance with this subchapter; or

(4) provide financial or other incentives to an attending physician to encourage the physician to provide care to an enrollee in a manner inconsistent with this subchapter. (V.T.I.C. Art. 21.52G, Sec. 4, as added Acts 75th Leg., R.S., Ch. 725.)

Sec. 1357.056. NOTICE OF COVERAGE. (a) An issuer of a

health benefit plan shall provide to each enrollee written notice of the coverage required under this subchapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.52G, Sec. 5, as added Acts 75th Leg., R.S., Ch. 725.)

Sec. 1357.057. RULES. The commissioner shall adopt rules necessary to administer this subchapter. (V.T.I.C. Art. 21.52G, Sec. 6, as added Acts 75th Leg., R.S., Ch. 725.)

CHAPTER 1358. DIABETES

SUBCHAPTER A. GUIDELINES FOR DIABETES CARE; MINIMUM COVERAGE REQUIRED

[Sections 1358.006-1358.050 reserved for expansion]

SUBCHAPTER B. SUPPLIES AND SERVICES ASSOCIATED WITH DIABETES TREATMENT

CHAPTER 1358. DIABETES

SUBCHAPTER A. GUIDELINES FOR DIABETES CARE; MINIMUM COVERAGE REQUIRED

Sec. 1358.001. DEFINITION. In this subchapter, "enrollee" means an individual entitled to coverage under a health benefit plan. (V.T.I.C. Art. 21.53D, Sec. 1(1), as added Acts 75th Leg., R.S., Ch. 1285.)

Sec. 1358.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884; or

(E) a health maintenance organization operating under Chapter 843;

(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(A) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(B) another analogous benefit arrangement; and

(3) health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53D, Sec. 2(a), as added Acts 75th Leg., R.S., Ch. 1285.)

Sec. 1358.003. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) only for dental or vision care; or

(F) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1358.002. (V.T.I.C. Art. 21.53D, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 1285.)

Sec. 1358.004. ADOPTION OF MINIMUM STANDARDS. The commissioner, in consultation with the Texas Diabetes Council, by rule shall adopt minimum standards for coverage provided to an enrollee with diabetes. (V.T.I.C. Art. 21.53D, Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 1285.)

Sec. 1358.005. COVERAGE REQUIRED. (a) A health benefit plan must provide coverage in accordance with the standards adopted under Section 1358.004.

(b) Coverage required under this section may not be subject to a deductible, coinsurance, or copayment requirement that exceeds the deductible, coinsurance, or copayment requirement applicable to other similar coverage provided under the health benefit plan. (V.T.I.C. Art. 21.53D, Secs. 3(b), (c), as added Acts 75th Leg., R.S., Ch. 1285.)

[Sections 1358.006-1358.050 reserved for expansion]

SUBCHAPTER B. SUPPLIES AND SERVICES ASSOCIATED WITH DIABETES TREATMENT

Sec. 1358.051. DEFINITIONS. In this subchapter:

(1) "Diabetes equipment" means:

(A) blood glucose monitors, including monitors designed to be used by blind individuals;

(B) insulin pumps and associated appurtenances;

(C) insulin infusion devices; and

(D) podiatric appliances for the prevention of complications associated with diabetes.

(2) "Diabetes supplies" means:

(A) test strips for blood glucose monitors;

(B) visual reading and urine test strips;

(C) lancets and lancet devices;

(D) insulin and insulin analogs;

(E) injection aids;

(F) syringes;

(G) prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and

(H) glucagon emergency kits.

(3) "Nutrition counseling" has the meaning assigned by Section 701.002, Occupations Code.

(4) "Qualified enrollee" means an individual eligible for coverage under a health benefit plan who has been diagnosed with:

(A) insulin dependent or noninsulin dependent diabetes;

(B) elevated blood glucose levels induced by pregnancy; or

(C) another medical condition associated with elevated blood glucose levels. (V.T.I.C. Art. 21.53G, Secs. 1(1), (2), (4), (5).)

Sec. 1358.052. APPLICABILITY OF SUBCHAPTER. This

subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

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

(v) a reciprocal exchange operating under Chapter 942; or

(vi) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53G, Sec. 2(a).)

Sec. 1358.053. EXCEPTION. This subchapter does not apply

to:

(1) a plan that provides coverage:

(A) only for a specified disease or another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1358.052. (V.T.I.C. Art. 21.53G, Sec. 2(b).)

Sec. 1358.054. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for the treatment of diabetes and

conditions associated with diabetes must provide to each qualified enrollee coverage for:

(1) diabetes equipment;

(2) diabetes supplies; and

(3) diabetes self-management training in accordance with the requirements of Section 1358.055.

(b) A health benefit plan may require a deductible, copayment, or coinsurance for coverage provided under this section. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for treatment of other analogous chronic medical conditions. (V.T.I.C. Art. 21.53G, Secs. 3, 6.)

Sec. 1358.055. DIABETES SELF-MANAGEMENT TRAINING. (a) Diabetes self-management training must be provided by a health care practitioner or provider who is:

(1) licensed, registered, or certified in this state to provide appropriate health care services; and

(2) acting within the scope of practice authorized by the license, registration, or certification.

(b) For purposes of this subchapter, "self-management training" includes:

(1) training provided to a qualified enrollee, after the initial diagnosis of diabetes, in the care and management of that condition, including nutrition counseling and counseling on the proper use of diabetes equipment and supplies;

(2) additional training authorized on the diagnosis of a physician or other health care practitioner of a significant

change in the qualified enrollee's symptoms or condition that requires changes in the qualified enrollee's self-management regime; and

(3) periodic or episodic continuing education training prescribed by an appropriate health care practitioner as warranted by the development of new techniques or treatments for diabetes.

(c) If the diabetes self-management training is provided on the written order of a physician or other health care practitioner, including a health care practitioner practicing under protocols jointly developed with a physician, the training must also include:

(1) a diabetes self-management training program recognized by the American Diabetes Association;

(2) diabetes self-management training provided by a multidisciplinary team:

(A) the nonphysician members of which are coordinated by:

(i) a diabetes educator who is certified by the National Certification Board for Diabetes Educators; or

(ii) an individual who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;

(B) that consists of at least a licensed dietitian and a registered nurse and may include a pharmacist and a social worker; and

(C) each member of which, other than a social worker, has recent didactic and experiential preparation in diabetes clinical and educational issues as determined by the member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training;

(3) diabetes self-management training provided by a diabetes educator certified by the National Certification Board for Diabetes Educators; or

(4) diabetes self-management training that provides one or more of the following components:

(A) a nutrition counseling component provided by a licensed dietitian, for which the licensed dietitian shall be paid;

(B) a pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid;

(C) a component provided by a physician assistant or registered nurse, for which the physician assistant or registered nurse shall be paid, except that the physician assistant or registered nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or

(D) a component provided by a physician.

(d) An individual may not provide a component of diabetes

self-management training under Subsection (c)(4) unless:

(1) the subject matter of the component is within the scope of the individual's practice; and

(2) the individual meets the education requirements, as determined by the individual's licensing agency in consultation with the commissioner of public health. (V.T.I.C. Art. 21.53G, Sec. 4.)

Sec. 1358.056. COVERAGE FOR NEW OR IMPROVED EQUIPMENT AND SUPPLIES. A health benefit plan must provide coverage for new or improved diabetes equipment or supplies, including improved insulin or another prescription drug, approved by the United States Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate. (V.T.I.C. Art. 21.53G, Sec. 5.)

Sec. 1358.057. RULES. (a) The commissioner shall adopt rules necessary to implement this subchapter.

(b) In adopting rules under this section, the commissioner may consult with the commissioner of public health and other appropriate entities. (V.T.I.C. Art. 21.53G, Sec. 7.)

CHAPTER 1359. FORMULAS FOR INDIVIDUALS WITH PHENYLKETONURIA OR OTHER HERITABLE DISEASES

CHAPTER 1359. FORMULAS FOR INDIVIDUALS WITH PHENYLKETONURIA OR OTHER HERITABLE DISEASES

Sec. 1359.001. DEFINITIONS. In this chapter:

(1) "Heritable disease" means an inherited disease that may result in mental or physical retardation or death.

(2) "Phenylketonuria" means an inherited condition that, if not treated, may cause severe mental retardation. (V.T.I.C. Art. 3.79, Secs. 1(2), (3).)

Sec. 1359.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that is a group policy, contract, or certificate of health insurance or an evidence of coverage delivered, issued for delivery, or renewed in this state by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842; or

(3) a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.79, Sec. 1(1).)

Sec. 1359.003. COVERAGE REQUIRED. (a) A group health benefit plan must provide coverage for formulas necessary to treat phenylketonuria or a heritable disease.

(b) The group health benefit plan must provide the coverage to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician. (V.T.I.C. Art. 3.79, Sec. 2.)

CHAPTER 1360. DIAGNOSIS AND TREATMENT AFFECTING TEMPOROMANDIBULAR JOINT

Sec. 1360.003. EXCEPTION

Sec. 1360.004. COVERAGE REQUIRED

Sec. 1360.005. DENTAL SERVICES COVERAGE NOT REQUIRED

CHAPTER 1360. DIAGNOSIS AND TREATMENT AFFECTING TEMPOROMANDIBULAR JOINT

Sec. 1360.001. DEFINITION. In this chapter, "temporomandibular joint" includes the jaw and the craniomandibular joint. (V.T.I.C. Art. 21.53A, Sec. 3(a) (part).)

Sec. 1360.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan delivered or issued for delivery in this state that:

(1) provides benefits for dental, medical, or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee

Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act;

(ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53A, Secs. 2(a), 3(a) (part).)

Sec. 1360.003. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for vision care; or

(G) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by

Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy;

(4) a small employer health benefit plan written under Chapter 1501;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1360.002. (V.T.I.C. Art. 21.53A, Sec. 2(b).)

Sec. 1360.004. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for medically necessary diagnostic or surgical treatment of conditions affecting skeletal joints must provide comparable coverage for diagnostic or surgical treatment of conditions affecting the temporomandibular joint if the treatment is medically necessary as a result of:

(1) an accident;

(2) a trauma;

(3) a congenital defect;

(4) a developmental defect; or

(5) a pathology.

(b) Coverage required under this section may be subject to any provision in the health benefit plan that is generally applicable to surgical treatment, including a requirement for precertification of coverage. (V.T.I.C. Art. 21.53A, Secs. 3(a) (part), (b), (c).)

Sec. 1360.005. DENTAL SERVICES COVERAGE NOT REQUIRED. (a) This chapter does not require a health benefit plan to provide coverage for dental services if dental services are not otherwise scheduled or provided as part of the coverage provided under the plan.

(b) A health benefit plan may not exclude from coverage under the plan an individual who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the individual's physician or by the dentist providing the dental care. (V.T.I.C. Art. 21.53A, Sec. 4.)

CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

Sec. 1361.001. DEFINITION. In this chapter, "qualified enrollee" means an individual entitled to coverage under a group health benefit plan who is:

(1) a postmenopausal woman who is not receiving estrogen replacement therapy;

(2) an individual with:

(A) vertebral abnormalities;

(B) primary hyperparathyroidism; or

(C) a history of bone fractures; or

(3) an individual who is:

(A) receiving long-term glucocorticoid therapy;

or

(B) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy. (V.T.I.C. Art. 21.53C, Secs. (b), (c) (part).)

Sec. 1361.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan delivered, issued for delivery, or renewed in this state that provides coverage for medical or surgical expenses incurred as a result of accident or sickness, including:

(1) a group insurance policy;

(2) a group contract issued by a group hospital service corporation operating under Chapter 842; and

(3) a group contract issued by a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 21.53C, Sec. (a).)

Sec. 1361.003. COVERAGE REQUIRED. A group health benefit plan must provide to a qualified enrollee coverage for medically accepted bone mass measurement to detect low bone mass and to determine the enrollee's risk of osteoporosis and fractures associated with osteoporosis. (V.T.I.C. Art. 21.53C, Sec. (c) (part).)

CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

Sec. 1362.001. APPLICABILITY OF CHAPTER

Sec. 1362.002. EXCEPTION

Sec. 1362.003. COVERAGE REQUIRED

Sec. 1362.004. NOTICE OF COVERAGE

Sec. 1362.005. RULES

CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

Sec. 1362.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement;

(2) is offered by:

(A) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(B) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53F, Sec. 2(a), as added Acts 75th Leg., R.S., Ch. 1287.)

Sec. 1362.002. EXCEPTION. This chapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy; or

(E) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1362.001. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 1287.)

Sec. 1362.003. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for diagnostic medical procedures must provide to each male enrolled in the plan coverage for expenses for an annual medically recognized diagnostic examination for the detection of prostate cancer.

(b) Coverage required under this section includes at a minimum:

(1) a physical examination for the detection of prostate cancer; and

(2) a prostate-specific antigen test used for the detection of prostate cancer for each male who:

(A) is at least 50 years of age and is asymptomatic; or

(B) is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor. (V.T.I.C. Art. 21.53F, Sec. 3, as added Acts 75th Leg., R.S., Ch. 1287.)

Sec. 1362.004. NOTICE OF COVERAGE. (a) A health benefit plan issuer shall provide to each individual enrolled in the plan

written notice of the coverage required under this chapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.53F, Sec. 4, as added Acts 75th Leg., R.S., Ch. 1287.)

Sec. 1362.005. RULES. The commissioner shall adopt rules necessary to administer this chapter. (V.T.I.C. Art. 21.53F, Sec. 5, as added Acts 75th Leg., R.S., Ch. 1287.)

CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF COLORECTAL CANCER

CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF COLORECTAL CANCER

Sec. 1363.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation

operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

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

(v) a stipulated premium company operating under Chapter 884; or

(vi) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation operating under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53S, Sec. 2(a).)

Sec. 1363.002. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy; or

(E) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1363.001. (V.T.I.C. Art. 21.53S, Sec. 2(b).)

Sec. 1363.003. MINIMUM COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for screening medical procedures must provide to each individual enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer coverage for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer.

(b) The minimum coverage required under this section must

include:

(1) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or

(2) a colonoscopy performed every 10 years. (V.T.I.C. Art. 21.53S, Sec. 3.)

Sec. 1363.004. NOTICE OF COVERAGE. (a) A health benefit plan issuer shall provide to each individual enrolled in the plan written notice of the coverage required under this chapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.53S, Sec. 4.)

Sec. 1363.005. RULES. The commissioner shall adopt rules as necessary to administer this chapter. (V.T.I.C. Art. 21.53S, Sec. 5.)

CHAPTER 1364. COVERAGE PROVISIONS RELATING TO HIV, AIDS, OR HIV-RELATED ILLNESSES

SUBCHAPTER A. EXCLUSION FROM OR DENIAL OF COVERAGE PROHIBITED

Sec. 1364.001. APPLICABILITY OF SUBCHAPTER

Sec. 1364.002. EXCEPTION

Sec. 1364.003. PROHIBITION

Sec. 1364.004. RULES

[Sections 1364.005-1364.050 reserved for expansion]

SUBCHAPTER B. CANCELLATION OF GROUP COVERAGE PROHIBITED

Sec. 1364.051. DEFINITIONS

Sec. 1364.052. APPLICABILITY OF SUBCHAPTER

Sec. 1364.053. PROHIBITION

[Sections 1364.054-1364.100 reserved for expansion]

SUBCHAPTER C. CERTAIN COVERAGES PROVIDED BY LOCAL

GOVERNMENTS

Sec. 1364.101. PROHIBITION ON EXCLUSION OR LIMITATION OF COVERAGES

CHAPTER 1364. COVERAGE PROVISIONS RELATING TO HIV, AIDS, OR HIV-RELATED ILLNESSES

SUBCHAPTER A. EXCLUSION FROM OR DENIAL OF COVERAGE PROHIBITED

Sec. 1364.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that is delivered, issued for delivery, or renewed and that is:

(1) a group accident and health insurance policy;

(2) a group contract issued by a group hospital service corporation operating under Chapter 842; or

(3) a group evidence of coverage issued by a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.51-6, Sec. 3C (part), as added Acts 71st Leg., R.S., Ch. 1041, Sec. 14.)

Sec. 1364.002. EXCEPTION. This subchapter does not apply to:

(1) a credit accident and health insurance policy subject to Chapter 1153;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance before April 1, 1975;

(3) accident or health coverage that is incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the department; or

(4) any policy or contract of insurance with a state agency, department, or board providing health services:

(A) to eligible individuals under Chapter 32, Human Resources Code; or

(B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

Sec. 1364.003. PROHIBITION. A group health benefit plan may not exclude or deny coverage for:

(1) human immunodeficiency virus (HIV);

(2) acquired immune deficiency syndrome (AIDS); or

(3) an HIV-related illness. (V.T.I.C. Art. 3.51-6, Sec. 3C (part), as added Acts 71st Leg., R.S., Ch. 1041, Sec. 14.)

Sec. 1364.004. RULES. The commissioner may adopt rules necessary to administer this subchapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C. Art. 3.51-6, Sec. 5.)

[Sections 1364.005-1364.050 reserved for expansion]

SUBCHAPTER B. CANCELLATION OF GROUP COVERAGE PROHIBITED

Sec. 1364.051. DEFINITIONS. In this subchapter, "AIDS" and "HIV" have the meanings assigned by Section 81.101, Health and Safety Code. (V.T.I.C. Art. 3.51-6D, Subsec. (a) (part).)

Sec. 1364.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies to an insurer that delivers or issues for delivery a group health insurance policy or contract in this state, including a group hospital service corporation operating under

Chapter 842. (V.T.I.C. Art. 3.51-6D, Subsec. (a) (part).)

Sec. 1364.053. PROHIBITION. (a) Except as provided by Subsection (b), an insurer may not cancel during the term of a group health insurance policy or contract an individual's coverage provided by the policy or contract because the individual:

(1) has been diagnosed as having AIDS or HIV;

(2) has been treated for AIDS or HIV; or

(3) is being treated for AIDS or HIV.

(b) The insurer may cancel the coverage provided by the policy or contract for fraud or misrepresentation in the obtaining of coverage by failure to disclose a diagnosis of AIDS or an HIV-related condition. (V.T.I.C. Art. 3.51-6D, Subsecs. (a) (part), (b).)

[Sections 1364.054-1364.100 reserved for expansion]

SUBCHAPTER C. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

Sec. 1364.101. PROHIBITION ON EXCLUSION OR LIMITATION OF COVERAGES. A political subdivision that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to the political subdivision's officers or employees may not contract for or provide coverage that excludes or limits coverage or services for:

(1) acquired immune deficiency syndrome, as defined by the Centers for Disease Control and Prevention of the United States Public Health Service; or

(2) human immunodeficiency virus infection. (V.T.I.C. Art. 3.51-5A, Subsec. (a) (part).)

CHAPTER 1365. LOSS OR IMPAIRMENT OF SPEECH OR HEARING

Sec. 1365.001. APPLICABILITY OF CHAPTER

Sec. 1365.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW

Sec. 1365.003. OFFER OF COVERAGE REQUIRED

Sec. 1365.004. RIGHT TO REJECT COVERAGE OR SELECT ALTERNATIVE COVERAGE

CHAPTER 1365. LOSS OR IMPAIRMENT OF SPEECH OR HEARING

Sec. 1365.001. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that provides hospital and medical coverage on an expense-incurred, service, or prepaid basis, including a group policy, contract, or plan that is offered in this state by:

(1) an insurer;

(2) a group hospital service corporation operating under Chapter 842; or

(3) a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

Sec. 1365.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this chapter. (New.)

Sec. 1365.003. OFFER OF COVERAGE REQUIRED. (a) A group health benefit plan issuer shall offer and make available under the plan coverage for the necessary care and treatment of loss or

impairment of speech or hearing.

(b) Coverage required under this section:

(1) may not be less favorable than coverage for physical illness generally under the plan; and

(2) must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as coverage for physical illness generally under the plan. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

Sec. 1365.004. RIGHT TO REJECT COVERAGE OR SELECT ALTERNATIVE COVERAGE. An offer of coverage required under Section 1365.003 is subject to the right of the group contract holder to reject the coverage or to select an alternative level of coverage that is offered by or negotiated with the group health benefit plan issuer. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

SUBCHAPTER A. COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES

Sec. 1366.001. APPLICABILITY OF SUBCHAPTER

Sec. 1366.002. EXCEPTION

Sec. 1366.003. OFFER OF COVERAGE REQUIRED

Sec. 1366.004. REJECTION OF OFFER

Sec. 1366.005. CONDITIONS APPLICABLE TO COVERAGE

Sec. 1366.006. CERTAIN ISSUERS OF HEALTH BENEFIT PLANS NOT REQUIRED TO OFFER COVERAGE

Sec. 1366.007. RULES

[Sections 1366.008-1366.050 reserved for expansion]

SUBCHAPTER B. MINIMUM INPATIENT STAY FOLLOWING BIRTH OF CHILD AND POSTDELIVERY CARE

CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

SUBCHAPTER A. COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES

Sec. 1366.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides benefits for hospital, medical, or surgical expenses incurred as a result of accident or sickness, including a group health insurance policy, health care service contract or plan, or other provision of group health benefits, coverage, or services in this state that is issued, entered into, or provided by:

(1) an insurer;

(2) a group hospital service corporation operating under Chapter 842;

(3) a health maintenance organization operating under Chapter 843; or

(4) an employer, multiple employer, union, association, trustee, or other self-funded or self-insured welfare or benefit plan, program, or arrangement. (V.T.I.C. Art. 3.51-6, Sec. 3A(a) (part).)

Sec. 1366.002. EXCEPTION. This subchapter does not apply to:

(1) a credit accident and health insurance policy subject to Chapter 1153;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance before April 1, 1975;

(3) accident and health coverages that are incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the commissioner; or

(4) any policy or contract of insurance with a state agency, department, or board providing health services:

(A) to eligible individuals under Chapter 32, Human Resources Code; or

(B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

Sec. 1366.003. OFFER OF COVERAGE REQUIRED. (a) Subject to this subchapter, an issuer of a group health benefit plan that provides pregnancy-related benefits for individuals covered under the plan shall offer and make available to each holder or sponsor of the plan coverage for services and benefits on an expense incurred, service, or prepaid basis for outpatient expenses that arise from in vitro fertilization procedures.

(b) Benefits for in vitro fertilization procedures required under this section must be provided to the same extent as benefits

provided for other pregnancy-related procedures under the plan. (V.T.I.C. Art. 3.51-6, Secs. 3A(a) (part), (b), (d).)

Sec. 1366.004. REJECTION OF OFFER. A rejection of an offer under Section 1366.003 to provide coverage for in vitro fertilization procedures must be in writing. (V.T.I.C. Art. 3.51-6, Sec. 3A(c).)

Sec. 1366.005. CONDITIONS APPLICABLE TO COVERAGE. The coverage offered under Section 1366.003 is required only if:

(1) the patient for the in vitro fertilization procedure is an individual covered under the group health benefit plan;

(2) the fertilization or attempted fertilization of the patient's oocytes is made only with the sperm of the patient's spouse;

(3) the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with:

(A) endometriosis;

(B) exposure in utero to diethylstilbestrol (DES);

(C) blockage of or surgical removal of one or both fallopian tubes; or

(D) oligospermia;

(4) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the group health benefit plan; and

(5) the in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards for programs of in vitro fertilization adopted by the American Society for Reproductive Medicine. (V.T.I.C. Art. 3.51-6, Sec. 3A(e).)

Sec. 1366.006. CERTAIN ISSUERS OF HEALTH BENEFIT PLANS NOT REQUIRED TO OFFER COVERAGE. An insurer, health maintenance organization, or self-insuring employer that is owned by or that is part of an entity, group, or order that is directly affiliated with a bona fide religious denomination that includes as an integral part of its beliefs and practices that in vitro fertilization is contrary to moral principles that the religious denomination considers to be an essential part of its beliefs is not required to offer coverage for in vitro fertilization under Section 1366.003. (V.T.I.C. Art. 3.51-6, Sec. 3A(f).)

Sec. 1366.007. RULES. The commissioner may adopt rules necessary to administer this subchapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C. Art. 3.51-6, Sec. 5.)

[Sections 1366.008-1366.050 reserved for expansion]

SUBCHAPTER B. MINIMUM INPATIENT STAY FOLLOWING BIRTH OF CHILD AND POSTDELIVERY CARE

Sec. 1366.051. SHORT TITLE. This subchapter may be cited as the Lee Alexandria Hanley Act. (V.T.I.C. Art. 21.53F, Sec. 1, as added Acts 75th Leg., R.S., Ch. 832.)

Sec. 1366.052. DEFINITIONS. In this subchapter:

(1) "Attending physician" means an obstetrician, pediatrician, or other physician who attends a woman who has given birth to a child or who attends a newborn child.

(2) "Postdelivery care" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. (V.T.I.C. Art. 21.53F, Secs. 2(1), 5(c) (part), as added Acts 75th Leg., R.S., Ch. 832.)

Sec. 1366.053. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization

operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act;

(ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53F, Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 832.)

Sec. 1366.054. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1366.053. (V.T.I.C. Art. 21.53F, Sec. 3(b), as added Acts 75th Leg., R.S., Ch. 832.)

Sec. 1366.055. COVERAGE FOR INPATIENT CARE REQUIRED. (a) Except as provided by Subsection (b), a health benefit plan that provides maternity benefits, including benefits for childbirth, must provide to a woman who has given birth to a child and the newborn child coverage for inpatient care in a health care facility for not less than:

(1) 48 hours after an uncomplicated vaginal delivery; and

(2) 96 hours after an uncomplicated delivery by cesarean section.

(b) A health benefit plan that provides to a woman who has given birth to a child and the newborn child coverage for in-home postdelivery care is not required to provide the coverage required

under Subsection (a) unless:

(1) the attending physician determines that inpatient care is medically necessary; or

(2) the woman requests inpatient care.

(c) For purposes of Subsection (a), the attending physician shall determine whether a delivery is complicated.

(d) This section does not require a woman who is eligible for coverage under a health benefit plan to:

(1) give birth to a child in a hospital or other health care facility; or

(2) remain under inpatient care in a hospital or other health care facility for any fixed term following the birth of a child. (V.T.I.C. Art. 21.53F, Sec. 4, as added Acts 75th Leg., R.S., Ch. 832.)

Sec. 1366.056. COVERAGE FOR POSTDELIVERY CARE REQUIRED. (a) If a decision is made to discharge a woman who has given birth to a child or the newborn child from inpatient care before the expiration of the minimum hours of coverage required under Section 1366.055(a), a health benefit plan must provide to the woman and child coverage for timely postdelivery care.

(b) The timeliness of the postdelivery care shall be determined in accordance with recognized medical standards for that care.

(c) The postdelivery care may be provided by a physician, registered nurse, or other appropriate licensed health care provider.

(d) Subject to Subsection (e), the postdelivery care may be

provided at:

(1) the woman's home;

(2) a health care provider's office;

(3) a health care facility; or

(4) another location determined to be appropriate under rules adopted by the commissioner.

(e) The coverage required under this section must give the woman the option to have the care provided in the woman's home. (V.T.I.C. Art. 21.53F, Secs. 5(a), (b), (c) (part), as added Acts 75th Leg., R.S., Ch. 832.)

Sec. 1366.057. PROHIBITED CONDUCT. An issuer of a health benefit plan may not:

(1) modify the terms and conditions of coverage based on a request by an enrollee for less than the minimum coverage required under Section 1366.055(a);

(2) offer to a woman who has given birth to a child a financial incentive or other compensation the receipt of which is contingent on the waiver by the woman of the minimum coverage required under Section 1366.055(a);

(3) refuse to accept a physician's recommendation for inpatient care made in consultation with the woman who has given birth to a child if the period of inpatient care recommended by the physician does not exceed the minimum periods recommended in guidelines for perinatal care developed by:

(A) the American College of Obstetricians and Gynecologists;

(B) the American Academy of Pediatrics; or

(C) another nationally recognized professional association of obstetricians and gynecologists or of pediatricians;

(4) reduce payments or other forms of reimbursement for inpatient care below the usual and customary rate of reimbursement for that care; or

(5) penalize a physician for recommending inpatient care for a woman or the woman's newborn child by:

(A) refusing to permit the physician to participate as a provider in the health benefit plan;

(B) reducing payments made to the physician;

(C) requiring the physician to:

(i) provide additional documentation; or

(ii) undergo additional utilization review; or

(D) imposing other analogous sanctions or disincentives. (V.T.I.C. Art. 21.53F, Sec. 6, as added Acts 75th Leg., R.S., Ch. 832.)

Sec. 1366.058. NOTICE OF COVERAGE. (a) An issuer of a health benefit plan shall provide to each individual enrolled in the plan written notice of the coverage required under this subchapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.53F, Secs. 2(2), 7, as added Acts 75th Leg., R.S., Ch. 832.)

Sec. 1366.059. RULES. The commissioner shall adopt rules necessary to administer this subchapter. (V.T.I.C. Art. 21.53F,

Sec. 8, as added Acts 75th Leg., R.S., Ch. 832.)

CHAPTER 1367. COVERAGE OF CHILDREN

SUBCHAPTER A. NEWBORN CHILDREN

Sec. 1367.001. APPLICABILITY OF SUBCHAPTER

Sec. 1367.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW

Sec. 1367.003. CERTAIN LIMITATIONS ON COVERAGE FOR NEWBORN CHILDREN PROHIBITED

[Sections 1367.004-1367.050 reserved for expansion]

SUBCHAPTER B. CHILDHOOD IMMUNIZATIONS

Sec. 1367.051. APPLICABILITY OF SUBCHAPTER

Sec. 1367.052. EXCEPTION

Sec. 1367.053. COVERAGE REQUIRED

Sec. 1367.054. COPAYMENT, DEDUCTIBLE, OR COINSURANCE REQUIREMENT PROHIBITED

Sec. 1367.055. RULES

[Sections 1367.056-1367.100 reserved for expansion]

SUBCHAPTER C. HEARING TEST

Sec. 1367.101. APPLICABILITY OF SUBCHAPTER

Sec. 1367.102. EXCEPTION

Sec. 1367.103. COVERAGE REQUIRED

Sec. 1367.104. COPAYMENT OR COINSURANCE REQUIREMENT PERMITTED; DEDUCTIBLE REQUIREMENT OR DOLLAR LIMIT PROHIBITED; NOTICE REQUIRED

Sec. 1367.105. RULES

[Sections 1367.106-1367.150 reserved for expansion]

SUBCHAPTER D. CHILD CRANIOFACIAL ABNORMALITIES

Sec. 1367.151. APPLICABILITY OF SUBCHAPTER

Sec. 1367.152. EXCEPTION

Sec. 1367.153. RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL ABNORMALITIES; DEFINITION REQUIRED

Sec. 1367.154. RULES

CHAPTER 1367. COVERAGE OF CHILDREN

SUBCHAPTER A. NEWBORN CHILDREN

Sec. 1367.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan delivered or issued for delivery in this state that is an individual or group policy of accident and health insurance, including a policy issued by a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-2, Sec. (E) (part).)

Sec. 1367.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

Sec. 1367.003. CERTAIN LIMITATIONS ON COVERAGE FOR NEWBORN CHILDREN PROHIBITED. A health benefit plan that provides maternity benefits or accident and health coverage for additional newborn children may not be issued in this state if the plan excludes or limits:

(1) initial coverage of a newborn child for a period of time; or

(2) coverage for congenital defects of a newborn

child. (V.T.I.C. Art. 3.70-2, Sec. (E) (part).)

[Sections 1367.004-1367.050 reserved for expansion]

SUBCHAPTER B. CHILDHOOD IMMUNIZATIONS

Sec. 1367.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885;

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

(E) a health maintenance organization operating under Chapter 843; or

(F) a multiple employer welfare arrangement subject to regulation under Chapter 846;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any

other law. (V.T.I.C. Art. 21.53F, Secs. 2(a), (c), as added Acts 75th Leg., R.S., Ch. 683.)

Sec. 1367.052. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described

by Section 1367.051. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 683.)

Sec. 1367.053. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide for each covered child from birth through the date of the child's sixth birthday coverage for:

(1) immunization against:

(A) diphtheria;

(B) haemophilus influenzae type b;

(C) hepatitis B;

(D) measles;

(E) mumps;

(F) pertussis;

(G) polio;

(H) rubella;

(I) tetanus; and

(J) varicella; and

(2) any other immunization that is required for the child by law.

(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

(c) In addition to the immunizations required under Subsection (a), a health maintenance organization that issues a health benefit plan shall provide under the plan coverage for

immunization against rotovirus. (V.T.I.C. Art. 20A.09F; Art. 21.53F, Secs. 3, 5, as added Acts 75th Leg., R.S., Ch. 683.)

Sec. 1367.054. COPAYMENT, DEDUCTIBLE, OR COINSURANCE REQUIREMENT PROHIBITED. (a) Coverage required under Section 1367.053(a) may not be made subject to a deductible, copayment, or coinsurance requirement.

(b) This section does not prohibit the application of a deductible, copayment, or coinsurance requirement to another service provided at the same time the immunization is administered. (V.T.I.C. Art. 21.53F, Sec. 6(a), as added Acts 75th Leg., R.S., Ch. 683.)

Sec. 1367.055. RULES. The commissioner may adopt reasonable rules necessary to implement this subchapter. (V.T.I.C. Art. 21.53F, Sec. 7, as added Acts 75th Leg., R.S., Ch. 683.)

[Sections 1367.056-1367.100 reserved for expansion]

SUBCHAPTER C. HEARING TEST

Sec. 1367.101. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

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

(C) a fraternal benefit society operating under

Chapter 885;

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

(E) a health maintenance organization operating under Chapter 843; or

(F) a multiple employer welfare arrangement subject to regulation under Chapter 846;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

(b) This subchapter applies to a health benefit plan described by Subsection (a) that provides coverage to a resident of this state, regardless of whether the plan issuer is located in or outside this state. (V.T.I.C. Art. 21.53F, Secs. 2(a), (c), 4(c) (part), as added Acts 75th Leg., R.S., Ch. 683.)

Sec. 1367.102. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of

sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.101. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 683.)

Sec. 1367.103. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide to each covered child coverage for:

(1) a screening test for hearing loss from birth through the date the child is 30 days of age, as provided by Chapter 47, Health and Safety Code; and

(2) necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months of

age.

(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

(c) This section does not require a health benefit plan to provide the coverage described by this section to a child of an individual residing in this state if the individual is:

(1) employed outside this state; and

(2) covered under a health benefit plan maintained for the individual by the individual's employer as an employment benefit. (V.T.I.C. Art. 21.53F, Secs. 4(a), (c) (part), 5, as added Acts 75th Leg., R.S., Ch. 683.)

Sec. 1367.104. COPAYMENT OR COINSURANCE REQUIREMENT PERMITTED; DEDUCTIBLE REQUIREMENT OR DOLLAR LIMIT PROHIBITED; NOTICE REQUIRED. (a) Coverage required under this subchapter:

(1) may be subject to a copayment or coinsurance requirement; and

(2) may not be subject to a deductible requirement or a dollar limit.

(b) The requirements of this section must be stated in the coverage document. (V.T.I.C. Art. 21.53F, Sec. 6(b), as added Acts 75th Leg., R.S., Ch. 683.)

Sec. 1367.105. RULES. The commissioner may adopt rules necessary to implement this subchapter. (V.T.I.C. Art. 21.53F, Secs. 4(b), 7, as added Acts 75th Leg., R.S., Ch. 683.)

[Sections 1367.106-1367.150 reserved for expansion]

SUBCHAPTER D. CHILD CRANIOFACIAL ABNORMALITIES

Sec. 1367.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act;

(ii) an entity not authorized under this code or another insurance law of this state that contracts directly

for health care services on a risk-sharing basis, including a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53W, Sec. 2(a).)

Sec. 1367.152. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement or other hospital expenses;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.151. (V.T.I.C. Art. 21.53W, Sec. 2(b).)

Sec. 1367.153. RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL ABNORMALITIES; DEFINITION REQUIRED. A health benefit plan that provides coverage for a child who is younger than 18 years of age must define "reconstructive surgery for craniofacial abnormalities" under the plan to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease. (V.T.I.C. Art. 21.53W, Sec. 3.)

Sec. 1367.154. RULES. The commissioner shall adopt rules necessary to administer this subchapter. (V.T.I.C. Art. 21.53W, Sec. 4.)

CHAPTER 1368. AVAILABILITY OF CHEMICAL DEPENDENCY COVERAGE

Sec. 1368.001. DEFINITIONS

Sec. 1368.002. APPLICABILITY OF CHAPTER

Sec. 1368.003. EXCEPTION

Sec. 1368.004. COVERAGE REQUIRED

Sec. 1368.005. MINIMUM COVERAGE REQUIREMENTS

Sec. 1368.006. LIMITATION ON COVERAGE

Sec. 1368.007. TREATMENT STANDARDS

Sec. 1368.008. USE OF ENDORSEMENT OR RIDER TO COMPLY WITH CHAPTER

CHAPTER 1368. AVAILABILITY OF CHEMICAL DEPENDENCY COVERAGE

Sec. 1368.001. DEFINITIONS. In this chapter:

(1) "Chemical dependency" means the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance.

(2) "Chemical dependency treatment center" means a facility that provides a program for the treatment of chemical dependency under a written treatment plan approved and monitored by a physician and that is:

(A) affiliated with a hospital under a contractual agreement with an established system for patient referral;

(B) accredited as a chemical dependency treatment center by the Joint Commission on Accreditation of Healthcare Organizations;

(C) licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or

(D) licensed, certified, or approved as a chemical dependency treatment program or center by another state agency.

(3) "Controlled substance" means an abusable volatile chemical, as defined by Section 485.001, Health and Safety Code, or a substance designated as a controlled substance under Chapter 481, Health and Safety Code. (V.T.I.C. Art. 3.51-9, Secs. 2, 2A(e).)

Sec. 1368.002. APPLICABILITY OF CHAPTER. This chapter

applies only to a group health benefit plan that provides hospital and medical coverage or services on an expense incurred, service, or prepaid basis, including a group insurance policy or contract or self-funded or self-insured plan or arrangement that is offered in this state by:

(1) an insurer;

(2) a group hospital service corporation operating under Chapter 842;

(3) a health maintenance organization operating under Chapter 843; or

(4) an employer, trustee, or other self-funded or self-insured plan or arrangement. (V.T.I.C. Art. 3.51-9, Sec. 2A(a) (part).)

Sec. 1368.003. EXCEPTION. This chapter does not apply to:

(1) an employer, trustee, or other self-funded or self-insured plan or arrangement with 250 or fewer employees or members;

(2) an individual insurance policy;

(3) an individual evidence of coverage issued by a health maintenance organization;

(4) a health insurance policy that provides only:

(A) cash indemnity for hospital or other confinement benefits;

(B) supplemental or limited benefit coverage;

(C) coverage for specified diseases or accidents;

(D) disability income coverage; or

(E) any combination of those benefits or coverages;

(5) a blanket insurance policy;

(6) a short-term travel insurance policy;

(7) an accident-only insurance policy;

(8) a limited or specified disease insurance policy;

(9) an individual conversion insurance policy or contract;

(10) a policy or contract designed for issuance to a person eligible for Medicare coverage or other similar coverage under a state or federal government plan; or

(11) an evidence of coverage provided by a health maintenance organization if the plan holder is the subject of a collective bargaining agreement that was in effect on January 1, 1982, and that has not expired since that date. (V.T.I.C. Art. 3.51-9, Secs. 2A(c), 3 (part).)

Sec. 1368.004. COVERAGE REQUIRED. (a) A group health benefit plan shall provide coverage for the necessary care and treatment of chemical dependency.

(b) Coverage required under this section may be provided:

(1) directly by the group health benefit plan issuer; or

(2) by another entity, including a single service health maintenance organization, under contract with the group health benefit plan issuer. (V.T.I.C. Art. 3.51-9, Sec. 2A(a) (part).)

Sec. 1368.005. MINIMUM COVERAGE REQUIREMENTS. (a) Except

as provided by Subsection (b), coverage required under this chapter:

(1) may not be less favorable than coverage provided for physical illness generally under the plan; and

(2) shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors that apply to coverage provided for physical illness generally under the plan.

(b) A group health benefit plan may set dollar or durational limits for coverage required under this chapter that are less favorable than for coverage provided for physical illness generally under the plan if those limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted under Section 1368.007. If guidelines and standards adopted under Section 1368.007 are not in effect, the dollar and durational limits may not be less favorable than for physical illness generally.

(c) This section does not require payment of a usual, customary, and reasonable rate for treatment of a covered individual if a health maintenance organization or preferred provider organization establishes a negotiated rate for the locality in which the covered individual customarily receives care. (V.T.I.C. Art. 3.51-9, Sec. 2A(a) (part).)

Sec. 1368.006. LIMITATION ON COVERAGE. (a) In this section, "treatment series" means a planned, structured, and organized program to promote chemical-free status that:

(1) may include different facilities or modalities; and

(2) is completed when the covered individual:

(A) is, on medical advice, discharged from:

(i) inpatient detoxification;

(ii) inpatient rehabilitation or treatment;

(iii) partial hospitalization or intensive outpatient treatment; or

(iv) a series of those levels of treatments without a lapse in treatment; or

(B) fails to materially comply with the treatment program for a period of 30 days.

(b) Notwithstanding Section 1368.005, coverage required under this chapter is limited to a lifetime maximum of three separate treatment series for each covered individual. (V.T.I.C. Art. 3.51-9, Sec. 2A(b).)

Sec. 1368.007. TREATMENT STANDARDS. (a) Coverage provided under this chapter for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital.

(b) The department by rule shall adopt standards formulated and approved by the department and the Texas Commission on Alcohol and Drug Abuse for use by insurers, other third-party reimbursement sources, and chemical dependency treatment centers.

(c) Standards adopted under this section must provide for:

(1) reasonable control of costs necessary for inpatient and outpatient treatment of chemical dependency, including guidelines for treatment periods; and

(2) appropriate utilization review of treatment as well as necessary extensions of treatment.

(d) Coverage required under this chapter is subject to the standards adopted under this section. (V.T.I.C. Art. 3.51-9, Sec. 2A(d).)

Sec. 1368.008. USE OF ENDORSEMENT OR RIDER TO COMPLY WITH CHAPTER. A group health benefit plan issuer that uses a policy form approved by the commissioner before November 10, 1981, may use an endorsement or rider to comply with this chapter if the endorsement or rider is approved by the commissioner as complying with this chapter and other provisions of this code. (V.T.I.C. Art. 3.51-9, Sec. 3 (part).)

CHAPTER 1369. BENEFITS RELATED TO PRESCRIPTION DRUGS AND DEVICES AND RELATED SERVICES

SUBCHAPTER A. COVERAGE OF PRESCRIPTION DRUGS IN GENERAL

[Sections 1369.006-1369.050 reserved for expansion]

SUBCHAPTER B. COVERAGE OF PRESCRIPTION DRUGS SPECIFIED BY DRUG FORMULARY

Sec. 1369.001. DEFINITIONS. In this subchapter:

(1) "Contraindication" means the potential for, or the occurrence of:

(A) an undesirable change in the therapeutic effect of a prescribed drug because of the presence of a disease condition in the patient for whom the drug is prescribed; or

(B) a clinically significant adverse effect of a prescribed drug on a disease condition of the patient for whom the drug is prescribed.

(2) "Drug" has the meaning assigned by Section 551.003, Occupations Code.

(3) "Indication" means a symptom, cause, or occurrence in a disease that points out the cause, diagnosis, course of treatment, or prognosis of the disease.

(4) "Peer-reviewed medical literature" means scientific studies published in a peer-reviewed national professional journal. (V.T.I.C. Art. 21.53M, Secs. 1(1), (2), (4), (5).)

Sec. 1369.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53M, Sec. 2(a).)

Sec. 1369.003. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.002. (V.T.I.C. Art. 21.53M, Sec. 2(b).)

Sec. 1369.004. COVERAGE REQUIRED. (a) A health benefit plan that covers drugs must cover any drug prescribed to treat an enrollee for a chronic, disabling, or life-threatening illness covered under the plan if the drug:

(1) has been approved by the United States Food and Drug Administration for at least one indication; and

(2) is recognized by the following for treatment of the indication for which the drug is prescribed:

(A) a prescription drug reference compendium approved by the commissioner for purposes of this section; or

(B) substantially accepted peer-reviewed medical literature.

(b) Coverage of a drug required under Subsection (a) must include coverage of medically necessary services associated with the administration of the drug.

(c) A health benefit plan issuer may not, based on a "medical necessity" requirement, deny coverage of a drug required under Subsection (a) unless the reason for the denial is unrelated to the legal status of the drug use.

(d) This section does not require a health benefit plan to cover:

(1) experimental drugs that are not otherwise approved for an indication by the United States Food and Drug Administration;

(2) any disease or condition that is excluded from coverage under the plan; or

(3) a drug that the United States Food and Drug Administration has determined to be contraindicated for treatment of the current indication. (V.T.I.C. Art. 21.53M, Sec. 3.)

Sec. 1369.005. RULES. The commissioner may adopt rules to implement this subchapter. (V.T.I.C. Art. 21.53M, Sec. 4.)

[Sections 1369.006-1369.050 reserved for expansion]

SUBCHAPTER B. COVERAGE OF PRESCRIPTION DRUGS SPECIFIED BY DRUG FORMULARY

Sec. 1369.051. DEFINITIONS. In this subchapter:

(1) "Drug formulary" means a list of drugs:

(A) for which a health benefit plan provides coverage;

(B) for which a health benefit plan issuer

approves payment; or

(C) that a health benefit plan issuer encourages or offers incentives for physicians to prescribe.

(2) "Enrollee" means an individual who is covered under a group health benefit plan, including a covered dependent.

(3) "Physician" means a person licensed as a physician by the Texas State Board of Medical Examiners.

(4) "Prescription drug" has the meaning assigned by Section 551.003, Occupations Code. (V.T.I.C. Art. 21.52J, Secs. 1(1), (2), (4), (5).)

Sec. 1369.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group contract or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.52J, Sec. 2(a).)

Sec. 1369.053. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under

a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.052. (V.T.I.C. Art. 21.52J, Sec. 2(b).)

Sec. 1369.054. NOTICE AND DISCLOSURE OF CERTAIN INFORMATION REQUIRED. An issuer of a group health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan shall:

(1) provide in plain language in the coverage documentation provided to each enrollee:

(A) notice that the plan uses one or more drug formularies;

(B) an explanation of what a drug formulary is;

(C) a statement regarding the method the issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary;

(D) a statement of how often the issuer reviews the contents of each drug formulary; and

(E) notice that an enrollee may contact the issuer to determine whether a specific drug is included in a particular drug formulary;

(2) disclose to an individual on request, not later than the third business day after the date of the request, whether a specific drug is included in a particular drug formulary; and

(3) notify an enrollee and any other individual who

requests information under this section that the inclusion of a drug in a drug formulary does not guarantee that an enrollee's health care provider will prescribe that drug for a particular medical condition or mental illness. (V.T.I.C. Art. 21.52J, Sec. 3.)

Sec. 1369.055. CONTINUATION OF COVERAGE REQUIRED; OTHER DRUGS NOT PRECLUDED. (a) An issuer of a group health benefit plan that covers prescription drugs shall offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date.

(b) This section does not prohibit a physician or other health professional who is authorized to prescribe a drug from prescribing a drug that is an alternative to a drug for which continuation of coverage is required under Subsection (a) if the alternative drug is:

(1) covered under the group health benefit plan; and

(2) medically appropriate for the enrollee. (V.T.I.C. Art. 21.52J, Sec. 4.)

Sec. 1369.056. ADVERSE DETERMINATION. (a) The refusal of a group health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of Section 2, Article 21.58A, if:

(1) the drug is not included in a drug formulary used by the group health benefit plan; and

(2) the enrollee's physician has determined that the drug is medically necessary.

(b) The enrollee may appeal the adverse determination under Sections 6 and 6A, Article 21.58A. (V.T.I.C. Art. 21.52J, Sec. 5.)

Sec. 1369.057. RULES. The commissioner may adopt rules to implement this subchapter. (V.T.I.C. Art. 21.52J, Sec. 6.)

[Sections 1369.058-1369.100 reserved for expansion]

SUBCHAPTER C. COVERAGE OF PRESCRIPTION CONTRACEPTIVE DRUGS AND DEVICES AND RELATED SERVICES

Sec. 1369.101. DEFINITIONS. In this subchapter:

(1) "Enrollee" means a person who is entitled to benefits under a health benefit plan.

(2) "Outpatient contraceptive service" means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy. (V.T.I.C. Art. 21.52L, Sec. 1, as added Acts 77th Leg., R.S., Ch. 1106.)

Sec. 1369.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.52L, Secs. 2(a), (b), as added Acts 77th Leg., R.S., Ch. 1106.)

Sec. 1369.103. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage only:

(A) for a specified disease or for another limited benefit other than for cancer;

(B) for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) for dental or vision care; or

(G) for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.102. (V.T.I.C. Art. 21.52L, Sec. 2(c), as added Acts 77th Leg., R.S., Ch. 1106.)

Sec. 1369.104. EXCLUSION OR LIMITATION PROHIBITED. (a) A health benefit plan that provides benefits for prescription drugs or devices may not exclude or limit benefits to enrollees for:

(1) a prescription contraceptive drug or device approved by the United States Food and Drug Administration; or

(2) an outpatient contraceptive service.

(b) This section does not prohibit a limitation that applies to all prescription drugs or devices or all services for which benefits are provided under a health benefit plan.

(c) This section does not require a health benefit plan to cover abortifacients or any other drug or device that terminates a pregnancy. (V.T.I.C. Art. 21.52L, Sec. 3, as added Acts 77th Leg., R.S., Ch. 1106.)

Sec. 1369.105. CERTAIN COST-SHARING PROVISIONS PROHIBITED.

(a) A health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing provision applicable to benefits for prescription contraceptive drugs or devices unless the amount of the required cost-sharing is the same as or less than the amount of the required cost-sharing applicable to benefits for other prescription drugs or devices under the plan.

(b) A health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing provision applicable to benefits for outpatient contraceptive services unless the amount of the required cost-sharing is the same as or less than the amount of the required cost-sharing applicable to benefits for other outpatient services under the plan. (V.T.I.C. Art. 21.52L, Sec. 4, as added Acts 77th Leg., R.S., Ch. 1106.)

Sec. 1369.106. CERTAIN WAITING PERIODS PROHIBITED. (a) A health benefit plan may not impose a waiting period applicable to benefits for prescription contraceptive drugs or devices unless the waiting period is the same as or shorter than any waiting period applicable to benefits for other prescription drugs or devices under the plan.

(b) A health benefit plan may not impose a waiting period applicable to benefits for outpatient contraceptive services unless the waiting period is the same as or shorter than any waiting period applicable to benefits for other outpatient services under the plan. (V.T.I.C. Art. 21.52L, Sec. 5, as added Acts 77th Leg., R.S., Ch. 1106.)

Sec. 1369.107. PROHIBITED CONDUCT. A health benefit plan issuer may not:

(1) solely because of the applicant's or enrollee's use or potential use of a prescription contraceptive drug or device or an outpatient contraceptive service, deny:

(A) the eligibility of an applicant to enroll in the plan;

(B) the continued eligibility of an enrollee for coverage under the plan; or

(C) the eligibility of an enrollee to renew coverage under the plan;

(2) provide a monetary incentive to an applicant for enrollment or an enrollee to induce the applicant or enrollee to accept coverage that does not satisfy the requirements of this subchapter; or

(3) reduce or limit a payment to a health care professional, or otherwise penalize the professional, because the professional prescribes a contraceptive drug or device or provides an outpatient contraceptive service. (V.T.I.C. Art. 21.52L, Sec. 6, as added Acts 77th Leg., R.S., Ch. 1106.)

Sec. 1369.108. EXEMPTION FOR ENTITIES ASSOCIATED WITH RELIGIOUS ORGANIZATION. (a) This subchapter does not require a health benefit plan that is issued by an entity associated with a religious organization or any physician or health care provider providing medical or health care services under the plan to offer, recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing a medical or health care service that violates the religious convictions of the organization, unless the prescription

contraceptive coverage is necessary to preserve the life or health of the enrollee.

(b) An issuer of a health benefit plan that excludes or limits coverage for medical or health care services under this section shall state the exclusion or limitation in:

(1) the plan's coverage document;

(2) the plan's statement of benefits;

(3) plan brochures; and

(4) other informational materials for the plan. (V.T.I.C. Art. 21.52L, Sec. 7, as added Acts 77th Leg., R.S., Ch. 1106.)

Sec. 1369.109. ENFORCEMENT. A health benefit plan issuer that violates this subchapter is subject to the enforcement provisions of Subtitle B, Title 2. (V.T.I.C. Art. 21.52L, Sec. 8, as added Acts 77th Leg., R.S., Ch. 1106.)

[Sections 1369.110-1369.150 reserved for expansion]

SUBCHAPTER D. PHARMACY BENEFIT CARDS

Sec. 1369.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating

under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53L, Sec. 2(a).)

Sec. 1369.152. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.151. (V.T.I.C. Art. 21.53L, Sec. 2(b).)

Sec. 1369.153. INFORMATION REQUIRED ON IDENTIFICATION CARD. (a) An issuer of a health benefit plan that provides pharmacy benefits to enrollees shall include on the identification card of each enrollee:

(1) the name or logo of the entity administering the pharmacy benefits if the entity is different from the health benefit plan issuer;

(2) the group number applicable to the enrollee;

(3) the effective date of the coverage evidenced by the card;

(4) a telephone number for contacting an appropriate person to obtain information relating to the pharmacy benefits provided under the plan; and

(5) copayment information for generic and brand-name

prescription drugs.

(b) This section does not require a health benefit plan issuer that administers its own pharmacy benefits to issue an identification card separate from any identification card issued to an enrollee to evidence coverage under the plan if the identification card issued to evidence coverage contains the information required by Subsection (a). (V.T.I.C. Art. 21.53L, Sec. 3.)

Sec. 1369.154. RULES. The commissioner shall adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 21.53L, Sec. 4.)

[Chapters 1370-1450 reserved for expansion]

SUBTITLE F. PHYSICIANS AND HEALTH CARE PROVIDERS

CHAPTER 1451. ACCESS TO CERTAIN PRACTITIONERS AND FACILITIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1451.001. DEFINITIONS; HEALTH CARE PRACTITIONERS

[Sections 1451.002-1451.050 reserved for expansion]

SUBCHAPTER B. DESIGNATION OF PRACTITIONERS UNDER ACCIDENT AND HEALTH INSURANCE POLICY

Sec. 1451.051. APPLICABILITY OF SUBCHAPTER

Sec. 1451.052. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW

Sec. 1451.053. PRACTITIONER DESIGNATION

Sec. 1451.054. TERMS USED TO DESIGNATE HEALTH CARE PRACTITIONERS

[Sections 1451.055-1451.100 reserved for expansion]

SUBCHAPTER C. SELECTION OF PRACTITIONERS

CHAPTER 1451. ACCESS TO CERTAIN PRACTITIONERS AND FACILITIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1451.001. DEFINITIONS; HEALTH CARE PRACTITIONERS. In this chapter:

(1) "Acupuncturist" means an individual licensed to practice acupuncture by the Texas State Board of Medical Examiners.

(2) "Advanced practice nurse" means an individual licensed by the Board of Nurse Examiners as a registered nurse and recognized by that board as an advanced practice nurse.

(3) "Audiologist" means an individual licensed to practice audiology by the State Board of Examiners for Speech-Language Pathology and Audiology.

(4) "Chemical dependency counselor" means an individual licensed by the Texas Commission on Alcohol and Drug Abuse.

(5) "Chiropractor" means an individual licensed by the Texas Board of Chiropractic Examiners.

(6) "Dentist" means an individual licensed to practice dentistry by the State Board of Dental Examiners.

(7) "Dietitian" means an individual licensed by the Texas State Board of Examiners of Dietitians.

(8) "Hearing instrument fitter and dispenser" means an individual licensed by the State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments.

(9) "Licensed master social worker--advanced clinical practitioner" means an individual licensed by the Texas State Board of Social Worker Examiners as a licensed master social worker with the order of recognition of advanced clinical practitioner.

(10) "Licensed professional counselor" means an individual licensed by the Texas State Board of Examiners of Professional Counselors.

(11) "Marriage and family therapist" means an individual licensed by the Texas State Board of Examiners of Marriage and Family Therapists.

(12) "Occupational therapist" means an individual licensed as an occupational therapist by the Texas Board of Occupational Therapy Examiners.

(13) "Optometrist" means an individual licensed to practice optometry by the Texas Optometry Board.

(14) "Physical therapist" means an individual licensed as a physical therapist by the Texas Board of Physical Therapy Examiners.

(15) "Physician" means an individual licensed to practice medicine by the Texas State Board of Medical Examiners. The term includes a doctor of osteopathic medicine.

(16) "Physician assistant" means an individual licensed by the Texas State Board of Physician Assistant Examiners.

(17) "Podiatrist" means an individual licensed to practice podiatry by the Texas State Board of Podiatric Medical Examiners.

(18) "Psychological associate" means an individual

licensed as a psychological associate by the Texas State Board of Examiners of Psychologists who practices solely under the supervision of a licensed psychologist.

(19) "Psychologist" means an individual licensed as a psychologist by the Texas State Board of Examiners of Psychologists.

(20) "Speech-language pathologist" means an individual licensed to practice speech-language pathology by the State Board of Examiners for Speech-Language Pathology and Audiology.

(21) "Surgical assistant" means an individual licensed as a surgical assistant by the Texas State Board of Medical Examiners. (V.T.I.C. Art. 3.70-2, Sec. (B) (part); Art. 21.52, Sec. 1 (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

[Sections 1451.002-1451.050 reserved for expansion]

SUBCHAPTER B. DESIGNATION OF PRACTITIONERS UNDER ACCIDENT AND HEALTH INSURANCE POLICY

Sec. 1451.051. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to an accident and health insurance policy, including an individual, blanket, or group policy.

(b) This subchapter applies to an accident and health insurance policy issued by a stipulated premium company subject to Chapter 884. (V.T.I.C. Art. 3.70-8, Secs. (a) (part), (b).)

Sec. 1451.052. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, the construction of policies under that chapter, rulemaking under that

chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

Sec. 1451.053. PRACTITIONER DESIGNATION. (a) An accident and health insurance policy may not make a benefit contingent on treatment or examination by one or more particular health care practitioners listed in Section 1451.001 unless the policy contains a provision that designates the practitioners whom the insurer will and will not recognize.

(b) The insurer may include the provision anywhere in the policy or in an endorsement attached to the policy. (V.T.I.C. Art. 3.70-2, Sec. (B) (part).)

Sec. 1451.054. TERMS USED TO DESIGNATE HEALTH CARE PRACTITIONERS. A provision of an accident and health insurance policy that designates the health care practitioners whom the insurer will and will not recognize must use the terms defined by Section 1451.001 with the meanings assigned by that section. (V.T.I.C. Art. 3.70-2, Sec. (B) (part).)

[Sections 1451.055-1451.100 reserved for expansion]

SUBCHAPTER C. SELECTION OF PRACTITIONERS

Sec. 1451.101. DEFINITIONS. In this subchapter:

(1) "Health insurance policy" means a policy, contract, or agreement described by Section 1451.102.

(2) "Insured" means an individual who is issued, is a party to, or is a beneficiary under a health insurance policy.

(3) "Insurer" means an insurer, association, or organization described by Section 1451.102.

(4) "Nurse first assistant" has the meaning assigned

by Section 301.1525, Occupations Code. (New; V.T.I.C. Art. 21.52, Sec. 1 (part), as amended Acts 77th Leg., R.S., Ch. 812.)

Sec. 1451.102. APPLICABILITY OF SUBCHAPTER. Except as provided by this subchapter, this subchapter applies only to an individual, group, blanket, or franchise insurance policy, insurance agreement, or group hospital service contract that provides health benefits, accident benefits, or health and accident benefits for medical or surgical expenses incurred as a result of an accident or sickness and that is delivered, issued for delivery, or renewed in this state by any incorporated or unincorporated insurance company, association, or organization, including:

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

(2) a general casualty company operating under Chapter 861;

(3) a life, health, and accident insurance company operating under Chapter 841 or 982;

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

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

(6) a mutual insurance company writing insurance other than life insurance operating under Chapter 883;

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

(8) a reciprocal exchange operating under Chapter 942;

(9) a statewide mutual assessment company, mutual assessment company, or mutual assessment life, health, and accident

association operating under Chapter 881 or 887; and

(10) a stipulated premium company operating under Chapter 884. (V.T.I.C. Art. 21.52, Secs. 1 (part), 2, 3(a) (part).)

Sec. 1451.103. CONFLICTING PROVISIONS VOID. (a) A provision of a health insurance policy that conflicts with this subchapter is void to the extent of the conflict.

(b) The presence in a health insurance policy of a provision void under Subsection (a) does not affect the validity of other policy provisions.

(c) An insurer shall bring each approved policy form that contains a provision that conflicts with this subchapter into compliance with this subchapter by use of:

(1) a rider or endorsement approved by the commissioner; or

(2) a new or revised policy form approved by the commissioner. (V.T.I.C. Art. 21.52, Sec. 3(e).)

Sec. 1451.104. NONDISCRIMINATORY PAYMENT OR REIMBURSEMENT; EXCEPTION. (a) An insurer may not classify, differentiate, or discriminate between scheduled services or procedures provided by a health care practitioner selected under this subchapter and performed in the scope of that practitioner's license and the same services or procedures provided by another type of health care practitioner whose services or procedures are covered by a health insurance policy, in regard to:

(1) the payment schedule or payment provisions of the policy; or

(2) the amount or manner of payment or reimbursement

under the policy.

(b) An insurer may not deny payment or reimbursement for services or procedures in accordance with the policy payment schedule or payment provisions solely because the services or procedures were performed by a health care practitioner selected under this subchapter.

(c) Notwithstanding Subsection (a), a health insurance policy may provide for a different amount of payment or reimbursement for scheduled services or procedures performed by an advanced practice nurse, nurse first assistant, licensed surgical assistant, or physician assistant if the methodology used to compute the amount is the same as the methodology used to compute the amount of payment or reimbursement when the services or procedures are provided by a physician. (V.T.I.C. Art. 21.52, Secs. 3(c) (part), (d) (part), as amended Acts 77th Leg., R.S., Chs. 812, 1014.)

Sec. 1451.105. SELECTION OF ACUPUNCTURIST. An insured may select an acupuncturist to provide the services or procedures scheduled in the health insurance policy that are within the scope of the acupuncturist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.106. SELECTION OF ADVANCED PRACTICE NURSE. An insured may select an advanced practice nurse to provide the services scheduled in the health insurance policy that are within the scope of the nurse's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.107. SELECTION OF AUDIOLOGIST. An insured may

select an audiologist to measure hearing to determine the presence or extent of the insured's hearing loss or provide aural rehabilitation services to the insured if the insured has a hearing loss and the services or procedures are scheduled in the health insurance policy. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.108. SELECTION OF CHEMICAL DEPENDENCY COUNSELOR. An insured may select a chemical dependency counselor to provide services or procedures scheduled in the health insurance policy that are within the scope of the counselor's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.109. SELECTION OF CHIROPRACTOR. An insured may select a chiropractor to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the chiropractor's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.110. SELECTION OF DENTIST. An insured may select a dentist to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the dentist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.111. SELECTION OF DIETITIAN. An insured may select a licensed dietitian or a provisionally licensed dietitian acting under the supervision of a licensed dietitian to provide the services scheduled in the health insurance policy that are within the scope of the dietitian's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.112. SELECTION OF HEARING INSTRUMENT FITTER AND DISPENSER. An insured may select a hearing instrument fitter and

dispenser to provide the services or procedures scheduled in the health insurance policy that are within the scope of the license of the fitter and dispenser. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.113. SELECTION OF LICENSED MASTER SOCIAL WORKER--ADVANCED CLINICAL PRACTITIONER. (a) An insured may select a licensed master social worker--advanced clinical practitioner to provide the services or procedures scheduled in the health insurance policy that:

(1) are within the scope of the social worker's license, including the provision of direct, diagnostic, preventive, or clinical services to individuals, families, and groups whose functioning is threatened or affected by social or psychological stress or health impairment; and

(2) are specified as services under the terms of the health insurance policy.

(b) The health insurance policy may require that services of a licensed master social worker--advanced clinical practitioner must be recommended by a physician. (V.T.I.C. Art. 21.52, Secs. 3(a) (part), (b) (part).)

Sec. 1451.114. SELECTION OF LICENSED PROFESSIONAL COUNSELOR. (a) An insured may select a licensed professional counselor to provide the services scheduled in the health insurance policy that are within the scope of the counselor's license.

(b) The health insurance policy may require that services of a licensed professional counselor must be recommended by a physician. (V.T.I.C. Art. 21.52, Secs. 3(a) (part), (b) (part).)

Sec. 1451.115. SELECTION OF SURGICAL ASSISTANT. An insured

may select a surgical assistant to provide the services or procedures scheduled in the health insurance policy that are within the scope of the assistant's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

Sec. 1451.116. SELECTION OF MARRIAGE AND FAMILY THERAPIST. (a) An insured may select a marriage and family therapist to provide the services scheduled in the health insurance policy that are within the scope of the therapist's license.

(b) The health insurance policy may require that services of a marriage and family therapist must be recommended by a physician. (V.T.I.C. Art. 21.52, Secs. 3(a) (part), (b) (part).)

Sec. 1451.117. SELECTION OF NURSE FIRST ASSISTANT. An insured may select a nurse first assistant to provide the services scheduled in the health insurance policy that:

(1) are within the scope of the nurse's license; and

(2) are requested by the physician whom the nurse is assisting. (V.T.I.C. Art. 21.52, Sec. 3(a) (part), as amended Acts 77th Leg., R.S., Ch. 812.)

Sec. 1451.118. SELECTION OF OCCUPATIONAL THERAPIST. An insured may select an occupational therapist to provide the services scheduled in the health insurance policy that are within the scope of the therapist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.119. SELECTION OF OPTOMETRIST. An insured may select an optometrist to provide the services or procedures scheduled in the health insurance policy that are within the scope of the optometrist's license. (V.T.I.C. Art. 21.52, Sec. 3(a)

(part).)

Sec. 1451.120. SELECTION OF PHYSICAL THERAPIST. An insured may select a physical therapist to provide the services scheduled in the health insurance policy that are within the scope of the therapist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.121. SELECTION OF PHYSICIAN ASSISTANT. An insured may select a physician assistant to provide the services scheduled in the health insurance policy that are within the scope of the assistant's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.122. SELECTION OF PODIATRIST. An insured may select a podiatrist to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the podiatrist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.123. SELECTION OF PSYCHOLOGICAL ASSOCIATE. An insured may select a psychological associate to provide the services scheduled in the health insurance policy that are within the scope of the associate's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

Sec. 1451.124. SELECTION OF PSYCHOLOGIST. An insured may select a psychologist to provide the services or procedures scheduled in the health insurance policy that are within the scope of the psychologist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.125. SELECTION OF SPEECH-LANGUAGE PATHOLOGIST. An insured may select a speech-language pathologist to evaluate

speech or language, provide habilitative or rehabilitative services to restore speech or language loss, or correct a speech or language impairment if the services or procedures are scheduled in the health insurance policy. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Sec. 1451.126. REIMBURSEMENT FOR PHYSICAL MODALITIES AND PROCEDURES BY HEALTH INSURER, ADMINISTRATOR, HEALTH MAINTENANCE ORGANIZATION, OR PREFERRED PROVIDER BENEFIT PLAN ISSUER. (a) A health insurer or licensed third-party administrator may not deny reimbursement to a health care practitioner for the provision of covered services of physical modalities and procedures that are within the scope of the practitioner's practice if the services are performed in strict compliance with:

(1) laws and rules related to that practitioner's license; and

(2) the terms of the insurance policy or other coverage agreement.

(b) A health maintenance organization or preferred provider benefit plan issuer may not deny reimbursement to a participating health care practitioner for services provided under a coverage agreement solely because of the type of practitioner providing the services if the services are performed in strict compliance with:

(1) laws and rules related to that practitioner's license; and

(2) the terms of the insurance policy or other coverage agreement.

(c) This section may not be construed to circumvent any

contractual provider network agreement between a health insurer or third-party administrator and a licensed health care practitioner. (V.T.I.C. Art. 21.52, Sec. 3A.)

Sec. 1451.127. DUTY OF PERSON ARRANGING PROVIDER CONTRACTS FOR HEALTH INSURER OR HEALTH MAINTENANCE ORGANIZATION. (a) A person who arranges contracts with providers on behalf of a health maintenance organization or health insurer shall comply with laws related to the duties of the organization or insurer to notify and consider providers for those contracts.

(b) A violation of this section:

(1) is an unlawful practice under Section 15.05, Business & Commerce Code; and

(2) constitutes restraint of trade. (V.T.I.C. Art. 21.52, Sec. 4.)

[Sections 1451.128-1451.150 reserved for expansion]

SUBCHAPTER D. ACCESS TO OPTOMETRISTS AND OPHTHALMOLOGISTS USED UNDER MANAGED CARE PLAN

Sec. 1451.151. DEFINITIONS. In this subchapter:

(1) "Managed care plan" means a plan under which a health maintenance organization, preferred provider benefit plan issuer, or other organization provides or arranges for health care benefits to plan participants and requires or encourages plan participants to use health care practitioners the plan designates.

(2) "Ophthalmologist" means a physician who specializes in ophthalmology. (V.T.I.C. Art. 21.52D, Sec. (a).)

Sec. 1451.152. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER. (a) This subchapter applies only to a managed care

plan that provides or arranges for benefits for vision or medical eye care services or procedures that are within the scope of an optometrist's or therapeutic optometrist's license.

(b) This subchapter does not require a managed care plan to provide vision or medical eye care services or procedures. (V.T.I.C. Art. 21.52D, Secs. (b) (part), (c).)

Sec. 1451.153. USE OF OPTOMETRIST, THERAPEUTIC OPTOMETRIST, OR OPHTHALMOLOGIST. (a) A managed care plan may not:

(1) discriminate against a health care practitioner because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist;

(2) restrict or discourage a plan participant from obtaining covered vision or medical eye care services or procedures from a participating optometrist, therapeutic optometrist, or ophthalmologist solely because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist;

(3) exclude an optometrist, therapeutic optometrist, or ophthalmologist as a participating practitioner in the plan because the optometrist, therapeutic optometrist, or ophthalmologist does not have medical staff privileges at a hospital or at a particular hospital; or

(4) exclude an optometrist, therapeutic optometrist, or ophthalmologist as a participating practitioner in the plan because the services or procedures provided by the optometrist, therapeutic optometrist, or ophthalmologist may be provided by another type of health care practitioner.

(b) A managed health care plan shall:

(1) include optometrists, therapeutic optometrists, and ophthalmologists as participating health care practitioners in the plan; and

(2) include the name of a participating optometrist, therapeutic optometrist, or ophthalmologist in any list of participating health care practitioners and give equal prominence to each name. (V.T.I.C. Art. 21.52D, Sec. (b) (part).)

[Sections 1451.154-1451.200 reserved for expansion]

SUBCHAPTER E. DENTAL CARE BENEFITS IN HEALTH INSURANCE POLICIES OR EMPLOYEE BENEFIT PLANS

Sec. 1451.201. DEFINITIONS. In this subchapter:

(1) "Dental care service" means a service provided to a person to prevent, alleviate, cure, or heal a human dental illness or injury.

(2) "Employee benefit plan" means a plan, fund, or program established or maintained by an employer or employee organization.

(3) "Health insurance policy" means any individual, group, blanket, or franchise insurance policy, insurance agreement, or group hospital service contract. (V.T.I.C. Art. 21.53, Sec. 1 (part).)

Sec. 1451.202. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER. (a) This subchapter applies only to an employee benefit plan or health insurance policy delivered, issued for delivery, renewed, or contracted for in this state to the extent that:

(1) the employee benefit plan is established or

maintained to provide dental care services, through insurance or otherwise, for the plan's participants or the beneficiaries of the plan's participants; or

(2) the health insurance policy provides benefits for dental care services.

(b) This subchapter does not apply to a health maintenance organization governed by Chapter 843.

(c) The exemptions and exceptions of Sections 881.002 and 881.004 and Article 21.41 do not apply to this subchapter.

(d) This subchapter does not require an employee benefit plan or health insurance policy to provide any type of benefits for dental care expenses. (V.T.I.C. Art. 21.53, Secs. 1(a) (part), (b) (part), 4 (part), 5, 6.)

Sec. 1451.203. CONFLICTING PROVISIONS. A provision of an employee benefit plan or health insurance policy that conflicts with this subchapter is void to the extent of the conflict. (V.T.I.C. Art. 21.53, Sec. 4 (part).)

Sec. 1451.204. CERTAIN CONDUCT PERMITTED. (a) Notwithstanding any other provision of this subchapter, a dentist may contract directly with a patient to provide dental care services to the patient as authorized by law.

(b) Notwithstanding any other provision of this subchapter, a person providing a health insurance policy or employee benefit plan or an employer or an employee organization may:

(1) make information available to its insureds, beneficiaries, participants, employees, or members regarding dental care services through the distribution of factually accurate

information about dental care services and the rates, fees, locations, and hours for the services if the information is distributed on the request of a dentist;

(2) establish an administrative mechanism to facilitate payments for dental care services from an insured, beneficiary, participant, employee, or member to a dentist chosen by the insured, beneficiary, participant, employee, or member; or

(3) nondiscriminatorily pay or reimburse its insured, beneficiary, participant, employee, or member for the cost of dental care services provided by a dentist chosen by the insured, beneficiary, participant, employee, or member. (V.T.I.C. Art. 21.53, Sec. 7.)

Sec. 1451.205. DISCLOSURE OF BENEFIT TERMS. An employee benefit plan or health insurance policy shall:

(1) if applicable, disclose that the benefit for dental care services offered is limited to the least costly treatment; and

(2) specify in dollars and cents the amount of the payment or reimbursement to be provided for dental care services or define and explain the standard on which payment of benefits or reimbursement for the cost of dental care services is based, such as:

(A) "usual and customary" fees;

(B) "reasonable and customary" fees;

(C) "usual, customary, and reasonable" fees; or

(D) words of similar meaning. (V.T.I.C. Art. 21.53, Sec. 3 (part).)

Sec. 1451.206. PAYMENT OR REIMBURSEMENT OF DENTIST. (a) The employee benefit plan or health insurance policy shall provide:

(1) that payment or reimbursement for a noncontracting provider dentist shall be the same as payment or reimbursement for a contracting provider dentist; and

(2) that the party to or beneficiary of the plan or policy may assign the right to payment or reimbursement to the dentist who provides the dental care services.

(b) Notwithstanding Subsection (a)(1), the employee benefit plan or health insurance policy is not required to make payment or reimbursement in an amount greater than:

(1) the amount specified in the plan or policy; or

(2) the fee the providing dentist charges for the dental care services provided.

(c) If the right to payment or reimbursement is assigned as provided by Subsection (a)(2):

(1) payment or reimbursement shall be made directly to the designated dentist; and

(2) direct payment to the designated dentist discharges the payor's obligation. (V.T.I.C. Art. 21.53, Sec. 3 (part).)

Sec. 1451.207. PROHIBITED CONDUCT. (a) An employee benefit plan or health insurance policy may not:

(1) interfere with or prevent an individual who is a party to or beneficiary of the plan or policy from selecting a dentist of the individual's choice to provide a dental care service the plan or policy offers if the dentist selected is licensed in

this state to provide the service;

(2) deny a dentist the right to participate as a contracting provider under the plan or policy if the dentist is licensed to provide the dental care services the plan or policy offers;

(3) authorize a person to regulate, interfere with, or intervene in the provision of dental care services a dentist provides a patient, including diagnosis, if the dentist practices within the scope of the dentist's license; or

(4) require a dentist to make or obtain a dental x-ray or other diagnostic aid in providing dental care services.

(b) Subsection (a)(4) does not prohibit a request for an existing dental x-ray or other existing diagnostic aid for a determination of benefits payable under an employee benefit plan or health insurance policy.

(c) This section does not prohibit the predetermination of benefits for dental care expenses before the attending dentist provides treatment. (V.T.I.C. Art. 21.53, Sec. 2.)

[Sections 1451.208-1451.250 reserved for expansion]

SUBCHAPTER F. ACCESS TO OBSTETRICAL OR GYNECOLOGICAL CARE

Sec. 1451.251. DEFINITION. In this subchapter, "enrollee" means an individual enrolled in a health benefit plan. (V.T.I.C. Art. 21.53D, Sec. 1(1), as added Acts 75th Leg., R.S., Ch. 912.)

Sec. 1451.252. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that requires an enrollee to obtain certain specialty health care services through a referral made by a primary care physician or other gatekeeper and

that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement;

(2) is offered by:

(A) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(B) an entity that is not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53D, Secs. 2(a), (b), (d), as added Acts 75th Leg., R.S., Ch. 912.)

Sec. 1451.253. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments instead of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to a liability insurance policy;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy;

(6) a long-term care insurance policy, including a

nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1451.252; or

(7) any health benefit plan that does not provide:

(A) benefits related to pregnancy; or

(B) well-woman care benefits. (V.T.I.C. Art. 21.53D, Sec. 2(c), as added Acts 75th Leg., R.S., Ch. 912.)

Sec. 1451.254. RULES. The commissioner shall adopt rules necessary to implement this subchapter. (V.T.I.C. Art. 21.53D, Sec. 6, as added Acts 75th Leg., R.S., Ch. 912.)

Sec. 1451.255. RIGHT OF FEMALE ENROLLEE TO SELECT OBSTETRICIAN OR GYNECOLOGIST. (a) Except as provided by Subsection (b), a health benefit plan shall permit a female enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide the enrollee with health care services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist.

(b) A health benefit plan may limit an enrollee's self-referral under Subsection (a) to only one participating obstetrician or gynecologist to provide both gynecological and obstetrical care to the enrollee. This subsection does not affect the right of an enrollee to select the physician who provides that care.

(c) This section does not preclude an enrollee from selecting a qualified physician, including a family physician or

internal medicine physician, to provide the enrollee with health care services described by Subsection (a).

(d) This section does not affect the authority of a health benefit plan issuer to establish selection criteria regarding other physicians who provide services under the plan. (V.T.I.C. Art. 21.53D, Secs. 3(a), (c), 4(e), as added Acts 75th Leg., R.S., Ch. 912.)

Sec. 1451.256. DIRECT ACCESS TO SERVICES OF OBSTETRICIAN OR GYNECOLOGIST. (a) In this section, "health care services" includes:

(1) one well-woman examination each year;

(2) care related to pregnancy;

(3) care for any active gynecological condition; and

(4) diagnosis, treatment, and referral for any disease or condition that is within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist.

(b) In addition to other benefits authorized under the health benefit plan, a health benefit plan shall permit an enrollee who selects an obstetrician or gynecologist under Section 1451.255 to have direct access to the health care services of that selected physician without:

(1) a referral from the enrollee's primary care physician; or

(2) prior authorization or precertification from the plan issuer.

(c) A health benefit plan may not impose a copayment or deductible for direct access to health care services as required by

this section unless the same copayment or deductible is imposed for access to other health care services provided under the plan.

(d) This section does not affect the authority of a health benefit plan issuer to require an obstetrician or gynecologist selected by an enrollee under Section 1451.255 to forward information concerning the medical care of the enrollee to the enrollee's primary care physician. (V.T.I.C. Art. 21.53D, Secs. 4(a), (b), (c), (d) (part), as added Acts 75th Leg., R.S., Ch. 912.)

Sec. 1451.257. AVAILABILITY OF PROVIDERS. To ensure access to services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist, a health benefit plan shall include in the classification of persons authorized to provide medical services under the plan a sufficient number of properly credentialed obstetricians and gynecologists. (V.T.I.C. Art. 21.53D, Sec. 3(b), as added Acts 75th Leg., R.S., Ch. 912.)

Sec. 1451.258. NOTICE OF AVAILABLE PROVIDERS. (a) A health benefit plan issuer shall provide to each person covered under the plan a timely written notice of the choices of the types of physician providers available for the direct access required under this subchapter.

(b) The notice must be stated in clear and accurate language. (V.T.I.C. Art. 21.53D, Sec. 5, as added Acts 75th Leg., R.S., Ch. 912.)

Sec. 1451.259. LIMITS ON PHYSICIAN SANCTIONS. (a) A health benefit plan may not sanction or terminate a primary care physician because of female enrollees' access to participating obstetricians

and gynecologists under this subchapter.

(b) A health benefit plan may not impose a financial or other penalty on an obstetrician or gynecologist selected under Section 1451.255, or on the enrollee who selected the physician, because the selected physician failed to provide to the enrollee's primary care physician information concerning the medical care of the enrollee if the selected physician made a reasonable good faith effort to forward the information. (V.T.I.C. Art. 21.53D, Secs. 4(d) (part), (f), as added Acts 75th Leg., R.S., Ch. 912.)

Sec. 1451.260. ADMINISTRATIVE PENALTY. An entity that operates a health benefit plan in violation of this subchapter is subject to an administrative penalty as provided by Chapter 84. (V.T.I.C. Art. 21.53D, Sec. 7, as added Acts 75th Leg., R.S., Ch. 912.)

[Sections 1451.261-1451.300 reserved for expansion]

SUBCHAPTER G. ACCESS TO DIETITIAN SERVICES

Sec. 1451.301. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, the construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

Sec. 1451.302. DIETITIAN SERVICES. An individual or group accident and health insurance policy delivered or issued for delivery in this state may not:

(1) exclude or deny coverage for services performed by:

(A) a dietitian; or

(B) a provisionally licensed dietitian acting under the supervision of a dietitian; or

(2) refuse payment or reimbursement for charges for services described by Subdivision (1) if the services:

(A) are in the scope of the dietitian's license;

(B) are related to an injury or illness the policy covers if the services are scheduled in the policy; and

(C) are provided under a professional recommendation of a physician whose treatment or examination for the injury or illness would be covered by the policy and would be payable or reimbursable under the policy. (V.T.I.C. Art. 3.70-2, Sec. (H), as amended Acts 70th Leg., R.S., Ch. 875, Sec. 2.)

[Sections 1451.303-1451.350 reserved for expansion]

SUBCHAPTER H. DISABILITY CERTIFIED BY PODIATRIST

Sec. 1451.351. LOSS OF INCOME BENEFITS FOR DISABILITY TREATABLE BY PODIATRIST. (a) This section applies only to an insurance policy delivered, issued for delivery, or renewed in this state that provides benefits covering loss of income as a result of an acute temporary disability caused by sickness or injury.

(b) An insurance policy may not deny payment of benefits described by Subsection (a) solely because the disability is certified or attested to by a podiatrist if the disability is caused by a sickness or injury that may be treated within the scope of the podiatrist's license. (V.T.I.C. Art. 21.52A.)

[Sections 1451.352-1451.400 reserved for expansion]

SUBCHAPTER I. USE OF OSTEOPATHIC HOSPITAL

Sec. 1451.401. CONTRACT WITH OSTEOPATHIC HOSPITAL. A health maintenance organization or preferred provider benefit plan issuer that contracts with a hospital to provide services to covered individuals may not refuse to contract with an osteopathic hospital solely because the hospital is an osteopathic hospital. (V.T.I.C. Art. 21.53B, Sec. (a).)

Sec. 1451.402. SERVICES AT OSTEOPATHIC HOSPITAL. A health maintenance organization or preferred provider benefit plan issuer that provides benefits for inpatient or outpatient services provided by an allopathic hospital shall seek to provide benefits for similar services provided by an osteopathic hospital if there is an osteopathic hospital within the service area of the health maintenance organization or preferred provider benefit plan issuer that will provide the services at a substantially similar cost. (V.T.I.C. Art. 21.53B, Sec. (b).)

Sec. 1451.403. REQUEST FOR ACTION OF COMMISSIONER. An aggrieved party may request that the commissioner conduct an investigation, review, hearing, or other proceeding to determine compliance with this subchapter. (V.T.I.C. Art. 21.53B, Sec. (c) (part).)

Sec. 1451.404. ENFORCEMENT. The commissioner shall take all reasonable actions to ensure compliance with this subchapter, including issuing orders and assessing penalties. (V.T.I.C. Art. 21.53B, Sec. (c) (part).)

CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS

SUBCHAPTER A. CREDENTIALING OF PHYSICIANS AND PROVIDERS BY HEALTH MAINTENANCE ORGANIZATION

CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS

SUBCHAPTER A. CREDENTIALING OF PHYSICIANS AND PROVIDERS BY HEALTH MAINTENANCE ORGANIZATION

Sec. 1452.001. APPLICABILITY OF CERTAIN DEFINITIONS. In this subchapter, a term defined by Section 843.002 has the meaning assigned by that section. (V.T.I.C. Art. 20A.01B, as added Acts 77th Leg., R.S., Ch. 1419.)

Sec. 1452.002. VERIFICATION OF PHYSICIAN'S LICENSE OR CERTIFICATE. The commissioner shall require a health maintenance organization to verify that a physician's license to practice medicine and any other certificate the physician is required to hold, including a certificate issued by the Department of Public Safety or the federal Drug Enforcement Administration or a

certificate issued under the Medicare program, is valid as of the date of:

(1) initial credentialing of the physician; and

(2) each recredentialing. (V.T.I.C. Art. 20A.39, Sec. (b).)

Sec. 1452.003. SITE VISIT FOR INITIAL CREDENTIALING. (a) The commissioner shall require a health maintenance organization that conducts a site visit for the purpose of initial credentialing of a physician or provider to evaluate during the visit a site's accessibility, appearance, space, medical or dental recordkeeping practices, availability of appointments, and confidentiality procedures.

(b) The commissioner may not require the health maintenance organization to evaluate the appropriateness of equipment during the site visit. (V.T.I.C. Art. 20A.39, Sec. (c).)

Sec. 1452.004. LIMITATION ON COMMISSIONER'S AUTHORITY. The commissioner may not require a health maintenance organization to:

(1) formally recredential a physician or provider more frequently than once in any three-year period;

(2) verify the validity of a license or certificate held by a physician as of a date other than the date of initial credentialing or recredentialing of the physician;

(3) use clinical personnel to perform a site visit for initial credentialing of a physician or provider unless clinical review is needed during the site visit; or

(4) require a site visit be performed for the purpose of recredentialing of a physician or provider. (V.T.I.C. Art.

20A.39, Sec. (d).)

Sec. 1452.005. SITE VISIT FOR CAUSE NOT PRECLUDED. This subchapter does not preclude a health maintenance organization from conducting a site visit of a physician or provider at any time for cause, including a complaint made by a member or another external complaint made to the health maintenance organization. (V.T.I.C. Art. 20A.39, Sec. (e).)

Sec. 1452.006. RULES RELATED TO SELECTION OF PHYSICIANS AND PROVIDERS BY HEALTH MAINTENANCE ORGANIZATION. A rule adopted by the commissioner under Section 843.102 that relates to implementation and maintenance by a health maintenance organization of a process for selecting and retaining affiliated physicians and providers must comply with:

(1) this subchapter; and

(2) standards adopted by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. (V.T.I.C. Art. 20A.39, Sec. (a).)

[Sections 1452.007-1452.050 reserved for expansion]

SUBCHAPTER B. STANDARDIZED FORMS

Sec. 1452.051. DEFINITION. In this subchapter, "physician" means an individual licensed to practice medicine in this state. (V.T.I.C. Art. 21.58D, Sec. 1.)

Sec. 1452.052. STANDARDIZED FORM FOR VERIFICATION OF PHYSICIAN CREDENTIALS. (a) The commissioner by rule shall:

(1) prescribe a standardized form for the verification of a physician's credentials; and

(2) require a public or private hospital, a health

maintenance organization operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of physician credentials.

(b) In prescribing a form under this section, the commissioner shall consider any credentialing application form that is widely used in this state. (V.T.I.C. Art. 21.58D, Sec. 2.)

CHAPTER 1453. DISCLOSURE OF REIMBURSEMENT GUIDELINES UNDER MANAGED CARE PLAN

Sec. 1453.001. DEFINITIONS

Sec. 1453.002. PROVISION OF INFORMATION REGARDING REIMBURSEMENT GUIDELINES

Sec. 1453.003. RULES

CHAPTER 1453. DISCLOSURE OF REIMBURSEMENT GUIDELINES UNDER MANAGED CARE PLAN

Sec. 1453.001. DEFINITIONS. In this chapter:

(1) "Health care provider" means:

(A) a hospital, emergency clinic, outpatient clinic, or other facility providing health care services; or

(B) an individual who is licensed in this state to provide health care services.

(2) "Managed care entity" means:

(A) a health maintenance organization;

(B) a preferred provider benefit plan issuer;

(C) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(D) another entity that offers a managed care plan, including:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

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

(v) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; and

(vi) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis.

(3) "Managed care plan" means a health benefit plan:

(A) under which health care services are provided through contracts with health care providers to individuals enrolled in or insured under the plan; and

(B) that provides financial incentives to individuals enrolled in or insured under the plan to use health care providers participating in the plan and procedures covered by the plan. (V.T.I.C. Art. 21.60, Sec. 1.)

Sec. 1453.002. PROVISION OF INFORMATION REGARDING REIMBURSEMENT GUIDELINES. (a) On the written request of an out-of-network health care provider, a managed care entity shall furnish to the provider a written description of the factors considered by the entity in determining the amount of reimbursement the provider may receive for goods or services provided to an

individual enrolled in or insured under the entity's managed care plan.

(b) This section does not require a managed care entity to disclose proprietary information that is prohibited from disclosure by a contract between the entity and a vendor that supplies payment or statistical data to the entity.

(c) A contract between a managed care entity and a vendor that supplies payment or statistical data to the entity may not prohibit the entity from disclosing under this section:

(1) the name of the vendor; or

(2) the methodology and origin of information used to determine the amount of reimbursement.

(d) A managed care entity that denies a request for information described by Subsection (b) shall send a copy of the request and the information requested to the department for review. (V.T.I.C. Art. 21.60, Sec. 2.)

Sec. 1453.003. RULES. The commissioner shall adopt rules as necessary to implement this chapter. (V.T.I.C. Art. 21.60, Sec. 3.)

CHAPTER 1454. EQUAL HEALTH CARE FOR WOMEN

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 1454.003-1454.050 reserved for expansion]

SUBCHAPTER B. REIMBURSEMENT FOR HEALTH CARE SERVICES

[Sections 1454.053-1454.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

CHAPTER 1454. EQUAL HEALTH CARE FOR WOMEN

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1454.001. DEFINITIONS. In this chapter:

(1) "Health care provider" means a home health aide, hospital, nurse practitioner, nurse midwife, outpatient care center, physician assistant, registered nurse, or surgery center.

(2) "Physician" has the meaning assigned by Section 151.002, Occupations Code. (V.T.I.C. Art. 21.53N, Sec. 1.)

Sec. 1454.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group,

blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

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

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(9) a small employer health benefit plan written under Chapter 1501. (V.T.I.C. Art. 21.53N, Sec. 2.)

[Sections 1454.003-1454.050 reserved for expansion]

SUBCHAPTER B. REIMBURSEMENT FOR HEALTH CARE SERVICES

Sec. 1454.051. EQUAL REIMBURSEMENT REQUIRED. A health benefit plan issuer that reimburses a physician or health care provider for reproductive health or oncology services provided to women must reimburse the physician or provider in an amount at least equal to the annual average compensation per hour or unit that would be paid in the service area to a physician or provider for the same

medical, surgical, hospital, pharmaceutical, nursing, or other similar resources used to provide the services if the resources would be used to provide health services exclusively to men or to the general population. (V.T.I.C. Art. 21.53N, Sec. 3.)

Sec. 1454.052. REIMBURSEMENT FOR ABORTION NOT REQUIRED. This chapter does not require a health benefit plan issuer to provide reimbursement for an abortion, as defined by the Family Code, or for a service related to an abortion. (V.T.I.C. Art. 21.53N, Sec. 6.)

[Sections 1454.053-1454.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

Sec. 1454.101. SANCTIONS AUTHORIZED. The sanctions authorized by Chapter 82 apply to a health benefit plan issuer that violates this chapter. (V.T.I.C. Art. 21.53N, Sec. 4(a) (part).)

Sec. 1454.102. CEASE AND DESIST PROCEDURES AND RESTITUTION FOR ATTORNEY'S FEES AUTHORIZED. The commissioner may use the cease and desist procedures authorized by Chapter 83 against a health benefit plan issuer that violates this chapter. In accordance with Chapter 83, the commissioner may order the health benefit plan issuer to make complete restitution for the violation, which may include restitution for the reasonable attorney's fees incurred by a person making a complaint under this chapter. (V.T.I.C. Art. 21.53N, Sec. 4(a) (part).)

Sec. 1454.103. ADMINISTRATIVE PENALTIES AUTHORIZED. (a) In addition to any sanctions authorized by this subchapter, the commissioner may impose an administrative penalty in accordance with Chapter 84 on a health benefit plan issuer that violates this

chapter.

(b) On a finding that a health benefit plan issuer knowingly violated this chapter, the commissioner may impose in addition to the administrative penalty authorized by Section 84.022 an administrative penalty that does not exceed $25,000. (V.T.I.C. Art. 21.53N, Sec. 4(b).)

Sec. 1454.104. AMOUNT OF DAMAGES. Notwithstanding this subchapter, in imposing a sanction or penalty for a violation of this chapter, the commissioner may order a health benefit plan issuer to pay the greater of complete or economic damages. (V.T.I.C. Art. 21.53N, Sec. 4(a) (part).)

Sec. 1454.105. APPLICABILITY OF CERTAIN PROCEDURAL REQUIREMENTS TO SANCTIONS OR ADMINISTRATIVE PENALTIES. Subchapter C, Chapter 84, applies to the imposition of a sanction or administrative penalty under this chapter. (V.T.I.C. Art. 21.53N, Sec. 4(d).)

Sec. 1454.106. INTERVENTION IN PROCEEDING. (a) In a proceeding relating to the imposition by the commissioner of a sanction or administrative penalty under this chapter, a person affected by an order of the commissioner, including a physician or health care provider, may intervene in the proceeding by filing a notice of intervention with the commissioner. The commissioner shall provide an affected person a reasonable period to intervene.

(b) At the time the commissioner notifies a health benefit plan issuer of the issuer's opportunity for a hearing regarding an alleged violation, the commissioner shall notify each affected person of all relevant information regarding the hearing.

(c) A person who intervenes under this section has the rights and powers of a party under Chapter 2001, Government Code. (V.T.I.C. Art. 21.53N, Sec. 4(e).)

Sec. 1454.107. TIME FOR COMMISSIONER'S DETERMINATION. Not later than the 120th day after the date a complaint alleging a violation of this chapter is filed with the department, the commissioner shall determine whether the alleged violation occurred and impose appropriate sanctions. (V.T.I.C. Art. 21.53N, Sec. 4(c).)

Sec. 1454.108. FAILURE OF COMMISSIONER TO MAKE DETERMINATION BY ORDER; ACTION IN DISTRICT COURT. (a) If the commissioner fails to determine by order in the time prescribed by Section 1454.107 whether a violation alleged in a complaint filed under this chapter occurred, the person who filed the complaint may bring an action in district court for the violation.

(b) The action must be commenced not later than the first anniversary of the date by which the commissioner is required to make a determination under Section 1454.107.

(c) In an action filed under this section, a court may:

(1) impose the sanctions authorized by this subchapter or similar sanctions;

(2) assess an additional civil penalty of $25,000 if the trier of fact finds the defendant knowingly violated this chapter; and

(3) award a claimant who prevails in an action filed under this section reasonable attorney's fees and court costs, including reasonable and necessary expert witness fees.

(d) On a finding by the court that an action filed under this section was groundless and brought in bad faith or brought for the purpose of harassment, the court shall award the defendant reasonable and necessary attorney's fees. (V.T.I.C. Art. 21.53N, Secs. 5(b), (c), (d).)

Sec. 1454.109. APPEAL OF COMMISSIONER'S ORDER. (a) A person affected by an order of the commissioner regarding a violation of this chapter, including a person who intervenes under Section 1454.106, may file an appeal in district court.

(b) The standard of review for an appeal filed under this section is substantial evidence. (V.T.I.C. Art. 21.53N, Sec. 5(a).)

CHAPTER 1455. TELEMEDICINE AND TELEHEALTH

CHAPTER 1455. TELEMEDICINE AND TELEHEALTH

Sec. 1455.001. DEFINITIONS. In this chapter:

(1) "Health professional" means:

(A) a physician;

(B) an individual who is:

(i) licensed or certified in this state to perform health care services; and

(ii) authorized to assist a physician in

providing telemedicine medical services that are delegated and supervised by the physician; or

(C) a licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service.

(2) "Physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(3) "Telehealth service" and "telemedicine medical service" have the meanings assigned by Section 57.042, Utilities Code. (V.T.I.C. Art. 21.53F, Secs. 1(2), (3), (4), (5), as added Acts 75th Leg., R.S., Ch. 880.)

Sec. 1455.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53F, Sec. 2(a), as added Acts 75th Leg., R.S., Ch. 880.)

Sec. 1455.003. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to a liability insurance policy;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1455.002. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 880.)

Sec. 1455.004. COVERAGE FOR TELEMEDICINE MEDICAL SERVICES AND TELEHEALTH SERVICES. (a) A health benefit plan may not exclude a telemedicine medical service or a telehealth service from coverage under the plan solely because the service is not provided through a face-to-face consultation.

(b) A health benefit plan may require a deductible, a copayment, or coinsurance for a telemedicine medical service or a telehealth service. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for a comparable medical service provided through a face-to-face consultation. (V.T.I.C. Art. 21.53F, Sec. 3, as added Acts 75th Leg., R.S., Ch. 880.)

Sec. 1455.005. RULES. Subject to Section 107.004, Occupations Code, the commissioner may adopt rules necessary to implement this chapter. (V.T.I.C. Art. 21.53F, Sec. 6(a), as added Acts 75th Leg., R.S., Ch. 880.)

[Chapters 1456-1500 reserved for expansion]

SUBTITLE G. HEALTH COVERAGE AVAILABILITY

CHAPTER 1501. HEALTH INSURANCE PORTABILITY

AND AVAILABILITY ACT

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 1501.012-1501.050 reserved for expansion]

SUBCHAPTER B. PURCHASING COOPERATIVES

CHAPTER 1501. HEALTH INSURANCE PORTABILITY AND AVAILABILITY ACT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1501.001. SHORT TITLE. This chapter may be cited as the Health Insurance Portability and Availability Act. (V.T.I.C. Art. 26.01.)

Sec. 1501.002. DEFINITIONS. In this chapter:

(1) "Agent" means a person who may act as an agent for the sale of a health benefit plan under a license issued under Title

13.

(2) "Dependent" means:

(A) a spouse;

(B) a child younger than 25 years of age, including a newborn child;

(C) a child of any age who is:

(i) medically certified as disabled; and

(ii) dependent on the parent;

(D) an individual who must be covered under:

(i) Section 1251.154; or

(ii) Section 1201.062; and

(E) any other child eligible under an employer's health benefit plan, including a child described by Section 1503.003.

(3) "Eligible employee" means an employee who works on a full-time basis and who usually works at least 30 hours a week. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an employee under a health benefit plan of a small or large employer. The term does not include an employee who:

(A) works on a part-time, temporary, seasonal, or substitute basis;

(B) is covered under:

(i) another health benefit plan; or

(ii) a self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income

Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or

(C) elects not to be covered under the employer's health benefit plan and is covered under:

(i) the Medicaid program;

(ii) another federal program, including the CHAMPUS program or Medicare program; or

(iii) a benefit plan established in another country.

(4) "Employee" means an individual employed by an employer.

(5) "Health benefit plan" means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

(A) accident-only or disability income insurance coverage or a combination of accident-only and disability income insurance coverage;

(B) credit-only insurance coverage;

(C) disability insurance coverage;

(D) coverage for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select benefit plans regulated in accordance with federal law;

(G) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or

benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(H) coverage that provides limited-scope dental or vision benefits;

(I) coverage provided by a single service health maintenance organization;

(J) workers' compensation insurance coverage or similar insurance coverage;

(K) coverage provided through a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(L) hospital indemnity or other fixed indemnity insurance coverage;

(M) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(N) short-term major medical contracts;

(O) liability insurance coverage, including general liability insurance coverage and automobile liability insurance coverage, and coverage issued as a supplement to liability insurance coverage, including automobile medical payment insurance coverage;

(P) coverage for on-site medical clinics;

(Q) coverage that provides other limited benefits specified by federal regulations; or

(R) other coverage that:

(i) is similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other coverage benefits; and

(ii) is specified by federal regulations.

(6) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including:

(A) an insurance company;

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

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

(7) "Health status related factor" means:

(A) health status;

(B) medical condition, including both physical and mental illness;

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

(G) evidence of insurability, including conditions arising out of acts of family violence; and

(H) disability.

(8) "Large employer" means a person who employed an average of at least 51 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. The term includes a governmental entity subject to Article 3.51-1, 3.51-2, 3.51-4, or 3.51-5, to Subchapter C, Chapter 1364, or to Chapter 1578 that otherwise meets the requirements of this subdivision. For purposes of this definition, a partnership is the employer of a partner.

(9) "Large employer health benefit plan" means a health benefit plan offered to a large employer.

(10) "Large employer health benefit plan issuer" means a health benefit plan issuer, to the extent that the issuer is offering, delivering, issuing for delivery, or renewing health benefit plans subject to Subchapters C and M.

(11) "Person" means an individual, corporation, partnership, or other legal entity.

(12) "Preexisting condition provision" means a provision that excludes or limits coverage as to a disease or condition for a specified period after the effective date of coverage.

(13) "Premium" means all amounts paid by a small or large employer and eligible employees as a condition of receiving coverage from a small or large employer health benefit plan issuer, including any fees or other contributions associated with a health benefit plan.

(14) "Small employer" means a person who employed an average of at least two employees but not more than 50 eligible

employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. The term includes a governmental entity subject to Article 3.51-1, 3.51-2, 3.51-4, or 3.51-5, to Subchapter C, Chapter 1364, or to Chapter 1578 that otherwise meets the requirements of this subdivision. For purposes of this definition, a partnership is the employer of a partner.

(15) "Small employer health benefit plan" means a health benefit plan developed by the commissioner under Subchapter F or any other health benefit plan offered to a small employer in accordance with Section 1501.252(c) or 1501.255.

(16) "Small employer health benefit plan issuer" means a health benefit plan issuer, to the extent that the issuer is offering, delivering, issuing for delivery, or renewing health benefit plans subject to Subchapters C-H.

(17) "Waiting period" means a period established by an employer that must elapse before an individual who is a potential enrollee in a health benefit plan is eligible to be covered for benefits. (V.T.I.C. Art. 26.02, Subdivs. (2), (8), (9), (10), (11), (12), (13), (15), (16), (17), (21), (24), (25); Art. 26.02, Subdivs. (30), (31), (32), (34), as amended Acts 77th Leg., R.S., Ch. 823; Art. 26.02, Subdivs. (29), (30), (31), (33), as amended Acts 77th Leg., R.S., Ch. 608.)

Sec. 1501.003. APPLICABILITY: SMALL EMPLOYER HEALTH BENEFIT PLANS. An individual or group health benefit plan is a small employer health benefit plan subject to Subchapters C-H if it provides health care benefits covering two or more eligible

employees of a small employer and:

(1) the employer pays a portion of the premium or benefits;

(2) the employer or a covered individual treats the health benefit plan as part of a plan or program for purposes of Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162); or

(3) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. Section 2510.3-1(j). (V.T.I.C. Art. 26.06, Subsec. (a).)

Sec. 1501.004. APPLICABILITY: LARGE EMPLOYER HEALTH BENEFIT PLANS. An individual or group health benefit plan is a large employer health benefit plan subject to Subchapters C and M if the plan provides health care benefits to eligible employees of a large employer and:

(1) the employer pays a portion of the premium or benefits;

(2) the employer or a covered individual treats the health benefit plan as part of a plan or program for purposes of Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162); or

(3) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. Section 2510.3-1(j). (V.T.I.C. Art. 26.81, Subsec. (a).)

Sec. 1501.005. EXCEPTION: CERTAIN INDIVIDUALLY UNDERWRITTEN POLICIES. Except as provided by Section 1501.003 or 1501.004, this chapter does not apply to an individual health

insurance policy that is subject to individual underwriting, even if the premium is paid through a payroll deduction method. (V.T.I.C. Art. 26.06, Subsec. (c); Art. 26.81, Subsec. (c).)

Sec. 1501.006. CERTIFICATION. (a) In accordance with rules adopted by the commissioner, each health benefit plan issuer shall certify that the issuer is offering, delivering, issuing for delivery, or renewing, or that the issuer intends to offer, deliver, issue for delivery, or renew:

(1) a health benefit plan to or through a small employer in this state that is subject to this chapter; or

(2) a health benefit plan to or through a large employer in this state that is subject to this chapter.

(b) A health benefit plan issuer must submit a revised certification to the commissioner only if the issuer changes its status as a small or large employer health benefit plan issuer or changes its intent to become a small or large employer health benefit plan issuer to the extent that its previous certification ceases to be accurate.

(c) The certification must include a statement that the health benefit plan issuer is complying with this chapter to the extent it applies to the issuer. (V.T.I.C. Arts. 26.07, 26.82.)

Sec. 1501.007. AFFILIATES. (a) In this section, "affiliate" has the meaning described by Section 823.003.

(b) For purposes of this chapter, health benefit plan issuers that are affiliates or that are eligible to file a consolidated tax return are considered to be one issuer, and a restriction imposed by this chapter applies as if the health

benefit plans delivered or issued for delivery to small employers in this state by the affiliates were issued by one issuer.

(c) Notwithstanding Subsection (b), a health maintenance organization that is an affiliate is considered to be a separate health benefit plan issuer for purposes of this chapter. (V.T.I.C. Art. 26.03.)

Sec. 1501.008. LATE ENROLLEES. (a) For purposes of this chapter, an employee or dependent eligible for enrollment in a small or large employer's health benefit plan is a late enrollee if the individual requests enrollment after the expiration of:

(1) the initial enrollment period established under the terms of the first plan for which the individual was eligible through the small or large employer; or

(2) an open enrollment period under Section 1501.156(a) or 1501.606(a).

(b) An employee or dependent eligible for enrollment is not a late enrollee if the individual:

(1) was covered under another health benefit plan or self-funded employer health benefit plan at the time the individual was eligible to enroll;

(2) declined enrollment in writing, at the time of the initial eligibility for enrollment, stating that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;

(3) has lost coverage under the other health benefit plan or self-funded employer health benefit plan as a result of:

(A) the termination of employment;

(B) a reduction in the number of hours of employment;

(C) the termination of the other plan's coverage;

(D) the termination of contributions toward the premium made by the employer; or

(E) the death of a spouse or divorce; and

(4) requests enrollment not later than the 31st day after the date coverage under the other health benefit plan or self-funded employer health benefit plan terminates.

(c) An employee or dependent eligible for enrollment is also not a late enrollee if the individual is:

(1) employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period;

(2) a spouse for whom a court has ordered coverage under a covered employee's plan and the request for enrollment of the spouse is made not later than the 31st day after the date the court order is issued;

(3) a child for whom a court has ordered coverage under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date the employer receives the court order; or

(4) a child of a covered employee who has lost coverage under Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s), or under Chapter 62, Health and Safety Code, and the request for enrollment is made

not later than the 31st day after the date on which the child loses coverage. (V.T.I.C. Art. 26.02, Subdiv. (18).)

Sec. 1501.009. SCHOOL DISTRICT ELECTION. (a) An independent school district may elect to participate as a small employer without regard to the number of eligible employees in the district. An independent school district that makes the election is treated as a small employer under this chapter for all purposes.

(b) An independent school district that is participating in the uniform group coverage program established under Article 3.50-7 may not participate in the small employer market under this section for health insurance coverage and may not renew a health insurance contract obtained in accordance with this section after the date on which the program of coverages provided under Article 3.50-7 is implemented. This subsection does not affect a contract for the provision of optional coverages not included in a health benefit plan under this chapter. (V.T.I.C. Art. 26.036.)

Sec. 1501.010. GENERAL RULES. The commissioner shall adopt rules necessary to:

(1) implement this chapter; and

(2) meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 26.04.)

Sec. 1501.011. DETERMINATION OF EMPLOYER STATUS FOR CERTAIN EMPLOYERS. (a) For an employer that did not exist throughout the calendar year preceding the year in which the determination of whether the employer is a small employer is made, the determination is based on the average number of employees and eligible employees the employer reasonably expects to employ on business days in the

calendar year in which the determination is made.

(b) For an employer that did not exist throughout the calendar year preceding the year in which the determination of whether the employer is a large employer is made, the determination is based on the average number of eligible employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made. (V.T.I.C. Art. 26.06, Subsec. (b); Art. 26.81, Subsec. (b).)

[Sections 1501.012-1501.050 reserved for expansion]

SUBCHAPTER B. PURCHASING COOPERATIVES

Sec. 1501.051. DEFINITIONS. In this subchapter:

(1) "Board of directors" means the board of directors elected by a private purchasing cooperative.

(2) "Board of trustees" means the board of trustees of the Texas cooperative.

(3) "Cooperative" means a purchasing cooperative established under this subchapter.

(4) "Texas cooperative" means the Texas Health Benefits Purchasing Cooperative established under Section 1501.052. (V.T.I.C. Art. 26.11.)

Sec. 1501.052. TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE; BOARD OF TRUSTEES. (a) The Texas Health Benefits Purchasing Cooperative is a nonprofit corporation established to make health care coverage available to small and large employers and their eligible employees and the eligible employees' dependents.

(b) The Texas cooperative is administered by a board of

trustees of six members appointed by the governor with the advice and consent of the senate. Three members must represent employers, two members must represent employees, and one member must represent the public.

(c) Members of the board of trustees serve staggered six-year terms, with the terms of two members expiring February 1 of each odd-numbered year.

(d) A member of the board of trustees may not be compensated for serving on the board but is entitled to reimbursement for actual expenses incurred in performing functions as a member of the board as provided by the General Appropriations Act. (V.T.I.C. Art. 26.13, Subsecs. (a), (b), (c), (d).)

Sec. 1501.053. TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE: EXECUTIVE DIRECTOR AND OTHER EMPLOYEES. (a) The board of trustees shall employ an executive director. The executive director may hire other employees of the Texas cooperative as necessary.

(b) Salaries for employees of the Texas cooperative and related costs may be paid from administrative fees collected from employers and participating health benefit plan issuers or other sources of funding arranged by the Texas cooperative. (V.T.I.C. Art. 26.13, Subsecs. (e), (g).)

Sec. 1501.054. REGIONAL SUBDIVISIONS OF TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE. The board of trustees may:

(1) develop regional subdivisions of the Texas cooperative; and

(2) authorize each subdivision to separately exercise

the powers and duties of a cooperative. (V.T.I.C. Art. 26.13, Subsec. (f).)

Sec. 1501.055. APPLICABILITY OF PUBLIC INFORMATION LAW TO TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE. The Texas cooperative is subject to the public information law, Chapter 552, Government Code. (V.T.I.C. Art. 26.12, Subsec. (b).)

Sec. 1501.056. PRIVATE PURCHASING COOPERATIVES. (a) Two or more small or large employers may form a private cooperative to purchase small or large employer health benefit plans. The cooperative must be organized as a nonprofit corporation and has the rights and duties provided by the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes).

(b) On receipt of a certificate of incorporation or certificate of authority from the secretary of state, the cooperative shall file written notice of the receipt of the certificate and a copy of the cooperative's organizational documents with the commissioner.

(c) Annually, the board of directors shall file with the commissioner a statement of all amounts collected and expenses incurred for each of the preceding three years. (V.T.I.C. Art. 26.14, Subsecs. (a), (b), (c).)

Sec. 1501.057. IMMUNITY. (a) The Texas cooperative or a member of the board of trustees, the executive director, or an employee or agent of the Texas cooperative is not liable for:

(1) an act performed in good faith in the execution of duties in connection with the cooperative; or

(2) an independent action of a small employer health

benefit plan issuer or a person who provides health care services under a health benefit plan.

(b) A private purchasing cooperative or a member of the board of directors, the executive director, or an employee or agent of the cooperative is not liable for:

(1) an act performed in good faith in the execution of duties in connection with the cooperative; or

(2) an independent action of a small or large employer health benefit plan issuer or a person who provides health care services under a health benefit plan. (V.T.I.C. Art. 26.13, Subsec. (h); Art. 26.14, Subsec. (d).)

Sec. 1501.058. POWERS AND DUTIES OF COOPERATIVES. (a) A cooperative shall:

(1) arrange for small or large employer health benefit plan coverage for small or large employer groups that participate in the cooperative by contracting with small or large employer health benefit plan issuers that meet the requirements established by Section 1501.061;

(2) collect premiums to cover the cost of:

(A) small or large employer health benefit plan coverage purchased through the cooperative; and

(B) the cooperative's administrative expenses;

(3) establish administrative and accounting procedures for the operation of the cooperative;

(4) establish procedures under which an applicant for or participant in coverage issued through the cooperative may have a grievance reviewed by an impartial person;

(5) contract with small or large employer health benefit plan issuers to provide services to small or large employers covered through the cooperative; and

(6) develop and implement a plan to maintain public awareness of the cooperative and publicize the eligibility requirements for, and the procedures for enrollment in, coverage through the cooperative.

(b) A cooperative may:

(1) contract with agents to market coverage issued through the cooperative;

(2) contract with a small or large employer health benefit plan issuer or third-party administrator to provide administrative services to the cooperative;

(3) negotiate the premiums paid by its members; and

(4) offer other ancillary products and services to its members that are customarily offered in conjunction with health benefit plans.

(c) A cooperative shall comply with:

(1) federal laws applicable to cooperatives and health benefit plans issued through cooperatives, to the extent required by state law or rules adopted by the commissioner; and

(2) state laws applicable to cooperatives and health benefit plans issued through cooperatives. (V.T.I.C. Art. 26.15, Subsecs. (a), (d).)

Sec. 1501.059. SELF-INSURED OR SELF-FUNDED PLAN PROHIBITED. A cooperative may not self-insure or self-fund any health benefit plan or portion of a plan. (V.T.I.C. Art. 26.15,

Subsec. (c).)

Sec. 1501.060. SCOPE OF GROUP COVERAGE. Subchapter B, Chapter 1251, does not limit the type of group that may be covered by a group health benefit plan issued through a cooperative. (V.T.I.C. Art. 26.12, Subsec. (a).)

Sec. 1501.061. REQUIREMENTS APPLICABLE TO HEALTH BENEFIT PLAN ISSUERS WITH WHICH COOPERATIVE MAY CONTRACT. A cooperative may contract only with a small or large employer health benefit plan issuer that desires to offer coverage through the cooperative and that demonstrates that the issuer:

(1) is in good standing with the department;

(2) has the capacity to administer health benefit plans;

(3) is able to monitor and evaluate the quality and cost-effectiveness of care and applicable procedures;

(4) is able to conduct utilization management and establish applicable procedures and policies;

(5) is able to ensure that enrollees have adequate access to health care providers, including adequate numbers and types of providers;

(6) has a satisfactory grievance procedure and is able to respond to enrollees' calls, questions, and complaints; and

(7) has financial capacity, either through satisfying financial solvency standards, as applied by the commissioner, or through appropriate reinsurance or other risk-sharing mechanisms. (V.T.I.C. Art. 26.15, Subsec. (b).)

Sec. 1501.062. COOPERATIVE NOT INSURER; AGENTS AND

ADMINISTRATORS. (a) A cooperative is not an insurer and the employees of the cooperative are not required to be licensed under Title 13.

(b) An agent or third-party administrator used and compensated by a cooperative must be licensed as required by Title 13.

(c) An agent used and compensated by a cooperative may market the products and services sponsored by the cooperative without being appointed by each small employer health benefit plan issuer participating in the cooperative. The agent may not market any other product or service of a participating issuer that is not sponsored by the cooperative unless the agent has been appointed by that issuer. (V.T.I.C. Art. 26.16, Subsecs. (a), (c), (d).)

Sec. 1501.063. COOPERATIVE AS EMPLOYER. A cooperative is considered an employer solely for the purposes of benefit elections under this code. (V.T.I.C. Art. 26.16, Subsec. (b).)

Sec. 1501.064. CERTAIN USE OF APPROPRIATED MONEY PROHIBITED. The Texas cooperative may not use money appropriated by the state to pay or otherwise subsidize any portion of the premium for a small employer covered through the cooperative. (V.T.I.C. Art. 26.13, Subsec. (i).)

[Sections 1501.065-1501.100 reserved for expansion]

SUBCHAPTER C. PROVISION OF COVERAGE

Sec. 1501.101. GEOGRAPHIC SERVICE AREAS. (a) A small or large employer health benefit plan issuer must file each of the issuer's geographic service areas with the commissioner. The commissioner may disapprove the use of a geographic service area by

a small or large employer health benefit plan issuer.

(b) A small employer health benefit plan issuer that refuses to issue a small employer health benefit plan in a geographic service area may not offer a health benefit plan to a small employer in the applicable service area before the fifth anniversary of the date of the refusal.

(c) A small or large employer health benefit plan issuer is not required to offer or issue a small or large employer health benefit plan to:

(1) a small or large employer that is not located within a geographic service area of the issuer;

(2) an employee of a small or large employer who neither resides nor works in the geographic service area of the issuer; or

(3) a small or large employer located within a geographic service area of the issuer with respect to which area the issuer demonstrates to the commissioner's satisfaction that the issuer:

(A) reasonably anticipates that it will not have the capacity to deliver services adequately because of obligations to existing covered individuals; and

(B) is acting uniformly without regard to the claims experience of the employer or any health status related factor of employees, employees' dependents, or new employees or dependents who may become eligible for the coverage.

(d) A small or large employer health benefit plan issuer that is unable to offer coverage in a geographic service area in

accordance with a determination made by the commissioner under Subsection (c)(3) may not offer a small or large employer benefit plan, as applicable, in that service area before the 180th day after the later of:

(1) the date the issuer refuses to offer coverage; or

(2) the date the issuer demonstrates to the satisfaction of the commissioner that it has regained the capacity to deliver services to small or large employers in the geographic service area.

(e) If the commissioner determines that requiring the acceptance of small or large employers under this chapter would place a small or large employer health benefit plan issuer in a financially impaired condition and that the issuer is acting uniformly without regard to the claims experience of the small or large employer or any health status related factors of eligible employees, eligible employees' dependents, or new employees or dependents who may become eligible for the coverage, the issuer may not offer coverage to small or large employers until the later of:

(1) the 180th day after the date the commissioner makes the determination; or

(2) the date the commissioner determines that accepting small or large employers would not place the issuer in a financially impaired condition. (V.T.I.C. Arts. 26.22, 26.85.)

Sec. 1501.102. PREEXISTING CONDITION PROVISION. (a) In this section, "creditable coverage" has the meaning assigned by Section 1205.004 and includes coverage provided under:

(1) a political subdivision health benefits risk pool;

and

(2) a short-term limited duration coverage plan.

(b) A preexisting condition provision in a small or large employer health benefit plan may apply only to coverage for a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the earlier of:

(1) the effective date of coverage; or

(2) the first day of the waiting period.

(c) A preexisting condition provision in a small or large employer health benefit plan may not apply to expenses incurred on or after the first anniversary of the initial effective date of coverage of the enrollee, including a late enrollee.

(d) A preexisting condition provision in a small or large employer health benefit plan may not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect until a date not more than 63 days before the effective date of coverage under the plan, excluding any waiting period.

(e) In determining whether a preexisting condition provision applies to an individual covered by a small or large employer health benefit plan, the plan issuer shall credit the time the individual was covered under previous creditable coverage if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under the plan. If the previous coverage was issued under a health benefit plan, any waiting period that applied before that coverage became effective

must also be credited against the preexisting condition provision period. (V.T.I.C. Art. 26.02, Subdiv. (7); Art. 26.035; Art. 26.49, Subsecs. (a), (b), (e), (f); Art. 26.90, Subsecs. (a), (b), (e), (f).)

Sec. 1501.103. TREATMENT OF CERTAIN CONDITIONS AS PREEXISTING PROHIBITED. (a) A small or large employer health benefit plan issuer may not treat genetic information as a preexisting condition described by Section 1501.102(b) in the absence of a diagnosis of the condition related to the information.

(b) A small or large employer health benefit plan issuer may not treat pregnancy as a preexisting condition described by Section 1501.102(b). (V.T.I.C. Art. 26.49, Subsecs. (c), (d); Art. 26.90, Subsecs. (c), (d).)

Sec. 1501.104. AFFILIATION PERIOD. (a) In this section, "affiliation period" means a period that, under a small or large employer health benefit plan offered by a health maintenance organization, must expire before the coverage becomes effective.

(b) A health maintenance organization may impose an affiliation period if the period is applied uniformly without regard to any health status related factor. The affiliation period may not exceed:

(1) two months for an enrollee, other than a late enrollee; or

(2) 90 days for a late enrollee.

(c) An affiliation period under a small or large employer health benefit plan must run concurrently with any applicable waiting period under the plan. A health maintenance organization

must credit an affiliation period against any preexisting condition provision period.

(d) During an affiliation period, a health maintenance organization:

(1) is not required to provide health care services or benefits to the participant or beneficiary; and

(2) may not charge a premium to the participant or beneficiary.

(e) A health maintenance organization may use an alternative method approved by the commissioner to address adverse selection. (V.T.I.C. Art. 26.02, Subdiv. (1); Art. 26.49, Subsec. (g); Art. 26.90, Subsec. (g).)

Sec. 1501.105. WAITING PERIOD PERMITTED. Sections 1501.102-1501.104 do not preclude application of a waiting period that applies to all new enrollees under a small or large employer health benefit plan. (V.T.I.C. Art. 26.49, Subsec. (h); Art. 26.90, Subsec. (h).)

Sec. 1501.106. CERTAIN LIMITATIONS OR EXCLUSIONS OF COVERAGE PROHIBITED. (a) A small or large employer health benefit plan may not limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident.

(b) This section does not preclude a small or large employer health benefit plan from limiting or excluding coverage for a preexisting condition in accordance with Section 1501.102. (V.T.I.C. Art. 26.21, Subsec. (m); Art. 26.83, Subsec. (m).)

Sec. 1501.107. DISCOUNTS, REBATES, AND REDUCTIONS. (a) A

small or large employer health benefit plan issuer may establish premium discounts, rebates, or a reduction in otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(b) A discount, rebate, or reduction established under this section does not violate Section 541.056(a). (V.T.I.C. Art. 26.33, Subsec. (e); Art. 26.89, Subsec. (b).)

Sec. 1501.108. RENEWABILITY OF COVERAGE; CANCELLATION. (a) Except as provided by Section 1501.109, a small or large employer health benefit plan issuer shall renew the small or large employer health benefit plan for any covered small or large employer, as applicable, at the employer's option, unless:

(1) a premium has not been paid as required by the terms of the plan;

(2) the employer has committed fraud or has intentionally misrepresented a material fact;

(3) the employer has not complied with the terms of the plan;

(4) no enrollee in the plan resides or works in the geographic service area of the small or large employer health benefit plan issuer or in the area for which the issuer is authorized to do business; or

(5) membership of the employer in an association terminates, but only if coverage is terminated uniformly without regard to a health status related factor of a covered individual.

(b) A small or large employer health benefit plan issuer may refuse to renew the coverage of a covered employee or dependent for

fraud or intentional misrepresentation of a material fact by that individual.

(c) A small or large employer health benefit plan issuer may not cancel a small or large employer health benefit plan except for a reason specified for refusal to renew under Subsection (a). A small or large employer health benefit plan issuer may not cancel the coverage of a covered employee or dependent except for a reason specified for refusal to renew under Subsection (b). (V.T.I.C. Arts. 26.23, 26.86.)

Sec. 1501.109. REFUSAL TO RENEW; DISCONTINUATION OF COVERAGE. (a) A small or large employer health benefit plan issuer may elect to refuse to renew all small or large employer health benefit plans delivered or issued for delivery by the issuer in this state or in a geographic service area approved under Section 1501.101. The issuer shall notify:

(1) the commissioner of the election not later than the 180th day before the date coverage under the first plan terminates under this subsection; and

(2) each affected covered small or large employer not later than the 180th day before the date coverage terminates for that employer.

(b) A small employer health benefit plan issuer that elects under this section to refuse to renew all small employer health benefit plans in this state or in an approved geographic service area may not write a new small employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date notice is provided to the

commissioner under Subsection (a).

(c) A large employer health benefit plan issuer that elects under this section to refuse to renew all large employer health benefit plans in this state or in an approved geographic service area may not write a new large employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date notice is provided to the commissioner under Subsection (a).

(d) A small or large employer health benefit plan issuer may elect to discontinue a particular type of small or large employer coverage only if the issuer:

(1) before the 90th day preceding the date of the discontinuation of the coverage:

(A) provides notice of the discontinuation to the employer and the commissioner; and

(B) offers to each employer the option to purchase other small or large employer coverage offered by the issuer at the time of the discontinuation; and

(2) acts uniformly without regard to the claims experience of the employer or any health status related factors of eligible employees, eligible employees' dependents, or new employees or dependents who may become eligible for the coverage. (V.T.I.C. Arts. 26.24, 26.87.)

Sec. 1501.110. NOTICE TO COVERED PERSONS. (a) A small or large employer health benefit plan issuer that cancels or refuses to renew coverage under a small or large employer health benefit plan under Section 1501.108 or 1501.109 shall, not later than the

30th day before the date termination of coverage is effective, notify the small or large employer of the cancellation of or refusal to renew coverage. The employer is responsible for notifying enrollees in the plan of the cancellation of or refusal to renew coverage.

(b) The notice provided to a small or large employer by a small or large employer health benefit plan issuer under this section is in addition to any other notice required by Section 1501.109. (V.T.I.C. Arts. 26.25, 26.88.)

Sec. 1501.111. WRITTEN STATEMENT OF DENIAL, CANCELLATION, OR REFUSAL TO RENEW REQUIRED. Denial by a small or large employer health benefit plan issuer of an application from a small or large employer for coverage from the issuer or cancellation of or refusal to renew coverage by a small or large employer health benefit plan issuer must:

(1) be in writing; and

(2) state the reason or reasons for the denial, cancellation, or refusal to renew. (V.T.I.C. Arts. 26.74, 26.94.)

[Sections 1501.112-1501.150 reserved for expansion]

SUBCHAPTER D. GUARANTEED ISSUE OF SMALL EMPLOYER HEALTH BENEFIT PLANS; CONTINUATION OF COVERAGE

Sec. 1501.151. GUARANTEED ISSUE. (a) A small employer health benefit plan issuer shall issue the small employer health benefit plan chosen by the small employer to each small employer that elects to be covered under the plan and agrees to satisfy the other requirements of the plan.

(b) A small employer health benefit plan issuer shall

provide small employer health benefit plans without regard to health status related factors.

(c) This chapter does not require a small employer to purchase health coverage for the employer's employees. (V.T.I.C. Art. 26.21, Subsecs. (a), (c) (part).)

Sec. 1501.152. EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT PROHIBITED. A small employer health benefit plan issuer may not exclude an eligible employee or dependent, including a late enrollee, who would otherwise be covered under a small employer group. (V.T.I.C. Art. 26.21, Subsec. (l).)

Sec. 1501.153. EMPLOYER CONTRIBUTION. (a) This chapter does not require a small employer to make an employer contribution to the premium paid to a small employer health benefit plan issuer, but the issuer may require an employer contribution in accordance with the issuer's usual and customary practices applicable to the issuer's employer group health benefit plans in this state. The issuer shall apply the employer contribution level uniformly to each small employer offered or issued coverage by the issuer in this state.

(b) If two or more small employer health benefit plan issuers participate in a purchasing cooperative established under Section 1501.056, each participating issuer may use the employer contribution requirement established by the cooperative for policies marketed by the cooperative.

(c) A small employer that elects to make an employer contribution to the premium paid to a small employer health benefit plan issuer is not required to pay any amount with respect to an

employee who elects not to be covered.

(d) A small employer may elect to pay the premium for additional coverage. (V.T.I.C. Art. 26.21, Subsecs. (b) (part), (c) (part).)

Sec. 1501.154. MINIMUM PARTICIPATION REQUIREMENT. (a) Except as provided by Section 1501.155, coverage is available under a small employer health benefit plan if at least 75 percent of a small employer's eligible employees elect to participate in the plan.

(b) If a small employer offers multiple health benefit plans, the collective participation in those plans must be at least:

(1) 75 percent of the employer's eligible employees; or

(2) if applicable, the lower participation level offered by the small employer health benefit plan issuer under Section 1501.155.

(c) A small employer health benefit plan issuer may elect not to offer a health benefit plan to a small employer that offers multiple health benefit plans if:

(1) the plans are provided by more than one issuer;

(2) the issuer would have less than 75 percent of the employer's eligible employees enrolled in the issuer's plan; and

(3) the issuer's plan is not provided through a purchasing cooperative. (V.T.I.C. Art. 26.21, Subsecs. (b) (part), (c) (part).)

Sec. 1501.155. EXCEPTION TO MINIMUM PARTICIPATION

REQUIREMENT. (a) A small employer health benefit plan issuer may offer a small employer health benefit plan to a small employer with a participation level of less than 75 percent of the employer's eligible employees if the issuer permits the same qualifying participation level for each small employer health benefit plan offered by the issuer in this state.

(b) A small employer health benefit plan issuer may offer a small employer health benefit plan to a small employer even if the employer's participation level is less than the issuer's qualifying participation level established in accordance with Subsection (a) if:

(1) the employer obtains a written waiver from each eligible employee who declines coverage under a health benefit plan offered to the employer stating that the employee was not induced or pressured to decline coverage because of the employee's risk characteristics; and

(2) the issuer accepts or rejects the entire group of eligible employees who choose to participate and excludes only those employees who have declined coverage.

(c) A small employer health benefit plan issuer may underwrite the group of eligible employees who do not decline coverage under Subsection (b).

(d) A small employer health benefit plan issuer may not provide coverage to a small employer or the employer's employees under Subsection (b) if the issuer or an agent for the issuer knows that the employer has induced or pressured an eligible employee or a dependent of the employee to decline coverage because of the

individual's risk characteristics.

(e) A small employer health benefit plan issuer, a small employer, or an agent may not use the exception provided by Subsection (b) to circumvent the requirements of this chapter. (V.T.I.C. Art. 26.21, Subsecs. (d), (e), (f).)

Sec. 1501.156. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) The initial enrollment period under a small employer health benefit plan for employees and dependents must be at least 31 days, with a 31-day open enrollment period provided annually.

(b) A small employer may establish a waiting period not to exceed 90 days from the first day of employment.

(c) A small employer health benefit plan issuer may not deny coverage to a new employee of a covered small employer or the employee's dependents if the issuer receives an application for coverage not later than the 31st day after the date employment begins or on completion of a waiting period established under Subsection (b).

(d) A small employer health benefit plan issuer may deny coverage to a late enrollee until the next annual open enrollment period and may subject the enrollee to a one-year preexisting condition provision as described by Section 1501.102. The period during which the preexisting condition provision applies may not exceed 18 months from the date of the initial application. (V.T.I.C. Art. 26.21, Subsecs. (h), (i), (j), (k).)

Sec. 1501.157. COVERAGE FOR NEWBORN CHILDREN. (a) A small employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee.

(b) Coverage of a newborn child of a covered employee under this section ends on the 32nd day after the date of the child's birth unless, not later than the 31st day after the date of birth, the small employer health benefit plan issuer receives:

(1) notice of the birth; and

(2) any required additional premium. (V.T.I.C. Art. 26.21, Subsec. (n).)

Sec. 1501.158. COVERAGE FOR ADOPTED CHILDREN. (a) A small employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured. A child is considered to be the child of an insured if the insured is a party to a suit in which the insured seeks to adopt the child.

(b) An adopted child of an insured may be enrolled, at the insured's option, not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final.

(c) Coverage of an adopted child of an insured under this section ends unless the small employer health benefit plan issuer receives notice of the adoption and any required additional premium not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final. (V.T.I.C. Art. 26.21A.)

Sec. 1501.159. CONTINUATION OF COVERAGE FOR CERTAIN DEPENDENTS. An employee's dependent may choose to continue

coverage under a small employer health benefit plan if:

(1) the dependent:

(A) is under one year of age; or

(B) has been covered by the small employer under a plan for at least one year;

(2) the dependent loses eligibility for coverage because of the death, divorce, or retirement of the employee, as provided by Subchapter G, Chapter 1251; and

(3) the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272) does not require continuation or conversion coverage for dependents of an employee. (V.T.I.C. Art. 26.21, Subsec. (o).)

[Sections 1501.160-1501.200 reserved for expansion]

SUBCHAPTER E. UNDERWRITING AND RATING OF SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.201. DEFINITIONS. In this subchapter:

(1) "Base premium rate" means, for each class of business and for a specific rating period, the lowest premium rate that is charged or that could be charged under a rating system for that class of business by a small employer health benefit plan issuer to small employers with similar case characteristics for small employer health benefit plans that provide the same or similar coverage.

(2) "Case characteristics" means, with respect to a small employer, the geographic area in which the employer's employees reside, the age and gender of the individual employees and their dependents, the number of employees and dependents, the

appropriate industry classification as determined by the small employer health benefit plan issuer, and other objective criteria established by the issuer that are considered by the issuer in setting premium rates for the employer. The term does not include:

(A) health status related factors;

(B) duration of coverage since the date of issuance of a health benefit plan; or

(C) whether a covered individual is or may become pregnant.

(3) "Class of business" means all small employers or a separate grouping of small employers established under this subchapter.

(4) "Index rate" means, for each class of business and for a specific rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and corresponding highest premium rate.

(5) "New business premium rate" means, for each class of business and for a specific rating period, the lowest premium rate that is charged or offered or that could be charged or offered by a small employer health benefit plan issuer to small employers with similar case characteristics for newly issued small employer health benefit plans that provide the same or similar coverage.

(6) "Rating period" means a calendar period during which premium rates established by a small employer health benefit plan issuer are assumed to be in effect. (V.T.I.C. Art. 26.02, Subdivs. (3), (5), (6), (14), (19), (26).)

Sec. 1501.202. ESTABLISHMENT OF CLASSES OF BUSINESS. (a)

Except as otherwise provided by this subchapter, a small employer health benefit plan issuer may not establish a separate class or classes of business for small employers.

(b) A small employer health benefit plan issuer may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(1) the issuer uses more than one type of system to market and sell small employer health benefit plans to small employers;

(2) the issuer has acquired a class of business from another small employer health benefit plan issuer; or

(3) the issuer provides coverage to one or more employer-based association groups.

(c) Except as provided by Subsection (e), a small employer health benefit plan issuer may not establish more than nine separate classes of business under this section.

(d) The commissioner may adopt rules to provide for a transition period to permit a small employer health benefit plan issuer to comply with Subsection (c) after acquiring an additional class of business from another small employer health benefit plan issuer.

(e) On application to the commissioner, the commissioner may approve the establishment of additional classes of business if the commissioner finds that the establishment of additional classes would enhance the efficiency and fairness of the health coverage market for small employers. (V.T.I.C. Art. 26.21, Subsec. (g);

Art. 26.31, Subsecs. (a), (b), (c), (d).)

Sec. 1501.203. ESTABLISHMENT OF CLASSES OF BUSINESS ON CERTAIN BASES PROHIBITED. (a) A small employer health benefit plan issuer may not establish a separate class of business based on:

(1) participation requirements; or

(2) whether the coverage provided to a small employer group is provided on a guaranteed issue basis or is subject to underwriting or proof of insurability.

(b) A small employer health benefit plan issuer may not directly or indirectly use as a criterion for establishing a separate class of business:

(1) the number of employees and dependents of a small employer; or

(2) except as provided by Section 1501.202(b)(3), the trade or occupation of the employees of a small employer or the industry or type of business of the small employer. (V.T.I.C. Art. 26.31, Subsecs. (e), (f), (g).)

Sec. 1501.204. INDEX RATES. Under a small employer health benefit plan:

(1) the index rate for a class of business may not exceed the index rate for any other class of business by more than 20 percent; and

(2) premium rates charged during a rating period to small employers in a class of business with similar case characteristics for the same or similar coverage, or premium rates that could be charged to those employers under the rating system for that class of business, may not vary from the index rate by more

than 25 percent. (V.T.I.C. Art. 26.32, Subsecs. (a), (b), (c).)

Sec. 1501.205. PREMIUM RATES: ESTABLISHMENT. (a) In this section:

(1) "Risk characteristic" means:

(A) a health status related factor;

(B) the duration of coverage; or

(C) any characteristic similar to a characteristic described by Paragraph (A) or (B) that is related to the health status or experience of a small employer group or of any member of a small employer group.

(2) "Risk load" means the percentage above the applicable base premium rate a small employer health benefit plan issuer charges to a small employer to reflect the risk characteristics associated with that particular small employer group.

(b) Small employer health benefit plan issuers shall develop premium rates for each small employer group in a two-step process. In the first step, the small employer health benefit plan issuer shall develop a base premium rate for each small employer group without regard to any risk characteristic of the group. In the second step, the small employer health benefit plan issuer may adjust the resulting base premium rate by the risk load of the group, subject to this subchapter, to reflect the risk characteristics of the group.

(c) The risk load assessed to a particular group shall reflect the risk characteristics of the particular group. (V.T.I.C. Art. 26.02, Subdivs. (28), (29), as amended Acts 77th

Leg., R.S., Ch. 823; Art. 26.32, Subsecs. (d), (e).)

Sec. 1501.206. PREMIUM RATES: ADJUSTMENTS. (a) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) the percentage change in the new business premium rate, measured from the first day of the preceding rating period to the first day of the new rating period;

(2) any adjustment, not to exceed 15 percent annually and adjusted pro rata for a rating period of less than one year, due to the claims experience, health status, or duration of coverage of the employees or dependents of employees of the small employer, as determined under the small employer health benefit plan issuer's rate manual for the class of business; and

(3) any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined under the issuer's rate manual for the class of business.

(b) An adjustment in the premium rate for claims experience, health status, or duration of coverage:

(1) may not be charged to individual employees or dependents; and

(2) must be applied uniformly to the rates charged for all employees and dependents of employees of the small employer. (V.T.I.C. Art. 26.33, Subsecs. (a), (b).)

Sec. 1501.207. PREMIUM RATE ADJUSTMENT IN CLOSED PLAN. For a closed health benefit plan under which a small employer health benefit plan issuer is no longer enrolling new small employers, the issuer shall use the percentage change in the base premium rate to

adjust premium rates under Section 1501.206(a)(1). The portion of change in premium rates computed under that subdivision may not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan under which the issuer is enrolling new small employers. (V.T.I.C. Art. 26.35.)

Sec. 1501.208. PREMIUM RATES: INDUSTRY CLASSIFICATION. A small employer health benefit plan issuer may use the industry classification to which a small employer belongs as a case characteristic in establishing the premium rate, but the highest rate factor associated with any industry classification may not exceed by more than 15 percent the lowest rate factor associated with any industry classification. (V.T.I.C. Art. 26.33, Subsec. (c).)

Sec. 1501.209. PREMIUM RATES: NUMBER OF EMPLOYEES. A small employer health benefit plan issuer may use the number of employees and dependents of a small employer as a case characteristic in establishing premium rates for the group. The highest rate factor associated with a classification based on the number of employees and dependents of a small employer may not exceed by more than 20 percent the lowest rate factor associated with a classification based on the number of employees and dependents of a small employer. (V.T.I.C. Art. 26.33, Subsec. (d).)

Sec. 1501.210. PREMIUM RATES: NONDISCRIMINATION. (a) A small employer health benefit plan issuer shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must

produce premium rates for identical groups that:

(1) differ only by the amounts attributable to health benefit plan design; and

(2) do not reflect differences because of the nature of the groups assumed to select particular health benefit plans.

(b) A small employer health benefit plan issuer shall treat each health benefit plan issued or renewed in the same calendar month as having the same rating period.

(c) Without the prior approval of the commissioner, a small employer health benefit plan issuer may not use case characteristics other than:

(1) the geographic area in which the small employer's employees reside;

(2) the age and gender of the individual employees and their dependents;

(3) the number of employees and dependents; and

(4) the appropriate industry classification.

(d) Premium rates for a small employer health benefit plan must comply with the requirements of this chapter, notwithstanding any assessment paid or payable by a small employer health benefit plan issuer.

(e) A small employer health benefit plan issuer may not transfer a small employer involuntarily into or out of a class of business. The issuer may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all other small employers in the employer's class of business without regard to case characteristics, claims

experience, health status, or duration of coverage since the issuance of the health benefit plan. (V.T.I.C. Art. 26.36, Subsecs. (a), (b), (c), (d), (f).)

Sec. 1501.211. RULES CONCERNING PREMIUM RATES. Rules adopted under Section 1501.010 may ensure that:

(1) rating practices used by small employer health benefit plan issuers are consistent with the purposes of this chapter; and

(2) differences in premium rates charged for each small employer health benefit plan are reasonable and reflect objective differences in plan design. (V.T.I.C. Art. 26.36, Subsec. (e).)

Sec. 1501.212. RESTRICTED PROVIDER NETWORK. (a) A small employer health benefit plan may use a restricted provider network to provide benefits under the plan.

(b) A small employer health benefit plan that uses a restricted provider network does not provide similar coverage to a plan that does not use a restricted provider network if the use of the network results in reduced premium rates charged to the small employer or substantial differences in claim costs. (V.T.I.C. Art. 26.37.)

Sec. 1501.213. PREMIUM RATES: HEALTH MAINTENANCE ORGANIZATION HEALTH BENEFIT PLAN. (a) The premium rates for a state-approved health benefit plan offered by a health maintenance organization under Section 1501.255 must be established in accordance with formulas or schedules of charges filed with the department.

(b) A health maintenance organization that participates in a purchasing cooperative that provides employees of small employers a choice of health benefit plans may use rating methods in accordance with this subchapter that are used by other small employer health benefit plan issuers participating in the same cooperative, including rating by age and gender, if the health maintenance organization has established:

(1) a separate class of business, as provided by Section 1501.202; and

(2) a separate line of business, as provided under Section 1501.255(b) and Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.). (V.T.I.C. Art. 26.38.)

Sec. 1501.214. ENFORCEMENT. If the commissioner determines that a small employer health benefit plan issuer subject to this chapter exceeds the applicable premium rate established under this subchapter, the commissioner may order restitution and assess penalties as provided by Chapter 82. (V.T.I.C. Art. 26.39.)

Sec. 1501.215. REPORTING REQUIREMENTS. (a) Annually, each small employer health benefit plan issuer that offers a small employer health benefit plan shall file with the commissioner an actuarial certification stating that the issuer's underwriting and rating methods:

(1) comply with accepted actuarial practices;

(2) are uniformly applied to each small employer health benefit plan covering a small employer; and

(3) comply with this subchapter.

(b) Each small employer health benefit plan issuer shall

maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based on commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(c) A small employer health benefit plan issuer shall make the information and documentation described in Subsection (b) available to the commissioner on request. Unless the information or documentation relates to a violation of this chapter, the information or documentation is considered proprietary and trade secret information and is not subject to disclosure by the commissioner to a person outside the department except as agreed to by the issuer or as ordered by a court. (V.T.I.C. Art. 26.41.)

[Sections 1501.216-1501.250 reserved for expansion]

SUBCHAPTER F. COVERAGE UNDER SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.251. EXCEPTION FROM CERTAIN MANDATED BENEFIT REQUIREMENTS. Except as expressly provided by this chapter, a small employer health benefit plan is not subject to a law that requires coverage or the offer of coverage of a health care service or benefit. (V.T.I.C. Art. 26.06, Subsec. (d).)

Sec. 1501.252. HEALTH BENEFIT PLANS. (a) A small employer health benefit plan issuer shall offer the following two health benefit plans as adopted by the commissioner:

(1) the catastrophic care health benefit plan; and

(2) the basic coverage health benefit plan.

(b) A small employer health benefit plan issuer may offer to a small employer additional benefit riders to either of the health benefit plans required by Subsection (a).

(c) Subject to this chapter, a small employer health benefit plan issuer may also offer to a small employer any other health benefit plan authorized under this code. Section 1501.251 does not apply to a health benefit plan offered to a small employer under this subsection. (V.T.I.C. Art. 26.42.)

Sec. 1501.253. COVERAGE REQUIREMENTS. (a) The commissioner by rule shall establish coverage requirements for the catastrophic care health benefit plan and the basic coverage health benefit plan.

(b) Coverage under the catastrophic care health benefit plan must be designed to provide necessary coverage in the event of catastrophic illness or injury. The commissioner shall establish deductibles and coinsurance requirements at levels that permit options for a covered individual to obtain affordable catastrophic coverage.

(c) Coverage under the basic coverage health benefit plan must be designed to provide basic hospital, medical, and surgical coverage. Benefits under the plan are limited to basic care requirements for illness and injury.

(d) The benefits provisions of the catastrophic care and basic coverage health benefit plan policies must include:

(1) all required or applicable definitions;

(2) a description of covered services required under the plan;

(3) a list of any exclusions or limitations to coverage; and

(4) the deductible and coinsurance options that are required or permitted under the plan. (V.T.I.C. Art. 26.44A, Subsecs. (a) (part), (b), (c), (d).)

Sec. 1501.254. ALCOHOL AND SUBSTANCE ABUSE BENEFITS. (a) This section applies only if the basic coverage health benefit plan developed by the commissioner under Section 1501.253 includes coverage for alcohol and substance abuse benefits.

(b) A small employer health benefit plan issuer may offer and the employees of a small employer group may accept a basic coverage health benefit plan without coverage for alcohol and substance abuse benefits if:

(1) at least 50 percent of the employees in writing:

(A) waive the benefits; and

(B) indicate that they have undergone alcoholism or substance abuse treatment or counseling within the preceding three years; and

(2) the exclusion of those benefits applies only to those employees. (V.T.I.C. Art. 26.44B.)

Sec. 1501.255. HEALTH MAINTENANCE ORGANIZATION PLANS. (a) In this section, "point-of-service contract" means a health benefit plan offered through a health maintenance organization that:

(1) includes corresponding indemnity benefits in addition to benefits relating to out-of-area or emergency services provided through insurers or group hospital service corporations; and

(2) permits the covered individual to obtain coverage under either the health maintenance organization conventional plan or the indemnity plan as determined in accordance with the terms of the contract.

(b) A health maintenance organization may offer:

(1) a state-approved health benefit plan that complies with this chapter, Chapters 843, 1271, 1272, and 1367, Subchapter A, Chapter 1452, Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments, and rules adopted under those laws;

(2) a health benefit plan developed by the commissioner under Section 1501.253 and additional benefit riders to the plan; or

(3) a point-of-service contract in connection with an insurer that includes optional coverage for out-of-area services, emergency care, or out-of-network care.

(c) A point-of-service contract offered under Subsection (b)(3) is subject to this chapter unless specifically exempted. The insurer with which the health maintenance organization offers a point-of-service contract is not required to otherwise make available the health benefit plans adopted under this subchapter if the insurer's small employer products are limited to the point-of-service contract. (V.T.I.C. Art. 26.02, Subdiv. (23); Art. 26.48.)

Sec. 1501.256. COORDINATION WITH FEDERAL LAW. (a) To the extent required to comply with federal law applicable to a small employer health benefit plan described by this subchapter, the

commissioner by rule may:

(1) modify the plan; or

(2) adopt a substitute for the plan.

(b) The commissioner shall use the Texas Health Benefits Purchasing Cooperative in implementing this section. (V.T.I.C. Art. 26.50.)

Sec. 1501.257. COST CONTAINMENT. (a) A small employer health benefit plan issuer may use cost containment and managed care features in a small employer health benefit plan, including:

(1) utilization review of health care services, including review of the medical necessity of hospital and physician services;

(2) case management, including discharge planning and review of stays in hospitals or other health care facilities;

(3) selective contracting with hospitals, physicians, and other health care providers;

(4) reasonable benefit differentials applicable to health care providers that participate or do not participate in restricted network arrangements;

(5) precertification or preauthorization for certain covered services; and

(6) coordination of benefits.

(b) A provision of a small employer health benefit plan that provides for coordination of benefits must comply with this chapter and guidelines established by the commissioner.

(c) Utilization review performed for any cost containment, case management, or managed care arrangement must comply with

Article 21.58A. (V.T.I.C. Art. 26.08.)

Sec. 1501.258. FORMS. (a) The commissioner shall:

(1) prescribe the benefits section of the catastrophic care health benefit plan and the basic coverage health benefit plan policy forms in accordance with Section 1501.253; and

(2) develop prototype policies for each of the health benefit plans that include all contractual provisions required to produce an entire contract in accordance with this code.

(b) With regard to each portion of the policy form for the catastrophic care health benefit plan or the basic coverage health benefit plan, other than the benefits section, a small employer health benefit plan issuer shall comply with:

(1) Chapter 1701 as it relates to policy form approval; and

(2) Chapter 1271 as it relates to evidence of coverage approval.

(c) A small employer health benefit plan issuer may not offer the catastrophic care health benefit plan or the basic coverage health benefit plan through a policy form or evidence of coverage that does not comply with this chapter. (V.T.I.C. Art. 26.43, Subsec. (a); Art. 26.44A, Subsec. (a) (part).)

Sec. 1501.259. RIDERS; FILING WITH COMMISSIONER. (a) A small employer health benefit plan issuer shall file with the commissioner, in a form and manner prescribed by the commissioner, each rider to a small employer health benefit plan to be used by the issuer, as authorized by Section 1501.252.

(b) A small employer health benefit plan issuer may use a

rider filed under this section after the 30th day after the date the rider is filed unless the commissioner disapproves its use.

(c) The commissioner, after notice and an opportunity for a hearing, may disapprove the continued use of a rider by a small employer health benefit plan issuer if the rider does not meet the requirements of this chapter and other applicable statutes. (V.T.I.C. Art. 26.44.)

Sec. 1501.260. PLAIN LANGUAGE REQUIRED. (a) A health benefit plan issuer may not issue and the commissioner may not approve a health benefit plan certificate or policy or a rider to a health benefit plan certificate or policy unless it is written in plain language.

(b) Each provision of a health benefit plan certificate or policy or a rider to a health benefit plan certificate or policy relating to renewal of coverage, conditions of coverage, or per occurrence or aggregate dollar limitations on coverage must be clearly explained in plain language.

(c) A health benefit plan issuer may not use and the commissioner may not approve a health benefit plan application form unless it is written in plain language.

(d) Subsections (a)-(c) do not apply if the specific language to be used is required by federal law or state statute or by rules implementing federal law.

(e) For purposes of Subsections (a)-(d), a health benefit plan certificate or policy, a rider to or a provision of a health benefit plan certificate or policy, or a health benefit plan application form is written in plain language if it achieves the

minimum score established by the commissioner on the Flesch reading ease test or an equivalent test selected by the commissioner.

(f) This section does not apply to:

(1) a health benefit plan group master policy; or

(2) a policy application or enrollment form for a health benefit plan group master policy. (V.T.I.C. Art. 26.43, Subsecs. (b), (c), (d), (e), (f), (g).)

[Sections 1501.261-1501.300 reserved for expansion]

SUBCHAPTER G. REINSURANCE FOR SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.301. DEFINITIONS. In this subchapter:

(1) "Board" means the board of directors of the Texas Health Reinsurance System.

(2) "Plan of operation" means the plan of operation of the system established under Section 1501.306.

(3) "Reinsured health benefit plan issuer" means a small employer health benefit plan issuer that participates in the system.

(4) "Risk-assuming health benefit plan issuer" means a small employer health benefit plan issuer that does not participate in the system.

(5) "System" means the Texas Health Reinsurance System established under this subchapter. (V.T.I.C. Art. 26.02, Subdivs. (4), (22), (27); Art. 26.02, Subdiv. (33), as amended Acts 77th Leg., R.S., Ch. 823; Art. 26.02, Subdivs. (28), (32), as amended Acts 77th Leg., R.S., Ch. 608.)

Sec. 1501.302. TEXAS HEALTH REINSURANCE SYSTEM. The Texas

Health Reinsurance System is a nonprofit entity administered by a board of directors and subject to the supervision and control of the commissioner. (V.T.I.C. Art. 26.53.)

Sec. 1501.303. SYSTEM BOARD OF DIRECTORS. (a) The board of directors of the system is composed of:

(1) nine members appointed by the commissioner; and

(2) the commissioner or the commissioner's representative, who serves as an ex officio member.

(b) Five of the appointed members must be representatives of reinsured health benefit plan issuers selected from individuals nominated by small employer health benefit plan issuers in this state according to procedures developed by the commissioner.

(c) Four of the appointed members must represent the public. A member representing the public may not:

(1) be an officer, director, or employee of an insurance company, agency, agent, broker, solicitor, or adjuster or any other business entity regulated by the department;

(2) be a person required to register under Chapter 305, Government Code; or

(3) be related to a person described by Subdivision (1) or (2) within the second degree by affinity or consanguinity.

(d) Appointed members serve two-year terms expiring December 31 of each odd-numbered year. A member's term continues until a successor is appointed.

(e) A member of the board may not be compensated for serving on the board but is entitled to reimbursement for actual expenses incurred in performing functions as a member of the board as

provided by the General Appropriations Act. (V.T.I.C. Art. 26.54, Subsecs. (a), (b), (c).)

Sec. 1501.304. OPEN MEETINGS; PUBLIC INFORMATION. The board is subject to:

(1) the open meetings law, Chapter 551, Government Code; and

(2) the public information law, Chapter 552, Government Code. (V.T.I.C. Art. 26.54, Subsec. (d).)

Sec. 1501.305. BOARD MEMBER IMMUNITY. (a) A member of the board is not liable for an act performed, or omission made, in good faith in the performance of powers and duties under this subchapter.

(b) A cause of action does not arise against a member of the board for an act or omission described by Subsection (a). (V.T.I.C. Art. 26.54, Subsec. (e).)

Sec. 1501.306. SYSTEM PLAN OF OPERATION. (a) The board shall submit to the commissioner a plan of operation and any amendments to that plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the system.

(b) The commissioner, after notice and hearing, may approve the plan of operation if the commissioner determines the plan:

(1) is suitable to ensure the fair, reasonable, and equitable administration of the system; and

(2) provides for the sharing of system gains or losses on an equitable and proportionate basis in accordance with this subchapter.

(c) The plan of operation is effective on the written

approval of the commissioner.

(d) The plan of operation must:

(1) establish procedures for:

(A) handling and accounting for system assets and money;

(B) making an annual fiscal report to the commissioner;

(C) selecting an administering health benefit plan issuer or third-party administrator and establishing the powers and duties of the administering issuer or third-party administrator;

(D) reinsuring risks in accordance with this subchapter; and

(E) collecting assessments from reinsured health benefit plan issuers to fund claims and administrative expenses incurred or estimated to be incurred by the system, including the imposition of penalties for late payment of an assessment; and

(2) provide for any additional matter necessary to implement and administer the system. (V.T.I.C. Art. 26.55, Subsecs. (a) (part), (c).)

Sec. 1501.307. SYSTEM POWERS. (a) The system has the general powers and authority granted under state law to an insurer or a health maintenance organization authorized to engage in business, except that the system may not directly issue a health benefit plan.

(b) The system may:

(1) enter into contracts necessary or proper to

implement this subchapter, including, with the commissioner's approval, contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued, including taking legal action necessary or proper to recover assessments and penalties for, on behalf of, or against the system or a reinsured health benefit plan issuer;

(3) take legal action necessary to avoid the payment of improper claims against the system;

(4) issue reinsurance contracts in accordance with this subchapter;

(5) establish guidelines, conditions, and procedures for reinsuring risks under the plan of operation;

(6) establish actuarial functions as appropriate for the operation of the system;

(7) assess reinsured health benefit plan issuers in accordance with Sections 1501.319-1501.323;

(8) appoint appropriate legal, actuarial, and other committees necessary to provide technical assistance in:

(A) the operation of the system;

(B) policy and other contract design; and

(C) any other function within the authority of the system; and

(9) borrow money for a period not to exceed one year to accomplish the purposes of the system.

(c) The system is exempt from all taxes. (V.T.I.C. Art.

26.56 (part).)

Sec. 1501.308. SYSTEM NOTES AS LEGAL INVESTMENT FOR SMALL EMPLOYER HEALTH BENEFIT PLAN ISSUER. A note or other evidence of indebtedness of the system that is not in default is a legal investment for a small employer health benefit plan issuer and may be carried as an admitted asset. (V.T.I.C. Art. 26.56 (part).)

Sec. 1501.309. SYSTEM AUDIT. (a) The transactions of the system are subject to audit by the state auditor in accordance with Chapter 321, Government Code.

(b) The state auditor shall report the cost of each audit conducted under this section to the board and the comptroller, and the board shall remit that amount to the comptroller. (V.T.I.C. Art. 26.57.)

Sec. 1501.310. ELECTION OF STATUS. (a) Each small employer health benefit plan issuer shall notify the commissioner of the issuer's election to operate as a risk-assuming health benefit plan issuer or as a reinsured health benefit plan issuer. An issuer that elects to operate as a risk-assuming health benefit plan issuer shall file an application in accordance with Section 1501.312.

(b) A small employer health benefit plan issuer's election under this section is effective until the fifth anniversary of the date of the election.

(c) The commissioner may permit a small employer health benefit plan issuer to modify its election at any time for good cause shown. (V.T.I.C. Art. 26.51, Subsecs. (a), (b).)

Sec. 1501.311. CHANGE IN STATUS. (a) The commissioner shall establish an application process for a small employer health

benefit plan issuer that elects to change its status under this subchapter.

(b) A reinsured health benefit plan issuer that elects to change its status to operate as a risk-assuming health benefit plan issuer may not continue to reinsure a small employer health benefit plan with the system. The issuer shall pay a prorated assessment based on business issued as a reinsured health benefit plan issuer for the portion of the year the business was reinsured. (V.T.I.C. Art. 26.51, Subsecs. (c), (d).)

Sec. 1501.312. APPLICATION TO OPERATE AS RISK-ASSUMING HEALTH BENEFIT PLAN ISSUER. (a) A small employer health benefit plan issuer may apply to operate as a risk-assuming health benefit plan issuer by filing an application with the commissioner in a form and manner prescribed by the commissioner.

(b) In evaluating an application, the commissioner shall consider the small employer health benefit plan issuer's:

(1) financial condition;

(2) history of rating and underwriting small employer groups;

(3) commitment to market fairly to all small employers in the state or in the issuer's established geographic service area; and

(4) experience managing the risk of small employer groups.

(c) The commissioner shall provide public notice of an application and shall provide at least a 60-day period for public comment before making a decision on the application. If the

commissioner does not act on the application before the 90th day after the date the commissioner receives the application, the issuer may request and the commissioner shall grant a hearing. (V.T.I.C. Art. 26.52, Subsecs. (a), (b), (c).)

Sec. 1501.313. RESCISSION OF APPROVAL TO OPERATE AS RISK-ASSUMING HEALTH BENEFIT PLAN ISSUER. The commissioner, after notice and hearing, may rescind approval to operate as a risk-assuming health benefit plan issuer if the commissioner finds that the issuer:

(1) is not financially able to support the assumption of risk from issuing coverage to small employers without the protection provided by the system;

(2) has failed to market fairly to all small employers in the state or in the issuer's established geographic service area; or

(3) has failed to provide coverage to eligible small employers. (V.T.I.C. Art. 26.52, Subsec. (d).)

Sec. 1501.314. REINSURANCE. (a) A small employer health benefit plan issuer may reinsure risks covered under a small employer health benefit plan with the system as provided by this subchapter.

(b) The system shall reinsure the level of coverage provided under the small employer health benefit plan.

(c) A small employer health benefit plan issuer may reinsure:

(1) an entire small employer group not later than the 60th day after the date the group's coverage under the small

employer health benefit plan takes effect;

(2) an eligible employee of a small employer or the employee's dependent not later than the 60th day after the date the person's coverage takes effect; or

(3) a newly eligible employee of a reinsured small employer group, the employee's dependent, or an individual covered under the small employer health benefit plan not later than the 60th day after the date the individual's coverage takes effect. (V.T.I.C. Art. 26.58, Subsecs. (a), (b), (c).)

Sec. 1501.315. LIMITS ON REINSURANCE. (a) The system may not reimburse a reinsured health benefit plan issuer for the claims of a reinsured individual until the issuer has incurred an initial level of claims of $5,000 in a calendar year for that individual for benefits covered by the system. In addition, the reinsured health benefit plan issuer is responsible for 10 percent of the next $50,000 of benefit payments during a calendar year, and the system shall reinsure the remainder. A reinsured health benefit plan issuer's liability to a reinsured individual may not exceed a maximum of $10,000 in a calendar year.

(b) The board annually shall adjust the initial level of claims and the maximum liability to be retained by a reinsured health benefit plan issuer under Subsection (a) to reflect increases in:

(1) costs; and

(2) the use of small employer health benefit plans in this state.

(c) An adjustment under Subsection (b) may not be less than

the annual change in the medical component of the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the United States Department of Labor unless the board proposes and the commissioner approves a lower adjustment factor. (V.T.I.C. Art. 26.58, Subsecs. (d), (e).)

Sec. 1501.316. TERMINATION OF REINSURANCE. A small employer health benefit plan issuer may terminate reinsurance with the system for one or more reinsured employees or dependents of employees of a small employer on a contract anniversary of the small employer health benefit plan. (V.T.I.C. Art. 26.58, Subsec. (f).)

Sec. 1501.317. APPLICATION OF MANAGED CARE PROCEDURES. Except as provided by the plan of operation, a reinsured health benefit plan issuer shall apply consistently with respect to reinsured and nonreinsured business all managed care procedures, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation. (V.T.I.C. Art. 26.58, Subsec. (g).)

Sec. 1501.318. PREMIUM RATES FOR REINSURANCE. (a) As part of the plan of operation, the board shall adopt a method to determine premium rates to be charged by the system for reinsuring small employer groups and individuals under this subchapter.

(b) The method adopted must:

(1) include a classification system for small employer groups that reflects the variations in premium rates allowed by this chapter; and

(2) provide for the development of base reinsurance premium rates that reflect the allowable variations.

(c) Subject to approval by the commissioner, the board shall establish the base reinsurance premium rates at levels that reasonably approximate the gross premiums charged to small employers by small employer health benefit plan issuers for small employer health benefit plans, adjusted to reflect retention levels required under this subchapter.

(d) The board shall periodically review the method adopted under this section, including the classification system and any rating factors, to ensure that the method reasonably reflects the claims experience of the system. The board may propose changes to the method. Any changes are subject to approval by the commissioner.

(e) An entire small employer group may be reinsured at a rate that is 1-1/2 times the base reinsurance premium rate for that group. An eligible employee of a small employer or the employee's dependent covered under a small employer health benefit plan may be reinsured at a rate that is five times the base reinsurance premium rate for that individual.

(f) The board may consider adjustments to the premium rates charged by the system to reflect the use of effective cost containment and managed care arrangements. (V.T.I.C. Art. 26.59.)

Sec. 1501.319. DETERMINATION OF NET LOSS. (a) Not later than March 1 of each year, the board shall determine the system's net loss for the preceding calendar year, including administrative expenses and incurred losses for the year, and report the net loss to the commissioner.

(b) In determining the net loss, the board shall take into

account investment income and other appropriate gains and losses. (V.T.I.C. Art. 26.60, Subsec. (a) (part).)

Sec. 1501.320. ASSESSMENTS TO RECOVER NET LOSSES. (a) The board shall recover any net loss of the system by assessing each reinsured health benefit plan issuer an amount determined annually by the board based on information in annual statements and other reports required by and filed with the board.

(b) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsured health benefit plan issuers. With the approval of the commissioner, the board may periodically change the assessment formula as appropriate. The board shall base the assessment formula on each reinsured issuer's share of:

(1) the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers to small employer groups in this state; and

(2) the premiums earned in the preceding calendar year from newly issued small employer health benefit plans delivered or issued for delivery during the calendar year by reinsured health benefit plan issuers to small employer groups in this state. (V.T.I.C. Art. 26.60, Subsec. (a) (part).)

Sec. 1501.321. LIMITS ON ASSESSMENTS. (a) The formula established under Section 1501.320(b) may not result in an assessment for a reinsured health benefit plan issuer that is less than 50 percent or more than 150 percent of an amount based on the proportion of the total premiums earned in the preceding calendar

year from small employer health benefit plans delivered or issued for delivery to small employer groups in this state by that issuer to the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery to small employer groups in this state by all reinsured health benefit plan issuers.

(b) In determining assessments, the board may not consider premiums earned by a reinsured health benefit plan issuer that are less than an amount determined by the board to justify the cost of collecting an assessment based on those premiums. (V.T.I.C. Art. 26.60, Subsec. (b).)

Sec. 1501.322. ADJUSTMENT TO ASSESSMENTS ON FEDERALLY QUALIFIED HEALTH MAINTENANCE ORGANIZATIONS. With the commissioner's approval, the board may adjust the formula established under Section 1501.320(b) for a reinsured health benefit plan issuer that is an approved health maintenance organization that is federally qualified under Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.), to the extent that any restriction is imposed on that issuer that is not imposed on other issuers. (V.T.I.C. Art. 26.60, Subsec. (c).)

Sec. 1501.323. ADVANCE INTERIM ASSESSMENTS. (a) The system may make advance interim assessments as reasonable and necessary for organizational and interim operating expenses.

(b) After the end of the fiscal year, the system shall credit an interim assessment made under this section as an offset against regular assessments due. (V.T.I.C. Art. 26.56 (part).)

Sec. 1501.324. LIMIT ON TOTAL ASSESSMENTS. The maximum

assessment amount payable for a calendar year may not exceed five percent of the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers in this state. (V.T.I.C. Art. 26.61, Subsec. (f).)

Sec. 1501.325. ESTIMATE OF ASSESSMENTS; EVALUATION AND PROTECTION OF SYSTEM. (a) Not later than March 1 of each year, the board shall file with the commissioner an estimate of the assessments necessary to fund the losses for small employer groups incurred by the system during the preceding calendar year.

(b) If the board determines that the necessary assessments exceed five percent of the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers to small employer groups in this state, the board shall evaluate the operation of the system and shall report its findings, including any recommendations for changes to the plan of operation, to the commissioner not later than April 1 of the year following the calendar year in which the losses were incurred. The evaluation must:

(1) include an estimate of future assessments; and

(2) consider:

(A) the administrative costs of the system;

(B) the appropriateness of the premiums charged;

(C) the level of health benefit plan issuer retention under the system; and

(D) the costs of coverage for small employer

groups.

(c) If the board fails to timely file a report required by Subsection (b), the commissioner may:

(1) evaluate the operations of the system; and

(2) implement amendments to the plan of operation that the commissioner considers necessary to reduce future losses and assessments.

(d) A reinsured health benefit plan issuer may not write small employer health benefit plans on a guaranteed issue basis during a calendar year if the assessment amount payable for the preceding calendar year is at least five percent of the total premiums earned in that calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers in this state.

(e) A reinsured health benefit plan issuer may not write small employer health benefit plans on a guaranteed issue basis after the board determines that the expected loss from the reinsurance system for a year will exceed the total amount of assessments payable at a rate of five percent of the total premiums earned for the preceding calendar year. A reinsured health benefit plan issuer may not resume writing small employer health benefit plans on a guaranteed issue basis until the board determines that the expected loss will be less than the maximum established by this subsection. (V.T.I.C. Art. 26.61, Subsecs. (a), (b), (c), (d), (e).)

Sec. 1501.326. DEFERMENT OF ASSESSMENT. (a) A reinsured health benefit plan issuer may petition the commissioner for a

deferment in whole or in part of an assessment imposed by the board.

(b) The commissioner may defer all or part of the assessment if the commissioner determines that payment of the assessment would endanger the ability of the reinsured health benefit plan issuer to fulfill its contractual obligations.

(c) The board shall assess the amount of a deferred assessment against other reinsured health benefit plan issuers in a manner consistent with the basis for assessment established by this subchapter.

(d) A reinsured health benefit plan issuer that receives a deferment:

(1) is liable to the system for the amount deferred; and

(2) until the issuer pays the outstanding assessment, may not:

(A) market, deliver, or issue for delivery a small employer health benefit plan; or

(B) reinsure any individual or group with the system. (V.T.I.C. Art. 26.62.)

[Sections 1501.327-1501.350 reserved for expansion]

SUBCHAPTER H. MARKETING OF SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.351. MARKETING REQUIREMENTS. (a) Each small employer health benefit plan issuer shall market a small employer health benefit plan to eligible small employers in this state through properly licensed agents.

(b) Each small employer purchasing a small employer health

benefit plan must be given a summary, in a format prescribed by the commissioner, of the health benefit plans established by the commissioner under Subchapter F.

(c) An agent shall offer and explain to a small employer on inquiry and request by the employer each health benefit plan established by the commissioner under Subchapter F. (V.T.I.C. Art. 26.71, Subsec. (a).)

Sec. 1501.352. HEALTH STATUS AND CLAIMS EXPERIENCE; PROHIBITED ACTS. (a) A small employer health benefit plan issuer or agent may not, because of the health status or claims experience of the eligible employees of a small employer and those employees' dependents, directly or indirectly encourage or direct the employer to:

(1) refrain from applying for coverage with the issuer;

(2) seek coverage from another issuer; or

(3) apply for a particular small employer health benefit plan.

(b) A small employer health benefit plan issuer may not directly or indirectly enter into an agreement or arrangement with an agent that provides for or results in compensation paid to the agent for the sale of small employer health benefit plans that varies because of health status or claims experience.

(c) Subsection (b) does not apply to an arrangement that provides compensation to an agent based on a percentage of premium, except that the percentage may not vary because of health status or claims experience.

(d) A small employer health benefit plan issuer or agent may not encourage a small employer to exclude an eligible employee from health coverage provided in connection with the employee's employment.

(e) A small employer health benefit plan issuer may not terminate, fail to renew, or limit its contract or agreement of representation with an agent for a reason related to the health status or claims experience of a small employer group placed by the agent with the issuer. (V.T.I.C. Art. 26.72; Art. 26.73, Subsec. (b).)

Sec. 1501.353. AGENT COMPENSATION. (a) A small employer health benefit plan issuer shall pay the same commission, percentage of premium, or other amount to an agent for renewal of a small employer health benefit plan as the issuer paid for original placement of the plan, except that the issuer may increase compensation for renewal of a plan to reflect an increase in the cost of living or similar factors.

(b) A small employer health benefit plan issuer may not implement, directly or indirectly, agent commission schedules that vary the level of agent commissions based on the size of the group or otherwise reduce access to small employer health benefit plans.

(c) Notwithstanding Subsection (b), a small employer health benefit plan issuer may:

(1) vary agent commission amounts or percentages based on group size if the variation in the commission amounts or percentages are inversely related to the size of the group;

(2) vary agent commission amounts or percentages based

on the cumulative premium paid by a single small employer over a specific period if the variation in the commission amounts or percentages are inversely related to the cumulative premium paid during the period; or

(3) pay agent commissions as a percentage of premiums charged to a small employer if the commission percentage is based on all premiums paid by the small employer. (V.T.I.C. Art. 26.73, Subsecs. (a), (c), (d).)

Sec. 1501.354. REQUIRED DISCLOSURES. (a) In connection with offering a small employer health benefit plan for sale, each small employer health benefit plan issuer and agent shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

(1) the extent to which premium rates for a specific small employer are established or adjusted based on the actual or expected variation in:

(A) claim costs; or

(B) health status of the employer's employees and their dependents;

(2) provisions concerning the issuer's right to change premium rates and factors other than claims experience that affect changes in premium rates;

(3) provisions relating to renewability of policies and contracts; and

(4) any preexisting condition provisions.

(b) On request by a small employer, each small employer health benefit plan issuer shall disclose the benefits and premiums

available under all small employer coverage for which the employer is qualified.

(c) A small employer health benefit plan issuer is not required to disclose information to a small employer that is proprietary or trade secret information under applicable law.

(d) Information provided under this section to a small employer must be provided in a manner that is:

(1) understandable by the average small employer; and

(2) sufficient to reasonably inform a small employer of its rights and obligations under a small employer health benefit plan. (V.T.I.C. Art. 26.40.)

Sec. 1501.355. RULES CONCERNING MARKETING AND AVAILABILITY. Rules adopted under Section 1501.010 may establish additional standards to provide for the fair marketing and broad availability of small employer health benefit plans to small employers in this state. (V.T.I.C. Art. 26.75.)

Sec. 1501.356. REPORTING REQUIREMENTS. (a) In this section, "case characteristics" has the meaning assigned by Section 1501.201.

(b) The department may require periodic reports by small employer health benefit plan issuers and agents regarding small employer health benefit plans issued by those issuers and agents. The reporting requirements must include information regarding:

(1) case characteristics; and

(2) the number of small employer health benefit plans in various categories that are marketed or issued to small employers. (V.T.I.C. Art. 26.71, Subsec. (b).)

Sec. 1501.357. VIOLATIONS. A violation of Section 1501.352 by a small employer health benefit plan issuer or agent is an unfair method of competition and an unfair or deceptive act or practice under Chapter 541. (V.T.I.C. Art. 26.76, Subsec. (a).)

Sec. 1501.358. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR. If a small employer health benefit plan issuer enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to offering small employer health benefit plans to small employers in this state, the third-party administrator is subject to Sections 1501.111, 1501.351-1501.353, and 1501.355-1501.357. (V.T.I.C. Art. 26.76, Subsec. (b).)

[Subchapters I-L reserved for expansion]

SUBCHAPTER M. LARGE EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.601. PARTICIPATION CRITERIA. (a) In this subchapter, "participation criteria" means any criteria or rules established by a large employer to determine the employees who are eligible for enrollment or continued enrollment under the terms of a health benefit plan.

(b) The participation criteria may not be based on health status related factors. (V.T.I.C. Art. 26.02, Subdiv. (20); Art. 26.83, Subsec. (a) (part).)

Sec. 1501.602. COVERAGE REQUIREMENTS. (a) A large employer health benefit plan issuer:

(1) may refuse to provide coverage to a large employer in accordance with the issuer's underwriting standards and criteria;

(2) shall accept or reject the entire group of individuals who meet the participation criteria and choose coverage; and

(3) may exclude only those employees or dependents who decline coverage.

(b) On issuance of a health benefit plan to a large employer, a large employer health benefit plan issuer shall provide coverage to the employees who meet the participation criteria without regard to an individual's health status related factors. (V.T.I.C. Art. 26.83, Subsecs. (a) (part), (b) (part).)

Sec. 1501.603. EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT PROHIBITED. A large employer health benefit plan issuer may not exclude an employee who meets the participation criteria or an eligible dependent, including a late enrollee, who would otherwise be covered under a large employer group. (V.T.I.C. Art. 26.83, Subsec. (l).)

Sec. 1501.604. DECLINING COVERAGE. (a) A large employer health benefit plan issuer shall obtain a written waiver from each employee who meets the participation criteria and declines coverage under a health benefit plan offered to a large employer. The waiver must ensure that the employee was not induced or pressured to decline coverage because of the employee's health status related factors.

(b) A large employer health benefit plan issuer may not provide coverage to a large employer or the employer's employees if the issuer or an agent for the issuer knows that the employer has induced or pressured an employee who meets the participation

criteria or a dependent of the employee to decline coverage because of the individual's health status related factors. (V.T.I.C. Art. 26.83, Subsecs. (c), (d).)

Sec. 1501.605. MINIMUM CONTRIBUTION OR PARTICIPATION REQUIREMENTS. (a) A large employer health benefit plan issuer may require a large employer to meet a minimum contribution or participation requirement as a condition of issuance or renewal in accordance with the issuer's usual and customary practices for all the issuer's employer health benefit plans in this state.

(b) A participation requirement may determine the percentage of eligible employees who meet the participation criteria and who must be enrolled in the health benefit plan.

(c) A large employer health benefit plan issuer may apply a participation requirement to a large employer's eligible employees, but may not apply the requirement to eligible dependents of those employees.

(d) A participation requirement must be stated in the health benefit plan contract and must be applied uniformly to each large employer offered or issued coverage by a large employer health benefit plan issuer in this state. (V.T.I.C. Art. 26.83, Subsec. (e).)

Sec. 1501.606. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) The initial enrollment period for employees meeting the participation criteria under a large employer health benefit plan must be at least 31 days, with a 31-day annual open enrollment period.

(b) A large employer may establish a waiting period. The

employer shall determine the duration of the waiting period.

(c) A new employee who meets the participation criteria may not be denied coverage if the application for coverage is received by the large employer not later than the 31st day after the later of:

(1) the date employment begins; or

(2) the date the waiting period established under Subsection (b) expires.

(d) If dependent coverage is offered to the enrollees under a large employer health benefit plan:

(1) the initial enrollment period for the dependents must be at least 31 days, with a 31-day annual open enrollment period; and

(2) a dependent of a new employee who meets the participation criteria may not be denied coverage if the application for coverage is received by the large employer not later than the 31st day after the latest of:

(A) the date on which the employment begins;

(B) the date the waiting period established under Subsection (b) expires; or

(C) the date the dependent becomes eligible for enrollment.

(e) A late enrollee may be excluded from coverage until the next annual open enrollment period and may be subject to a one-year preexisting condition provision as described by Section 1501.102. The period during which a preexisting condition provision applies may not exceed 18 months from the date of the initial application.

(V.T.I.C. Art. 26.83, Subsecs. (f), (g), (h), (i), (j), (k).)

Sec. 1501.607. COVERAGE FOR NEWBORN CHILDREN. (a) A large employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee.

(b) Coverage of a newborn child of a covered employee under this section ends on the 32nd day after the date of the child's birth unless:

(1) children are eligible for coverage under the large employer health benefit plan; and

(2) not later than the 31st day after the date of birth, the large employer health benefit plan issuer receives:

(A) notice of the birth; and

(B) any required additional premium. (V.T.I.C. Art. 26.84, Subsec. (a).)

Sec. 1501.608. COVERAGE FOR ADOPTED CHILDREN. (a) This section applies only if children are eligible for coverage under a large employer health benefit plan.

(b) A large employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured. A child is considered to be the adopted child of an insured if the insured is a party to a suit in which the insured seeks to adopt the child.

(c) An adopted child of an insured may be enrolled, at the insured's option, not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final.

(d) Coverage of an adopted child of an insured under this

section ends unless the large employer health benefit plan issuer receives notice of the adoption and any required additional premium not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final. (V.T.I.C. Art. 26.84, Subsecs. (b), (c), (d).)

Sec. 1501.609. COVERAGE FOR UNMARRIED CHILDREN. (a) This section applies only if children are eligible for coverage under a large employer health benefit plan.

(b) Any limiting age applicable under a large employer health benefit plan to an unmarried child of an enrollee is 25 years of age. (V.T.I.C. Art. 26.84, Subsec. (e).)

Sec. 1501.610. PREMIUM RATES; ADJUSTMENTS. (a) A large employer health benefit plan issuer may charge premiums in accordance with this section to the group of employees or dependents who meet the participation criteria and do not decline coverage.

(b) A large employer health benefit plan issuer may not charge an adjustment to premium rates for individual employees or dependents for health status related factors or duration of coverage. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of employees of a large employer.

(c) Subsection (b) does not restrict the amount that a large employer may be charged for coverage. (V.T.I.C. Art. 26.83, Subsec. (b) (part); Art. 26.89, Subsec. (a).)

Sec. 1501.611. MARKETING REQUIREMENTS. On request, each large employer purchasing a health benefit plan shall be given a summary of all plans for which the employer is eligible. (V.T.I.C. Art. 26.91, Subsec. (a).)

Sec. 1501.612. ENCOURAGING EXCLUSION OF EMPLOYEE PROHIBITED. A large employer health benefit plan issuer or agent may not encourage a large employer to exclude an employee who meets the participation criteria from health coverage provided in connection with the employee's employment. (V.T.I.C. Art. 26.92.)

Sec. 1501.613. AGENTS. A large employer health benefit plan issuer may not terminate, fail to renew, or limit its contract or agreement of representation with an agent because of health status related factors of a large employer group placed by the agent with the issuer. (V.T.I.C. Art. 26.93.)

Sec. 1501.614. REPORTING OF CLAIMS INFORMATION. (a) This section applies only to an insured employer health benefit plan.

(b) An employer carrier, on written request from an insured employer covered by that carrier, shall report to the employer information from the 12 months preceding the date of the report regarding:

(1) the total amount of charges submitted to the carrier for persons covered under the employer health benefit plan;

(2) the total amount of payments made by the carrier to health care providers for persons covered under the plan; and

(3) to the extent available, information on claims paid by type of health care provider, including total hospital charges, physician charges, pharmaceutical charges, and other

charges.

(c) An employer carrier shall provide information requested by an employer under this section annually not later than the 30th day before the anniversary or renewal date of the employer's health benefit plan.

(d) Notwithstanding Subsection (c), an employer carrier is not required to provide information under Subsection (b) earlier than the 30th day after the date of the initial written request.

(e) An employer carrier may not report any information required under this section if the release of the information is prohibited by federal law or regulation.

(f) An employer carrier shall provide claim information under this section in the aggregate, without information through which a specific individual covered by the health insurance or evidence of coverage may be identified. (V.T.I.C. Art. 26.96.)

Sec. 1501.615. ADDITIONAL REPORTING REQUIREMENTS. The department may require periodic reports by large employer health benefit plan issuers and agents regarding the large employer health benefit plans issued by those issuers. The reporting requirements must:

(1) require information regarding the number of plans in various categories that are marketed or issued to large employers; and

(2) comply with federal law, including regulations. (V.T.I.C. Art. 26.91, Subsec. (b).)

Sec. 1501.616. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR. If a large employer health benefit plan issuer enters into an

agreement with a third-party administrator to provide administrative, marketing, or other services related to offering large employer health benefit plans to large employers in this state, the third-party administrator is subject to this subchapter and Subchapter C. (V.T.I.C. Art. 26.95.)

CHAPTER 1502. HEALTH BENEFIT PLANS FOR CHILDREN

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1502.001. APPLICABILITY OF CHAPTER

Sec. 1502.002. RULES

[Sections 1502.003-1502.050 reserved for expansion]

SUBCHAPTER B. CHILDREN'S HEALTH BENEFIT PLAN

Sec. 1502.051. CHILDREN'S HEALTH BENEFIT PLAN

Sec. 1502.052. MANDATED BENEFIT PROVISIONS INAPPLICABLE

Sec. 1502.053. EXEMPTION FROM CERTAIN TAXES

CHAPTER 1502. HEALTH BENEFIT PLANS FOR CHILDREN

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1502.001. APPLICABILITY OF CHAPTER. This chapter applies only to the issuer of a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation

operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act or another analogous benefit arrangement; or

(ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 27.02.)

Sec. 1502.002. RULES. The commissioner may adopt rules to implement this chapter. (V.T.I.C. Art. 27.06.)

[Sections 1502.003-1502.050 reserved for expansion]

SUBCHAPTER B. CHILDREN'S HEALTH BENEFIT PLAN

Sec. 1502.051. CHILDREN'S HEALTH BENEFIT PLAN. A health benefit plan issuer may offer a children's health benefit plan that provides coverage only to children younger than 18 years of age.

The issuer may offer the plan only if the commissioner approves the plan's structure and the benefits offered under the plan. (V.T.I.C. Art. 27.03.)

Sec. 1502.052. MANDATED BENEFIT PROVISIONS INAPPLICABLE. A children's health benefit plan is not subject to any law that requires coverage or the offer of coverage of a health care service or benefit. (V.T.I.C. Art. 27.04.)

Sec. 1502.053. EXEMPTION FROM CERTAIN TAXES. A children's health benefit plan issuer is not subject to the premium tax or the tax on revenues imposed under Chapter 222 with respect to money received for coverage provided under that plan. (V.T.I.C. Art. 27.05.)

CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

Sec. 1503.001. APPLICABILITY OF CHAPTER

Sec. 1503.002. EXCEPTION

Sec. 1503.003. COVERAGE OF CERTAIN STUDENTS

CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

Sec. 1503.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) an analogous benefit arrangement; or

(2) is offered by:

(A) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(B) another entity that:

(i) is not authorized under this code or another insurance law of this state; and

(ii) contracts directly for health care services on a risk-sharing basis, including a capitation basis. (V.T.I.C. Art. 21.24-2, Sec. 2(a).)

Sec. 1503.002. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to a liability insurance policy;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1503.001. (V.T.I.C. Art. 21.24-2, Sec. 2(b).)

Sec. 1503.003. COVERAGE OF CERTAIN STUDENTS. (a) A health benefit plan may not condition coverage for a child younger than 25 years of age on the child's being enrolled at an educational institution.

(b) A health benefit plan that requires as a condition of coverage for a child up to 25 years of age that the child be a full-time student at an educational institution must provide the coverage:

(1) for the entire academic term during which the

child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student; and

(2) continuously until the 10th day of instruction of the subsequent academic term, on which date the health benefit plan may terminate coverage for the child if the child does not return to full-time student status before that date.

(c) For purposes of this section, determination of the full-time student status of a child is made in the manner provided by the educational institution at which the child is enrolled. (V.T.I.C. Art. 21.24-2, Sec. 3.)

CHAPTER 1504. MEDICAL CHILD SUPPORT

SUBCHAPTER A. GENERAL PROVISIONS

SUBCHAPTER B. DUTIES OF HEALTH BENEFIT PLAN ISSUER

Sec. 1504.055. PROCEDURE FOR CLAIMS

[Sections 1504.056-1504.100 reserved for expansion]

SUBCHAPTER C. PROHIBITED CONDUCT

Sec. 1504.101. DENIAL OF ENROLLMENT ON CERTAIN GROUNDS PROHIBITED

Sec. 1504.102. ASSIGNMENT OF MEDICAL SUPPORT RIGHTS: DIFFERENT REQUIREMENTS PROHIBITED

CHAPTER 1504. MEDICAL CHILD SUPPORT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1504.001. DEFINITIONS. In this chapter:

(1) "Child" has the meaning assigned by Section 101.003, Family Code.

(2) "Child support agency" has the meaning assigned by Section 101.004, Family Code.

(3) "Custodial parent" means an individual who:

(A) is a managing conservator of a child or a possessory conservator of a child who is a parent of the child; or

(B) is a guardian of the person or other custodian of a child and is designated as guardian or custodian by a court or administrative agency of this or another state.

(4) "Health benefit plan issuer" means:

(A) an insurance company, group hospital service corporation, or health maintenance organization that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or agreement, a group hospital service contract, or an evidence of coverage that provides benefits for medical or surgical expenses incurred as a result of an accident or sickness;

(B) a governmental entity subject to Subchapter D, Chapter 1355, Subchapter C, Chapter 1364, Chapter 1578, or Article 3.51-1, 3.51-2, 3.51-4, or 3.51-5;

(C) the issuer of a multiple employer welfare arrangement as defined by Section 846.001; or

(D) the issuer of a group health plan as defined by Section 607, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1167).

(5) "Medical assistance" means medical assistance under the state Medicaid program. (V.T.I.C. Art. 3.96-1.)

Sec. 1504.002. RULES. (a) The commissioner shall adopt reasonable rules as necessary to implement this chapter and 42 U.S.C. Section 1396a(a)(60), including rules that define acts that constitute unfair or deceptive practices under Subchapter I, Chapter 541.

(b) The commissioner shall adopt rules that define "comparable health coverage" in a manner that:

(1) is consistent with federal law; and

(2) complies with the requirements necessary to maintain federal Medicaid funding. (V.T.I.C. Art. 3.96-8, Sec. (c); Art. 3.96-10.)

Sec. 1504.003. VIOLATION OF CHAPTER: RELIEF AVAILABLE TO INJURED PERSON. A health benefit plan issuer that violates this chapter is subject to the same penalties, and an injured person has the same rights and remedies, as those provided by Subchapter D, Chapter 541. (V.T.I.C. Art. 3.96-9.)

[Sections 1504.004-1504.050 reserved for expansion]

SUBCHAPTER B. DUTIES OF HEALTH BENEFIT PLAN ISSUER

Sec. 1504.051. ENROLLMENT OF CERTAIN CHILDREN REQUIRED. (a) A health benefit plan issuer shall permit a parent to enroll a child in dependent health coverage offered through the issuer regardless of any enrollment period restriction if the parent is:

(1) eligible for dependent health coverage; and

(2) required by a court order or administrative order to provide health insurance coverage for the child.

(b) A health benefit plan issuer shall enroll a child of a parent described by Subsection (a) in dependent health coverage offered through the issuer if:

(1) the parent does not apply to obtain health coverage for the child through the issuer; and

(2) the child, a custodial parent of the child, or a child support agency having a duty to collect or enforce support for the child applies for the coverage. (V.T.I.C. Art. 3.96-3.)

Sec. 1504.052. CHILD RESIDING OUTSIDE SERVICE AREA; COMPARABLE HEALTH COVERAGE REQUIRED. (a) A health benefit plan issuer may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child does not reside in the issuer's service area.

(b) A health benefit plan issuer may not enforce an otherwise applicable provision of the health coverage that would deny, limit, or reduce payment of a claim for a covered child who resides outside the issuer's service area but inside the United States.

(c) For a covered child who resides outside the health

benefit plan issuer's service area and whose coverage under a policy or plan is required by a medical support order, the issuer shall provide coverage that is comparable health coverage to that provided to other dependents under the policy or plan.

(d) Comparable health coverage may include coverage in which a health benefit plan issuer uses different procedures for service delivery and health care provider reimbursement. Comparable health coverage may not include coverage:

(1) that is limited to emergency services only; or

(2) for which the issuer charges a higher premium. (V.T.I.C. Art. 3.96-2 (part); Art. 3.96-8, Secs. (a), (b).)

Sec. 1504.053. CANCELLATION OR NONRENEWAL OF COVERAGE FOR CERTAIN CHILDREN. (a) A health benefit plan issuer may not cancel or refuse to renew health coverage provided to a child who is enrolled or entitled to enrollment under this chapter unless satisfactory written evidence is filed with the issuer showing that:

(1) the court or administrative order that required the coverage is not in effect; or

(2) the child:

(A) is enrolled in comparable health coverage; or

(B) will be enrolled in comparable health coverage that takes effect not later than the effective date of the cancellation or nonrenewal.

(b) For purposes of this section, a child is not enrolled or entitled to enrollment under this chapter if the child's eligibility for health coverage ends because the parent ceases to

be eligible for dependent health coverage. (V.T.I.C. Art. 3.96-4.)

Sec. 1504.054. CONTINUATION OR CONVERSION OF COVERAGE. (a) If a child's eligibility for dependent health coverage ends because the parent ceases to be eligible for the coverage and the coverage provides for the continuation or conversion of the coverage for the child, the health benefit plan issuer shall notify the custodial parent and the child support agency of the costs and other requirements for continuing or converting the coverage.

(b) The health benefit plan issuer shall, on application of a parent of the child, a child support agency, or the child, enroll or continue enrollment of a child whose eligibility for coverage ended under Subsection (a). (V.T.I.C. Art. 3.96-5.)

Sec. 1504.055. PROCEDURE FOR CLAIMS. (a) A health benefit plan issuer that provides health coverage to a child through a covered parent of the child shall:

(1) provide to each custodial parent of the child or to an adult child documents and other information necessary for the child to obtain benefits under the coverage, including:

(A) the name of the issuer;

(B) the number of the policy or evidence of coverage;

(C) a copy of the policy or evidence of coverage and schedule of benefits;

(D) a health coverage membership card;

(E) claim forms; and

(F) any other document or information necessary to submit a claim in accordance with the issuer's policies and

procedures;

(2) permit a custodial parent, health care provider, state agency that has been assigned medical support rights, or adult child to submit claims for covered services without the approval of the covered parent; and

(3) make payments on covered claims submitted in accordance with this subsection directly to a custodial parent, health care provider, adult child, or state agency making a claim.

(b) A health benefit plan issuer shall provide to a state agency that provides medical assistance to the child or shall provide to a child support agency that enforces medical support on behalf of a child the information necessary to obtain reimbursement of medical services provided to or paid on behalf of the child. (V.T.I.C. Art. 3.96-6, Sec. (b); Art. 3.96-7.)

[Sections 1504.056-1504.100 reserved for expansion]

SUBCHAPTER C. PROHIBITED CONDUCT

Sec. 1504.101. DENIAL OF ENROLLMENT ON CERTAIN GROUNDS PROHIBITED. A health benefit plan issuer may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child:

(1) has a preexisting condition;

(2) was born out of wedlock;

(3) is not claimed as a dependent on the parent's federal income tax return;

(4) does not reside with the parent; or

(5) receives or has applied for medical assistance. (V.T.I.C. Art. 3.96-2 (part).)

Sec. 1504.102. ASSIGNMENT OF MEDICAL SUPPORT RIGHTS: DIFFERENT REQUIREMENTS PROHIBITED. A health benefit plan issuer may not require a state agency that has been assigned the rights of an individual who is eligible for medical assistance and is covered for health benefits from the issuer to comply with a requirement that is different from a requirement imposed on an agent or assignee of any other covered individual. (V.T.I.C. Art. 3.96-6, Sec. (a).)

CHAPTER 1505. GROUP INSURANCE PLANS FOR PERSONS 65 YEARS OF AGE OR OLDER

CHAPTER 1505. GROUP HEALTH INSURANCE PLANS FOR PERSONS 65 YEARS OF AGE OR OLDER

Sec. 1505.001. DEFINITION. In this chapter, "health insurer" means an insurance company authorized to provide a hospital, surgical, and medical expense insurance plan in this state, including:

(1) a stock insurance company;

(2) a reciprocal or interinsurance exchange;

(3) a Lloyd's plan;

(4) a fraternal benefit society;

(5) a stipulated premium company; and

(6) a mutual insurance company, including a statewide mutual assessment company or a local mutual aid association. (V.T.I.C. Art. 3.71, Sec. 1 (part).)

Sec. 1505.002. PLANS FOR CERTAIN PERSONS 65 YEARS OF AGE OR OLDER. (a) Two or more health insurers may provide a hospital, surgical, and medical expense insurance plan under a group insurance policy that covers residents of this state who are at least 65 years of age and the spouses of those residents.

(b) The participating health insurers may enter into agreements regarding matters within the scope of this chapter, including:

(1) premium rates;

(2) policy provisions; and

(3) sales, administrative, technical, and accounting procedures.

(c) Each participating health insurer is subject to regulation under the laws of this state and is severally liable on a group insurance policy issued under this chapter. (V.T.I.C. Art. 3.71, Secs. 1 (part), 2 (part).)

Sec. 1505.003. APPLICATION AND OTHER EVIDENCE OF INSURANCE FORMS. An application, policy, certificate, or other evidence of insurance form for an insurance plan under this chapter is subject to Chapter 1701. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

Sec. 1505.004. EXECUTION OF POLICY. An authorized person may execute an insurance policy subject to this chapter on behalf of the participating health insurers. (V.T.I.C. Art. 3.71, Sec. 1 (part).)

Sec. 1505.005. USE OF UNINCORPORATED ENTITY. (a) The participating health insurers may issue the group insurance policy in their own names or in the name of an unincorporated association, trust, or other organization formed for the sole purposes of this chapter and evidenced by a written contract executed by the insurers. An unincorporated association, trust, or other organization formed under this subsection may sue and be sued in the name of the association, trust, or organization.

(b) A person licensed as a general life, accident, and health agent or as a general property and casualty agent under Chapter 4051 or 4054 may act in the licensed capacity in connection with an insurance policy or a certificate of insurance issued by an unincorporated association, trust, or other organization formed under Subsection (a). The agent is not required to notify the department that the person has been appointed to act for that purpose. (V.T.I.C. Art. 3.71, Secs. 1 (part), 3.)

Sec. 1505.006. REQUIRED FILINGS; DEPARTMENT APPROVAL. (a) The participating health insurers shall provide for the filing with the department on behalf of the insurers of:

(1) a copy of any contract of association or organization or trust agreement entered into by the insurers under this chapter;

(2) the schedule of premium rates to be charged for the

insurance coverage; and

(3) the plan for operating and marketing the insurance.

(b) Except as provided by Subsection (c), a contract, schedule, or plan described by Subsection (a) may not be effective until approved by the commissioner.

(c) A contract, schedule, or plan described by Subsection (a) that is not approved or disapproved in a written order of the commissioner on or before the 30th day after the date on which the document is filed with the department is considered approved on the 31st day after the date of filing. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

Sec. 1505.007. EFFECT OF COMMISSIONER DISAPPROVAL. If, after notice and public hearing, the commissioner determines under reasonable assumptions that a premium rate charged for the insurance coverage offered under this chapter or the plan for operating and marketing that insurance is excessive, inadequate, or contrary to the public interest or that any activity or practice performed in connection with the insurance is unfair, unreasonable, or contrary to the public interest, the commissioner shall:

(1) enter an order containing the commissioner's determination and disapproving the premium rate or plan or the activity or practice; and

(2) require the discontinuance of the premium rate, plan, activity, or practice within a period that is not less than 30 days after the date of the commissioner's order containing the determination. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

Sec. 1505.008. EXEMPTION FROM PREMIUM TAXES. Each premium received for group insurance coverage authorized by this chapter is exempt from any premium tax imposed by any other law of this state. (V.T.I.C. Art. 3.71, Sec. 4.)

Sec. 1505.009. EXEMPTION FROM CERTAIN ANTITRUST REQUIREMENTS. An association, trust, or other organization formed and operated in accordance with this chapter or an insurance business conducted in accordance with this chapter is not considered a combination in restraint of trade, an illegal monopoly, or an attempt to lessen competition or fix prices arbitrarily and does not otherwise violate the antitrust laws of this state. (V.T.I.C. Art. 3.71, Sec. 5.)

CHAPTER 1506. TEXAS HEALTH INSURANCE RISK POOL

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 1506.008-1506.050 reserved for expansion]

SUBCHAPTER B. BOARD OF DIRECTORS

CHAPTER 1506. TEXAS HEALTH INSURANCE RISK POOL

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1506.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of directors of the pool.

(2) "Health benefit arrangement" means a plan, program, contract, or other arrangement through which an employer provides health care services, other than health care services

covered through a health benefit plan issuer, to the employer's officers, employees, or other personnel.

(3) "Health benefit plan issuer" means an entity that provides health benefit plan coverage in this state, including stop-loss or excess loss insurance. The term includes:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885;

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

(E) a health maintenance organization;

(F) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

(G) an eligible surplus lines insurer operating under Chapter 981;

(H) an insurer providing stop-loss or excess loss insurance to physicians, health care providers, or hospitals or to any benefit arrangements to the extent permitted by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); and

(I) any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(4) "Health maintenance organization" means an entity that holds a certificate of authority to operate under Chapter 843.

(5) "Hospital" means a hospital for which a license is

issued under Chapter 241, Health and Safety Code, or that is owned or operated by the federal or state government.

(6) "Physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

(7) "Pool" means the Texas Health Insurance Risk Pool. (V.T.I.C. Art. 3.77, Secs. 2(2), (8), (9), (11), (12), (14), (16).)

Sec. 1506.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) In this chapter, "health benefit plan" means an individual or group health benefit plan and includes:

(1) a hospital or medical expense incurred policy;

(2) coverage of medical or health care services offered by:

(A) a group hospital service corporation operating under Chapter 842;

(B) a fraternal benefit society operating under Chapter 885;

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

(D) a health maintenance organization;

(E) a multiple employer welfare arrangement subject to Chapter 846; or

(F) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; and

(3) any other health care plan or arrangement that pays for or furnishes medical or health care services by insurance or otherwise.

(b) In this chapter, "health benefit plan" does not include:

(1) short-term insurance;

(2) accident insurance;

(3) a plan providing coverage only for dental or vision care;

(4) fixed indemnity insurance, including hospital indemnity insurance;

(5) credit insurance;

(6) long-term care insurance;

(7) disability income insurance;

(8) other limited benefit coverage, including specified disease coverage;

(9) coverage issued as a supplement to liability insurance;

(10) insurance arising out of a workers' compensation or similar law;

(11) automobile medical payment insurance; or

(12) insurance coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in a liability insurance policy or equivalent self-insurance. (V.T.I.C. Art. 3.77, Sec. 2(7).)

Sec. 1506.003. DEFINITION OF DEPENDENT. In this chapter, "dependent" means:

(1) a resident spouse or unmarried child younger than 25 years of age; or

(2) a child who is:

(A) a full-time student younger than 25 years of age who is financially dependent on the parent;

(B) 18 years of age or older and is an individual for whom a person may be obligated to pay child support; or

(C) disabled and dependent on the parent regardless of the age of the child. (V.T.I.C. Art. 3.77, Sec. 2(5).)

Sec. 1506.004. AUDIT OF POOL. (a) Annually, the state auditor shall conduct a special audit of the pool under Chapter 321, Government Code. The special audit must include a financial audit and an economy and efficiency audit.

(b) The state auditor shall report the cost of each audit conducted under this section to the board and the comptroller. The board shall remit that amount to the comptroller. (V.T.I.C. Art. 3.77, Sec. 15.)

Sec. 1506.005. RULES. The commissioner may adopt rules necessary and proper to implement this chapter. (V.T.I.C. Art. 3.77, Sec. 8 (part).)

Sec. 1506.006. COMPLAINT PROCEDURES. (a) An applicant for or participant in coverage from the pool is entitled to have complaints against the pool reviewed by a grievance committee appointed by the board.

(b) The grievance committee shall report to the board after completion of the review of each complaint.

(c) The board shall retain each written complaint concerning the pool at least until the third anniversary of the date the pool received the complaint. (V.T.I.C. Art. 3.77, Sec. 14.)

Sec. 1506.007. PROVISION OF INFORMATION ABOUT POOL. (a) A health benefit plan issuer may provide to its insureds and

enrollees a notice relating to the existence of the pool that contains the address from which an insured or enrollee may obtain information about the coverage offered by the pool, the eligibility for and cost of the coverage, and other information that allows an insured or enrollee to compare the issuer's health benefit plan coverage provided to the insured or enrollee with the coverage offered by the pool.

(b) A health benefit plan issuer providing notice under this section shall provide the notice as prescribed by the commissioner.

(c) A health benefit plan issuer does not incur any liability solely for providing notice under this section. (V.T.I.C. Art. 3.77, Secs. 2(1), 16(a), (b) (part).)

[Sections 1506.008-1506.050 reserved for expansion]

SUBCHAPTER B. BOARD OF DIRECTORS

Sec. 1506.051. GOVERNANCE OF POOL; BOARD MEMBERSHIP. (a) The pool is governed by a board of directors.

(b) The board consists of nine members appointed by the commissioner as follows:

(1) at least two, but not more than four, members must be individuals who are affiliated with a health benefit plan issuer authorized to write health benefit plans in this state;

(2) at least two of the members must be individuals or the parents of individuals who are covered by the pool or are reasonably expected to qualify for coverage by the pool; and

(3) the other members of the board may be selected from individuals such as:

(A) a physician licensed to practice in this

state by the Texas State Board of Medical Examiners;

(B) a hospital administrator;

(C) an advanced nurse practitioner; or

(D) a representative of the public who is not:

(i) employed by or affiliated with an insurance company or insurance plan, group hospital service corporation, or health maintenance organization; or

(ii) licensed as, employed by, or affiliated with a physician, hospital, or other health care provider.

(c) For purposes of Subsection (b), an individual who is required to register under Chapter 305, Government Code, because of the individual's activities with respect to health benefit plan-related matters is affiliated with a health benefit plan issuer.

(d) An individual is not disqualified under Subsection (b)(3)(D)(i) from representing the public if the individual's only affiliation with an insurance company or insurance plan, group hospital service corporation, or health maintenance organization is as an insured or as an individual who has coverage through a plan provided by the corporation or organization. (V.T.I.C. Art. 3.77, Secs. 4(a), (b) (part), (c), (d).)

Sec. 1506.052. PRESIDING OFFICER. The commissioner shall designate one member of the board to serve as presiding officer at the pleasure of the commissioner. (V.T.I.C. Art. 3.77, Sec. 4(g).)

Sec. 1506.053. TERMS; VACANCY. (a) Members of the board serve staggered six-year terms.

(b) The commissioner shall fill a vacancy on the board by appointing, for the unexpired term, an individual who has the appropriate qualifications to fill that position. (V.T.I.C. Art. 3.77, Secs. 4(b) (part), (e).)

Sec. 1506.054. PER DIEM; REIMBURSEMENT. A member of the board is entitled to:

(1) a per diem in the amount provided by the General Appropriations Act for state officials for each day the member performs duties as a board member; and

(2) reimbursement of expenses incurred while performing duties as a board member in the amount provided by the General Appropriations Act for state officials. (V.T.I.C. Art. 3.77, Sec. 4(f).)

Sec. 1506.055. MEMBER'S IMMUNITY. (a) A member of the board is not liable for an act or omission made in good faith in the performance of powers and duties under this chapter.

(b) A cause of action does not arise against a member of the board for an act or omission described by Subsection (a). (V.T.I.C. Art. 3.77, Sec. 4(h).)

Sec. 1506.056. ADJUSTMENTS. (a) The board may adjust deductibles, the amounts of stop-loss coverage, and the periods governing preexisting conditions under Section 1506.155 to preserve the financial integrity of the pool.

(b) Not later than the 30th day after the date the board makes an adjustment under this section, the board shall submit to the commissioner a written report containing a description of and the reasons for the adjustment. (V.T.I.C. Art. 3.77, Sec. 11(c).)

Sec. 1506.057. ANNUAL REPORT OF POOL'S ACTIVITIES. (a) Not later than June 1 of each year, the board shall submit a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the commissioner.

(b) The report must summarize the activities of the pool in the calendar year preceding the year in which the report is submitted and must include information relating to net written and earned premiums, plan enrollment, administration expenses, and paid and incurred losses. (V.T.I.C. Art. 3.77, Sec. 6(d).)

Sec. 1506.058. ADDITIONAL POWERS AND DUTIES. The commissioner by rule may establish powers and duties of the board in addition to those provided by this chapter. (V.T.I.C. Art. 3.77, Sec. 8 (part).)

[Sections 1506.059-1506.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF POOL

Sec. 1506.101. PURPOSES OF POOL. (a) The purposes of the pool are to:

(1) provide for access to quality health care at minimum cost to the public;

(2) relieve the insurable population of the disruptive cost of sharing coverage; and

(3) maximize reliance on strategies of managed care proven by the private sector.

(b) The pool is not intended to diminish the availability of traditional health care coverage to consumers who are eligible for that coverage. (V.T.I.C. Art. 3.77, Secs. 1(c), (d).)

Sec. 1506.102. EMPLOYEES; COMMITTEES. (a) The pool may

employ and set the compensation of any persons necessary to assist the pool in carrying out its responsibilities and functions.

(b) The pool may appoint appropriate legal, actuarial, and other committees necessary to provide technical assistance in operating the pool and performing any of the functions of the pool. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Sec. 1506.103. PROVIDING COVERAGE. (a) The pool may provide health benefit coverage to an individual who is eligible for that coverage under this chapter.

(b) The pool may issue health benefit coverage subject to this chapter and the pool's plan of operation under Section 1506.201.

(c) The pool may issue additional types of health benefit coverage to provide optional coverages that comply with applicable provisions of state and federal law, including a Medicare supplement benefit plan. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Sec. 1506.104. CHARGES, FORMULAS, AND FORMS. (a) The pool may establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, and claim reserve formulas and perform actuarial functions appropriate to the operation of the pool.

(b) The pool may adopt policy forms, endorsements, and riders and applications for coverage. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Sec. 1506.105. PREMIUM RATES. (a) The pool may not charge premium rates that are unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of

providing the coverage.

(b) Separate schedules of premium rates based on age, sex, and geographic location may apply for individual risks.

(c) Premium rates and premium rate schedules may be adjusted for appropriate risk factors, including age and variation in claim costs. The pool may consider appropriate risk factors in accordance with established actuarial and underwriting practices.

(d) The pool shall establish the standard risk rate. In establishing the rate, the pool shall use reasonable actuarial techniques and consider the premium rates charged by other health benefit plan issuers offering health benefit coverage to individuals. The rate must reflect anticipated experience and expenses for health benefit coverage.

(e) Initial pool premium rates may not be less than 125 percent or greater than 150 percent of rates established as applicable for individual standard rates. Subsequent premium rates shall be established to provide fully for all of the expected costs of claims, including recovery of prior losses, expenses of operation, investment income from claim reserves, and any other cost factors, subject to the limitations described in this subsection. In no event may pool premium rates exceed 200 percent of rates applicable to individual standard risks.

(f) The pool shall submit each rate and rate schedule to the commissioner for approval. The pool may not use a rate or rate schedule before the rate or schedule is approved by the commissioner. In evaluating a rate or rate schedule of the pool, the commissioner shall consider the factors provided by this

section. (V.T.I.C. Art. 3.77, Sec. 9.)

Sec. 1506.106. REINSURANCE. The pool may provide for reinsurance on a facultative or treaty basis or on both facultative and treaty bases. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Sec. 1506.107. CONTRACTS. (a) The pool may enter into a contract that is necessary to carry out this chapter, including, with the approval of the commissioner, a contract with:

(1) a similar pool in another state for the joint performance of common administrative functions; or

(2) another organization for the performance of administrative functions.

(b) The pool may contract for stop-loss insurance for risks incurred by the pool. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Sec. 1506.108. LEGAL ACTION. (a) The pool may sue or be sued.

(b) The pool may take any legal action necessary to:

(1) avoid payment of improper claims against the pool or the coverage provided by or through the pool; or

(2) recover or collect amounts due the pool, including:

(A) assessments due the pool;

(B) amounts erroneously or improperly paid by the pool; and

(C) amounts paid by the pool as a mistake of fact or law. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Sec. 1506.109. COST CONTAINMENT. (a) The pool may provide for and use cost containment measures and requirements, including

preadmission screening, the requirement of a second surgical opinion, concurrent utilization review subject to Article 21.58A, and individual case management, to make the coverage offered by the pool more cost-effective.

(b) The pool may design, use, contract for, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations. (V.T.I.C. Art. 3.77, Secs. 2(1), 6(b) (part).)

Sec. 1506.110. BORROWING. The pool may borrow money as necessary to implement the purposes of the pool. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Sec. 1506.111. ADDITIONAL AUTHORITY. In addition to the other powers granted to the pool under this chapter, the pool may exercise any of the authority that a health benefit plan issuer authorized to write health benefit plans in this state may exercise under the law of this state. (V.T.I.C. Art. 3.77, Sec. 6(a).)

[Sections 1506.112-1506.150 reserved for expansion]

SUBCHAPTER D. POOL COVERAGE AND BENEFITS

Sec. 1506.151. MINIMUM POOL COVERAGE. (a) The pool shall offer coverage consistent with major medical expense coverage to each eligible individual who is not eligible for Medicare.

(b) The board, with the approval of the commissioner, shall establish:

(1) the coverages to be provided by the pool;

(2) the applicable schedules of benefits; and

(3) any exclusions to coverage and other limitations.

(c) The benefits provisions of the pool's coverage must include:

(1) all required or applicable definitions;

(2) a description of covered services required under the pool;

(3) a list of any exclusions or limitations to coverage; and

(4) the deductibles, coinsurance options, and copayment options that are required or permitted. (V.T.I.C. Art. 3.77, Secs. 11(a), (b).)

Sec. 1506.152. ELIGIBILITY FOR COVERAGE. (a) An individual who is a legally domiciled resident of this state is eligible for coverage from the pool if the individual:

(1) provides to the pool evidence that the individual maintained health benefit plan coverage for the preceding 18 months with no gap in coverage longer than 63 days and with the most recent coverage being provided through an employer-sponsored plan, church plan, or government plan;

(2) provides to the pool evidence that the individual maintained health benefit plan coverage under another state's qualified Health Insurance Portability and Accountability Act health program that was terminated because the individual did not reside in that state and submits an application for pool coverage not later than the 63rd day after the date the coverage described by this subdivision was terminated; or

(3) has been a legally domiciled resident of this state for the preceding 30 days, is a citizen of the United States

or has been a permanent resident of the United States for at least three continuous years, and provides to the pool:

(A) a notice of rejection of, or refusal to issue, substantially similar individual health benefit plan coverage from a health benefit plan issuer, other than an insurer that offers only stop-loss, excess loss, or reinsurance coverage, if the rejection or refusal was for health reasons;

(B) certification from an agent or salaried representative of a health benefit plan issuer that states that the agent or salaried representative cannot obtain substantially similar individual coverage for the individual from any health benefit plan issuer that the agent or salaried representative represents because, under the underwriting guidelines of the health benefit plan issuer, the individual will be denied coverage as a result of a medical condition of the individual;

(C) an offer to issue substantially similar individual coverage only with conditional riders;

(D) a notice of refusal by a health benefit plan issuer to issue substantially similar individual coverage except at a rate exceeding the pool rate; or

(E) a diagnosis of the individual with one of the medical or health conditions on the list adopted under Section 1506.154.

(b) Each dependent of an individual who is eligible for coverage from the pool is also eligible for coverage from the pool.

(c) If an individual who obtains coverage from the pool under Subsection (a) is a child, each parent, grandparent, brother,

sister, or child of that individual who resides with that individual is also eligible for coverage from the pool.

(d) The board shall develop a form to be used for certification under Subsection (a)(3)(B). Before it may be used, the form must be approved by the commissioner. (V.T.I.C. Art. 3.77, Secs. 2(6), (17), 10(a), (b), (c).)

Sec. 1506.153. INELIGIBILITY FOR COVERAGE. Notwithstanding Section 1506.152, an individual is not eligible for coverage from the pool if:

(1) on the date pool coverage is to take effect, the individual has health benefit plan coverage from a health benefit plan issuer or health benefit arrangement in effect;

(2) at the time the individual applies to the pool, the individual is eligible for other health care benefits, including benefits from the continuation of coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.), as amended (COBRA), other than:

(A) coverage, including COBRA or other continuation coverage or conversion coverage, maintained for any preexisting condition waiting period under a pool policy;

(B) employer group coverage conditioned by a limitation of the kind described by Section 1506.152(a)(3)(A) or (C); or

(C) individual coverage conditioned by a limitation described by Section 1506.152(a)(3)(C) or (D);

(3) within 12 months before the date the individual applies to the pool, the individual terminated coverage in the

pool, unless the individual demonstrates a good faith reason for the termination;

(4) the individual is confined in a county jail or imprisoned in a state prison;

(5) any of the individual's premiums are paid for or reimbursed under a government-sponsored program or by a government agency or health care provider, other than as an otherwise qualifying full-time employee of a government agency or health care provider or as a dependent of such an employee;

(6) the individual's prior coverage with the pool was terminated:

(A) during the 12-month period preceding the date of application for nonpayment of premiums; or

(B) for fraud; or

(7) the individual is eligible for health benefit plan coverage provided in connection with a policy, plan, or program paid for or sponsored by an employer, even though the employer coverage is declined. (V.T.I.C. Art. 3.77, Secs. 10(e), (h) (part).)

Sec. 1506.154. LIST OF COVERED CONDITIONS. (a) The board shall adopt a list of medical or health conditions for which an individual is eligible for pool coverage under Section 1506.152(a)(3)(E) without applying for health benefit plan coverage.

(b) The board may amend the list as appropriate. (V.T.I.C. Art. 3.77, Sec. 6(c) (part).)

Sec. 1506.155. PREEXISTING CONDITIONS. (a) Except as

provided by this section and Section 1506.056, pool coverage excludes charges or expenses incurred before the first anniversary of the effective date of coverage with regard to any condition for which medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

(b) The exclusion provided by Subsection (a) does not apply to an individual who:

(1) was continuously covered for a period of at least 12 months, excluding any waiting period, by health benefit plan coverage that terminated not earlier than the 63rd day before the effective date of coverage under the pool; and

(2) applied for pool coverage not later than the 63rd day after the date the health benefit plan coverage described by Subdivision (1) terminated.

(c) If an individual was covered by health benefit plan coverage that was in effect at any time during the 12-month period preceding the effective date of the individual's coverage under the pool, the pool shall subtract from the exclusion period required under Subsection (a) the period that the individual was covered under that health benefit plan and any waiting period that applied before that health benefit plan coverage became effective. (V.T.I.C. Art. 3.77, Sec. 12.)

Sec. 1506.156. BENEFIT REDUCTION. The pool shall reduce benefits otherwise payable under pool coverage by:

(1) the total amount paid or payable through any other health benefit plan or health benefit arrangement; and

(2) the total amount of hospital or medical expense benefits paid or payable under:

(A) workers' compensation coverage;

(B) automobile insurance, regardless of whether provided on the basis of fault or no fault; or

(C) a state or federal law or program. (V.T.I.C. Art. 3.77, Sec. 11(d).)

Sec. 1506.157. RECOVERY OF CERTAIN AMOUNTS. (a) The pool has a cause of action against an eligible individual for the recovery of the amount of benefits paid that are not for covered expenses.

(b) Benefits due from the pool may be reduced or refused as an offset against an amount recoverable under this section. (V.T.I.C. Art. 3.77, Sec. 11(e).)

Sec. 1506.158. TERMINATION OF POOL COVERAGE. (a) An individual's pool coverage ends:

(1) on the date the individual ceases to be a legally domiciled resident of this state, unless the individual:

(A) is a student younger than 25 years of age and is financially dependent on the parent;

(B) is a child for whom an individual may be obligated to pay child support; or

(C) is a child who is disabled and dependent on the parent, regardless of the age of the child;

(2) on the date the individual requests coverage to end;

(3) on the date the individual covered by the pool

dies;

(4) on the date state law requires cancellation of the coverage;

(5) at the option of the pool, on the 31st day after the date the pool sends to the individual any inquiry concerning the individual's eligibility, including an inquiry concerning the individual's residence, to which the individual does not reply;

(6) on the 31st day after the date a premium payment for pool coverage becomes due if the payment is not made before that day; or

(7) at the time the individual ceases to meet the eligibility requirements for coverage.

(b) Notwithstanding Subsection (a), the coverage of an individual who ceases to meet the eligibility requirements for coverage terminates on the earlier of:

(1) the first premium due date after the date the pool determines the individual does not meet the eligibility requirements; or

(2) the first day of the first month after the month in which the pool determines the individual does not meet the eligibility requirements.

(c) The pool has the sole discretion to determine that an individual does not meet the eligibility requirements for coverage.

(d) An individual may maintain pool coverage for the period the individual is satisfying a preexisting waiting period under another health benefit plan or health benefit arrangement intended to replace the pool coverage. (V.T.I.C. Art. 3.77, Secs. 10(d),

(f), (g).)

Sec. 1506.159. PROHIBITION ON ARRANGEMENT OR ATTEMPTED ARRANGEMENT OF CERTAIN POOL COVERAGE; PENALTY. (a) A health benefit plan issuer, agent, third-party administrator, or other person authorized or licensed under this code may not arrange or assist in, or attempt to arrange or assist in, the application for coverage from or placement in the pool of an individual who is not eligible under Section 1506.153(7) for coverage from the pool for the purpose of separating the person from health benefit plan coverage offered or provided in connection with employment that would be available to the person as an employee or a dependent of an employee.

(b) A violation of this section is an unfair method of competition and an unfair or deceptive act or practice under Chapter 541. (V.T.I.C. Art. 3.77, Sec. 10(h) (part).)

[Sections 1506.160-1506.200 reserved for expansion]

SUBCHAPTER E. OPERATION OF POOL

Sec. 1506.201. PLAN OF OPERATION. (a) Operation and management of the pool is governed by a plan of operation. The plan of operation includes the articles, bylaws, and operating rules of the pool that are adopted by the board.

(b) The plan of operation must ensure the fair, reasonable, and equitable administration of the pool.

(c) In addition to complying with the other requirements of this chapter, the plan of operation must include procedures for:

(1) operation of the pool;

(2) selection of an administrator as provided by

Section 1506.202;

(3) creation of a fund, under management of the board, for administrative expenses;

(4) handling, accounting, and auditing of money and other assets of the pool;

(5) development and implementation of a program to:

(A) publicize the existence of the pool, the eligibility requirements for coverage under the pool, and enrollment procedures; and

(B) foster public awareness of the pool;

(6) creation of a grievance committee to review complaints presented by applicants for coverage from the pool and individuals who are covered by the pool; and

(7) other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this chapter.

(d) The board shall amend the plan of operation as necessary to carry out this chapter. An amendment to the plan of operation must be approved by the commissioner before it becomes a part of the plan. (V.T.I.C. Art. 3.77, Secs. 2(15), 5(a) (part), (b), (f).)

Sec. 1506.202. POOL ADMINISTRATOR. (a) The board may select one or more health benefit plan issuers or a third-party administrator authorized by the department to administer the pool. The selection must be made under a competitive bidding process in accordance with the plan of operation.

(b) The board shall establish criteria for evaluating the bids submitted under this section. The criteria must include:

(1) the bidder's proven ability to handle individual health benefit plans;

(2) the bidder's efficiency of claims paying procedures;

(3) an estimate of total charges for administering the pool;

(4) the bidder's ability to administer the pool in a cost-efficient manner; and

(5) the bidder's financial condition and stability. (V.T.I.C. Art. 3.77, Secs. 7(a), (b).)

Sec. 1506.203. ADMINISTRATOR'S TERM; SUCCEEDING TERM. (a) A person selected as a pool administrator serves in that capacity for a three-year term beginning on the date the board issues its order making the selection.

(b) Not later than one year before the expiration of a pool administrator's term, the board shall invite all health benefit plan issuers, including the pool administrator, to submit bids to serve as a pool administrator for the succeeding administration period. The selection of the succeeding pool administrator must be made not later than the sixth calendar month preceding the month in which the pool administrator's term expires. (V.T.I.C. Art. 3.77, Secs. 7(c), (d).)

Sec. 1506.204. ADMINISTRATOR'S FUNCTIONS. (a) A pool administrator shall perform the functions relating to the pool that are assigned to the administrator.

(b) The assigned functions may include:

(1) performing eligibility and administrative claims

payment functions for the pool;

(2) establishing a billing procedure for collection of premiums from individuals covered by the pool;

(3) performing functions necessary to ensure timely payment of benefits to individuals covered by the pool, including:

(A) providing information relating to the proper manner of submitting a claim for benefits to the pool and distributing claim forms; and

(B) evaluating the eligibility of each claim for payment by the pool;

(4) submitting regular reports to the board relating to the operation of the pool; and

(5) determining after each calendar year the net written and earned premiums, expenses of administration, and paid and incurred losses of the pool for that calendar year and reporting that information to the board and the commissioner.

(c) The board shall determine the form, content, and time of submission of the reports required under Subsection (b)(4).

(d) The commissioner shall prescribe the forms to be used to report the information under Subsection (b)(5).

(e) The board shall determine the times at which a pool administrator is to perform the billing functions for the pool. (V.T.I.C. Art. 3.77, Secs. 7(e), (g), (h).)

Sec. 1506.205. PAYMENTS TO ADMINISTRATOR. (a) The pool shall pay a pool administrator for the administrator's expenses incurred in performing duties and functions as provided by the plan of operation.

(b) Except as provided by Subsection (c), the total amount of administrative costs and fees paid in a calendar year to all pool administrators may not exceed 12.5 percent of the gross premium receipts of the pool for the calendar year.

(c) The commissioner may approve payment of a higher amount, not to exceed 15 percent of the gross premium receipts of the pool for the calendar year, if the commissioner determines that the higher amount is necessary to pay the administrative costs and fees of the pool. (V.T.I.C. Art. 3.77, Sec. 7(f).)

[Sections 1506.206-1506.250 reserved for expansion]

SUBCHAPTER F. ASSESSMENTS FOR OPERATION OF POOL

Sec. 1506.251. INTERIM ASSESSMENTS. (a) The board may assess health benefit plan issuers, including making advance interim assessments, as reasonable and necessary for the pool's organizational and interim operating expenses.

(b) The board shall credit an interim assessment as an offset against any regular assessment that is due after the end of the fiscal year. (V.T.I.C. Art. 3.77, Sec. 13(a).)

Sec. 1506.252. DETERMINATION OF NET LOSS. (a) After the end of each fiscal year, the board shall determine for the preceding calendar year any net loss of the pool, including administrative expenses and incurred losses, and report the net loss to the commissioner.

(b) In determining the net loss, the board shall take into account investment income and other appropriate gains and losses. (V.T.I.C. Art. 3.77, Sec. 13(c) (part).)

Sec. 1506.253. ASSESSMENTS TO COVER NET LOSSES. (a) The

board shall recover any net loss of the pool by assessing each health benefit plan issuer an amount determined annually by the board based on information in annual statements and other reports required by and filed with the board.

(b) The amount of a health benefit plan issuer's assessment is computed by multiplying the total amount required to be assessed against all health benefit plan issuers by a number computed by dividing:

(1) the gross premiums collected by the issuer for health benefit plans in this state during the preceding calendar year; by

(2) the gross premiums collected by all issuers for health benefit plans in this state during the preceding calendar year.

(c) For purposes of Subsection (b), gross health benefit plan premiums do not include Medicare supplement benefit plan premiums subject to Chapter 1652 or small employer health benefit plan premiums subject to Subchapters A-H, Chapter 1501. (V.T.I.C. Art. 3.77, Secs. 13(c) (part), (d) (part).)

Sec. 1506.254. ASSESSMENT DUE DATE; INTEREST. (a) An assessment is due on the date specified by the board that is not earlier than the 30th day after the date written notice of the assessment is transmitted to the health benefit plan issuer.

(b) Interest accrues on the unpaid amount of an assessment at a rate equal to the prime lending rate, as published in the most recent issue of the Wall Street Journal and determined as of the date the assessment becomes delinquent, plus three percent.

(V.T.I.C. Art. 3.77, Sec. 13(d) (part).)

Sec. 1506.255. ABATEMENT OR DEFERMENT OF ASSESSMENT. (a) A health benefit plan issuer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board. The commissioner may abate or defer all or part of the assessment if the commissioner determines that payment of the assessment would endanger the ability of the health benefit plan issuer to fulfill its contractual obligations.

(b) If all or part of an assessment against a health benefit plan issuer is abated or deferred, the amount of the abatement or deferment shall be assessed against the other health benefit plan issuers in a manner consistent with the method for computing assessments under this subchapter.

(c) A health benefit plan issuer receiving an abatement or deferment under this section remains liable to the pool for the deficiency. (V.T.I.C. Art. 3.77, Sec. 13(e).)

Sec. 1506.256. USE OF EXCESS FROM ASSESSMENTS. (a) In this section, "future losses" includes reserves for claims incurred but not reported.

(b) If the total amount of the assessments exceeds the pool's actual losses and administrative expenses, the board shall deposit the excess in an interest-bearing account and shall use money in that account to offset future losses or to reduce future assessments. (V.T.I.C. Art. 3.77, Sec. 13(b).)

Sec. 1506.257. COLLECTION OF ASSESSMENTS. The pool may recover or collect assessments made under this subchapter. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Sec. 1506.258. PROCEDURES, CRITERIA, AND FORMS. The commissioner by rule shall provide the procedures, criteria, and forms necessary to implement, collect, and deposit assessments under this subchapter. (V.T.I.C. Art. 3.77, Sec. 8 (part).)

SECTION 4. SUBTITLE I, TITLE 8, INSURANCE CODE. Title 8, Insurance Code, is amended by adding Subtitle I to read as follows:

SUBTITLE I. SPECIALIZED COVERAGES

CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

SUBTITLE I. SPECIALIZED COVERAGES

CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

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CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1651.001. APPLICABILITY OF CHAPTER. (a) Notwithstanding Section 101.053(b)(5) and subject to Subsection (b), this chapter applies only to:

(1) an individual long-term care benefit plan that is delivered or issued for delivery in this state;

(2) a group long-term care benefit plan that is:

(A) delivered or issued for delivery in this state; and

(B) issued to an eligible group as described by Subchapter B, Chapter 1251;

(3) a certificate issued under a group long-term care benefit plan issued to an eligible group as described by Subchapter B, Chapter 1251, if the certificate is delivered or issued for delivery in this state, regardless of the place where the plan is delivered or issued for delivery; and

(4) an evidence of coverage delivered or issued for delivery in this state for long-term care.

(b) This chapter applies only to a policy, certificate, or evidence of coverage that is issued by:

(1) a capital stock insurance company, including a life, health and accident, or general casualty insurance company;

(2) a mutual life insurance company;

(3) a mutual assessment life insurance company, including a statewide mutual assessment corporation, local mutual aid association, and burial association;

(4) a mutual or mutual assessment association, including an association subject to Section 887.101;

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

(6) a mutual or natural premium life or casualty insurance company;

(7) a fraternal benefit society;

(8) a Lloyd's plan insurer;

(9) a reciprocal or interinsurance exchange;

(10) a nonprofit medical, hospital, or dental service corporation, including a company subject to Chapter 842;

(11) a stipulated premium company;

(12) a health maintenance organization under Chapter 843; or

(13) another insurer required to be licensed by the department. (V.T.I.C. Art. 3.70-12, Secs. 1(a), (b), 2(2), (3).)

Sec. 1651.002. EXEMPTIONS. This chapter does not apply to:

(1) a certificate that is delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state; or

(2) a benefit plan that is not advertised, marketed, or offered as a long-term care benefit plan or nursing home benefit plan. (V.T.I.C. Art. 3.70-12, Secs. 1(d), (e).)

Sec. 1651.003. LONG-TERM CARE BENEFIT PLAN DEFINED. (a) In this chapter, "long-term care benefit plan" means an insurance policy or group certificate, or rider to the policy or certificate, or evidence of coverage issued by a health maintenance organization subject to Chapter 843, that is advertised or marketed as

providing, or offered or designed to provide, coverage for not less than 12 consecutive months for each covered individual on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital.

(b) The term includes a plan or rider, other than a group or individual annuity or life insurance policy, that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

(c) The term does not include an insurance policy, group certificate, or evidence of coverage that is offered primarily to provide:

(1) basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage; or

(2) basic or single health care services. (V.T.I.C. Art. 3.70-12, Sec. 2(4).)

Sec. 1651.004. RULES. (a) In addition to other rules required or authorized by this chapter, the department may adopt reasonable rules that are necessary and proper to carry out this chapter.

(b) Rules adopted under this section must include

requirements no less favorable than the minimum standards for long-term care benefit plans adopted in any model laws or regulations relating to minimum standards for benefits for long-term care benefit plans and in accordance with all applicable federal law. (V.T.I.C. Art. 3.70-12, Sec. 7.)

Sec. 1651.005. CONSTRUCTION OF CHAPTER. This chapter may not be construed to enlarge the powers of an entity listed in Section 1651.001. (V.T.I.C. Art. 3.70-12, Sec. 1(c).)

Sec. 1651.006. CONFLICTS WITH OTHER PROVISIONS. This chapter prevails to the extent of any conflict with another provision of this code. (V.T.I.C. Art. 3.70-12, Sec. 6 (part).)

[Sections 1651.007-1651.050 reserved for expansion]

SUBCHAPTER B. BENEFIT PLAN STANDARDS

Sec. 1651.051. MINIMUM STANDARDS. (a) The commissioner by rule shall establish:

(1) specific standards for provisions of long-term care benefit plans; and

(2) standards for full and fair disclosure setting forth the manner, content, and required disclosures for the marketing and sale of those benefit plans.

(b) The standards are in addition to and must be in accordance with:

(1) applicable laws of this state, including Chapter 1201;

(2) applicable federal law; and

(3) any rules, regulations, and standards required by federal law.

(c) The standards must address:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) coverage of dependents;

(5) coverage of parents of the insured or enrollee and parents of the spouse of the insured or enrollee;

(6) preexisting conditions;

(7) termination of insurance;

(8) continuation or conversion;

(9) probationary periods;

(10) benefit limitations, exceptions, and reductions;

(11) elimination periods;

(12) requirements for replacement;

(13) recurrent conditions;

(14) definitions of terms; and

(15) inflation protection.

(d) The standards may:

(1) establish standard claim forms;

(2) establish standard benefits for:

(A) skilled nursing care;

(B) intermediate nursing care;

(C) custodial care; and

(D) home health care;

(3) require coverage for skilled nursing care, intermediate nursing care, and custodial care to facilitate comparison among long-term care products;

(4) require long-term care benefit plan issuers to offer coverage for home health care benefits;

(5) require that rates may not be increased for a covered individual unless:

(A) the covered individual requests and receives a change of benefits; or

(B) the increase applies to all members of the class to which the individual has been assigned by the benefit plan issuer; or

(6) require a benefit plan issuer to pay for a service covered by the benefit plan that is provided by an institution licensed to provide that service under Chapter 242, Health and Safety Code.

(e) Rules adopted under this section must include requirements no less favorable than the minimum standards of benefits for long-term care benefit plans adopted in any model laws or regulations relating to minimum standards for benefits for long-term care benefit plans and required by federal law. (V.T.I.C. Art. 3.70-12, Secs. 3(a), (b), (c), (d).)

Sec. 1651.052. PREEXISTING CONDITIONS. (a) A long-term care benefit plan may not contain a provision that denies coverage for a claim for losses incurred more than six months after the effective date of coverage for a preexisting condition.

(b) A long-term care benefit plan may not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective

date of coverage.

(c) The commissioner by rule may:

(1) establish additional reasonable regulation of preexisting conditions consistent with this section and Section 1651.051; and

(2) extend a limitation period specified in this section as to a specific age group category in a specific benefit plan form if the commissioner finds that the extension is in the best interest of the public.

(d) Rules adopted under this section must comply with Section 1651.051(e). (V.T.I.C. Art. 3.70-12, Secs. 3(d), (e).)

Sec. 1651.053. LOSS RATIO STANDARDS. (a) A long-term care benefit plan must provide a benefit plan holder with benefits that are reasonable in relation to the rates charged.

(b) The commissioner shall adopt reasonable rules to establish minimum standards for loss ratios of long-term care benefit plans on the basis of:

(1) incurred claims experience;

(2) earned premiums;

(3) the period for which rates are computed to provide coverage;

(4) experienced and projected trends;

(5) concentration of experience within early benefit plan duration;

(6) expected claim fluctuations;

(7) experience refunds;

(8) adjustments;

(9) dividends;

(10) renewability features;

(11) all relevant expense factors;

(12) interest;

(13) reserves;

(14) mix of business by risk classification; and

(15) product features otherwise affecting claims experience.

(c) Annually, each entity providing a long-term care benefit plan in this state shall:

(1) file its rates, rating schedule, and supporting documentation to demonstrate compliance with the applicable loss ratio standards of this state; and

(2) comply with any other filing requirement adopted by the commissioner relating to loss ratios.

(d) Rules adopted under this section shall be no less favorable to the holders of long-term care benefit plans than any model laws, rules, and regulations adopted in connection with minimum standards for benefits for long-term care benefit plans. (V.T.I.C. Art. 3.70-12, Sec. 4.)

Sec. 1651.054. NOTICE OF RIGHT TO REFUND. (a) In this section, "applicant" means:

(1) in the case of an individual long-term care benefit plan, the individual who seeks to contract for insurance or other health benefits; and

(2) in the case of a group long-term care benefit plan, the proposed certificate holder.

(b) A long-term care benefit plan must have a notice prominently printed on the first page of or attached to the benefit plan document.

(c) The notice must state in substance that, if the applicant is not satisfied for any reason after examining the benefit plan document, the applicant is entitled to:

(1) return the document not later than the 30th day after the date of its delivery; and

(2) have any premium refunded.

(d) The long-term care benefit plan issuer shall pay in a timely manner the refund directly to the individual or entity that paid the premium. (V.T.I.C. Art. 3.70-12, Secs. 2(1), 5.)

Sec. 1651.055. RATE STABILIZATION. (a) The commissioner shall adopt rules to stabilize long-term care premium rates by:

(1) ensuring that:

(A) initial rates for long-term care benefit plan forms are adequate; and

(B) any rate schedule increases for long-term care benefit plans made after issuance of the plans are justified, adequate, and reasonable in relation to benefits provided to plan holders;

(2) requiring any appropriate plan terms;

(3) imposing penalties on insurers or other entities subject to this chapter that violate a rule adopted under this section; and

(4) protecting plan holders affected by a rate schedule increase.

(b) Except as provided by this subsection, the commissioner shall adopt rules under this section that are consistent with nationally recognized models relating to the stabilization of long-term care premium rates that existed on January 1, 2001. The commissioner may adopt rules consistent with any of those models as they are amended after January 1, 2001. The commissioner shall adopt rules under this subsection that:

(1) to the extent possible, contribute to the uniformity of state laws; and

(2) protect consumers.

(c) In adopting rules under this section, the commissioner may exempt long-term care benefit plans from the requirements of Sections 1651.053(a), (b), and (d). (V.T.I.C. Art. 3.70-12, Sec. 5A.)

CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 1652.006-1652.050 reserved for expansion]

SUBCHAPTER B. BENEFITS

Sec. 1652.001. DEFINITIONS. In this chapter:

(1) "Applicant" means:

(A) an individual who seeks to contract for insurance or other health benefits under an individual Medicare supplement benefit plan; or

(B) the proposed certificate holder of a group Medicare supplement benefit plan.

(2) "Approved regulatory program" means a state regulatory program that complies with the requirements of Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(3) "Medicare" means the Health Insurance for the Aged Act (42 U.S.C. Section 1395 et seq.), as amended. (V.T.I.C. Art. 3.74, Secs. 1(b)(1), (4); New.)

Sec. 1652.002. MEDICARE SUPPLEMENT BENEFIT PLAN. (a) "Medicare supplement benefit plan" means a group or individual policy of accident and health insurance, a subscriber contract of a group hospital service corporation operating under Chapter 842, or, to the extent required by federal law, an evidence of coverage issued by a health maintenance organization operating under Chapter 843 that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of an individual eligible for Medicare.

(b) A policy, contract, subscriber contract, or evidence of coverage is not considered to be a Medicare supplement benefit plan if it is:

(1) a policy, contract, subscriber contract, or

evidence of coverage of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination, for employees or former employees, or a combination, or for members or former members, or a combination, of the labor organizations;

(2) a policy or health care benefit plan, including a policy or contract of group insurance, a group contract of a group hospital service corporation operating under Chapter 842, or a group evidence of coverage issued by a health maintenance organization operating under Chapter 843 that is not marketed or held to be a Medicare supplement benefit plan; or

(3) an individual or group evidence of coverage issued in accordance with a contract under Section 1833 or 1876, Social Security Act (42 U.S.C. Section 1395l or 1395mm), by a health maintenance organization operating under Chapter 843.

(c) The commissioner by rule may modify the definition of "Medicare supplement benefit plan" provided by Subsection (a) to the extent necessary for this state to qualify as a state with an approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 1(b)(3).)

Sec. 1652.003. APPLICABILITY OF CHAPTER. This chapter applies to an individual or group Medicare supplement benefit plan delivered or issued for delivery in this state and, regardless of the place where the plan was delivered or issued for delivery, a certificate that was issued under a group Medicare supplement benefit plan and delivered or issued for delivery in this state, if the plan or certificate is issued by:

(1) a capital stock insurance company, including a

life, health and accident, and general casualty insurance company;

(2) a mutual life insurance company;

(3) a mutual assessment life insurance company, including a statewide mutual assessment company, local mutual aid association, and burial association;

(4) a mutual or mutual assessment association of any kind, including an association subject to Section 887.102;

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

(6) a mutual or natural premium life or casualty insurance company;

(7) a fraternal benefit society;

(8) a Lloyd's plan;

(9) a reciprocal or interinsurance exchange;

(10) a nonprofit hospital, medical, or dental service corporation, including a corporation operating under Chapter 842;

(11) a stipulated premium company;

(12) another insurer that by law is required to be authorized by the department; or

(13) a health maintenance organization operating under Chapter 843, to the extent required by federal law. (V.T.I.C. Art. 3.74, Secs. 1(a) (part), (b)(2).)

Sec. 1652.004. CONSTRUCTION OF CHAPTER. (a) This chapter may not be construed to enlarge the powers of an entity described by Section 1652.003.

(b) This chapter controls to the extent of any conflict with another provision of this code. (V.T.I.C. Art. 3.74, Secs. 1(a)

(part), 7 (part).)

Sec. 1652.005. RULES NECESSARY FOR CERTIFICATION. In addition to other rules required or authorized by this chapter, the commissioner shall adopt reasonable rules necessary and proper to carry out this chapter, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certification as a state with an approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 10.)

[Sections 1652.006-1652.050 reserved for expansion]

SUBCHAPTER B. BENEFITS

Sec. 1652.051. MINIMUM STANDARDS. (a) The commissioner shall adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different Medicare supplement benefit plans. The standards are in addition to and must be in accordance with:

(1) applicable laws of this state, including Chapters 842 and 1201;

(2) applicable federal law, rules, regulations, and standards; and

(3) any model rules and regulations required by federal law, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(b) The standards may include provisions relating to:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) probationary periods;

(5) benefit limitations, exceptions, and reductions;

(6) elimination periods;

(7) requirements for replacement;

(8) recurrent conditions;

(9) definitions of terms; and

(10) exclusions required by state or federal law.

(c) The commissioner may adopt reasonable rules that specifically prohibit benefit plan provisions that:

(1) are not otherwise specifically authorized by statute; and

(2) the commissioner determines are unjust, unfair, or unfairly discriminatory to a person who is covered or proposed for coverage.

(d) Rules adopted under this section must include requirements that are at least equal to those required by federal law, rules, regulations, and standards, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Secs. 2(c), (d), (f).)

Sec. 1652.052. MINIMUM STANDARDS FOR BENEFITS AND CLAIM PAYMENTS. (a) The commissioner shall adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans.

(b) The standards for benefits and claim payments must include the requirements for certification of Medicare supplement benefit plans prescribed by Section 1882, Social Security Act (42

U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 3.)

Sec. 1652.053. DUPLICATE BENEFITS PROHIBITED. A Medicare supplement benefit plan or certificate in force in this state may not contain benefits that duplicate benefits provided by Medicare. (V.T.I.C. Art. 3.74, Sec. 2(a).)

Sec. 1652.054. BASIC PLAN. An entity described by Section 1652.003 that offers for sale in this state a Medicare supplement benefit plan must offer a basic Medicare supplement benefit plan that:

(1) provides only those benefits common to all Medicare supplement benefit plans; and

(2) meets but does not exceed the minimum standards of benefits for Medicare supplement benefit plans adopted by the commissioner and authorized by Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 2(b) (part).)

Sec. 1652.055. ADDITIONAL BENEFITS. (a) In addition to the basic Medicare supplement benefit plan described by Section 1652.054, an entity may offer additional Medicare supplement benefit plans for sale in this state.

(b) The combination of benefits provided by an additional plan must conform to one of the benefit packages adopted by the commissioner and authorized by Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(c) The commissioner by rule shall provide for the approval of new or innovative benefits that may be provided in a plan other than the basic plan and that otherwise comply with this subchapter.

The benefits must:

(1) be offered in a manner consistent with the goal of Medicare supplement benefit plan simplification; and

(2) meet the requirements prescribed by Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 2(b) (part).)

Sec. 1652.056. COVERAGE FOR MAMMOGRAPHY. (a) In this section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

(b) Each Medicare supplement benefit plan must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer.

(c) The coverage for the annual screening may not be less favorable than coverage for other radiological examinations and must be subject to the same dollar limits, deductibles, and coinsurance factors. (V.T.I.C. Art. 3.74, Sec. 3A.)

Sec. 1652.057. WAIVER OF WAITING PERIOD. (a) An entity that delivers or issues for delivery in this state a Medicare supplement benefit plan or certificate that replaces a Medicare supplement benefit plan or certificate shall give credit for the satisfaction or partial satisfaction of any waiting period, elimination period, or probationary period for a preexisting condition that has been satisfied under the plan being replaced.

(b) A replacement plan that clearly provides a new or

additional benefit may include appropriate and clearly stated periods as a condition for payment of the new or additional benefit. (V.T.I.C. Art. 3.74, Sec. 8.)

Sec. 1652.058. COVERAGE FOR PREEXISTING CONDITION. (a) A Medicare supplement benefit plan may not contain a provision that excludes coverage for a claim for losses incurred more than six months after the effective date of coverage for a preexisting condition.

(b) A Medicare supplement benefit plan may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage. (V.T.I.C. Art. 3.74, Sec. 2(e).)

[Sections 1652.059-1652.100 reserved for expansion]

SUBCHAPTER C. LOSS RATIO STANDARDS

Sec. 1652.101. LOSS RATIO STANDARDS. (a) A Medicare supplement benefit plan must return to a plan holder benefits that are reasonable in relation to the premium charged.

(b) The commissioner shall adopt reasonable rules to establish minimum loss ratio standards for Medicare supplement benefit plans. The standards must be established:

(1) on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage;

(2) in accordance with accepted actuarial principles and practices; and

(3) to the extent necessary for the state to obtain or

retain certification as a state with an approved regulatory program. (V.T.I.C. Art. 3.74, Secs. 4(a), (d).)

Sec. 1652.102. FILING REQUIREMENTS. (a) Annually, each entity providing Medicare supplement benefit plans in this state shall file with the department the entity's rates, rating schedule, and supporting documentation demonstrating that:

(1) the entity is complying with the applicable loss ratio standards of this state; and

(2) the actual and expected losses in relation to premiums comply with the requirements of this subchapter and the rules adopted by the commissioner.

(b) The documentation required by Subsection (a) must include a report of the ratio of incurred losses to covered premiums for the preceding calendar year, illustrated by calendar year of issue.

(c) The commissioner may adopt rules relating to filing requirements for rates, rating schedules, and loss ratios. (V.T.I.C. Art. 3.74, Secs. 4(b), (c).)

Sec. 1652.103. REVIEW OF PREMIUM INCREASES. (a) The commissioner by rule shall provide a process for reviewing and approving or disapproving a proposed premium increase relating to a Medicare supplement benefit plan.

(b) The rules must comply with federal law, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 4(f).)

Sec. 1652.104. BENEFIT CHANGES. (a) Before the date on which a Medicare benefit change required by federal law takes

effect, each entity providing in this state a Medicare supplement benefit plan existing on the effective date of the change shall file with the commissioner, in accordance with Chapter 1701:

(1) each appropriate premium adjustment necessary to produce the loss ratios originally anticipated for the applicable plan, accompanied by any supporting documents necessary to justify the adjustment; and

(2) each appropriate rider, endorsement, or plan form necessary to modify the coverage so as to eliminate benefit duplications with Medicare.

(b) A rider, endorsement, or plan form required by Subsection (a) must provide a clear description of the Medicare supplement benefits provided by the plan. (V.T.I.C. Art. 3.74, Sec. 4(e).)

Sec. 1652.105. REPORTING LOSS RATIO INFORMATION TO SECRETARY OF HEALTH AND HUMAN SERVICES. To the extent necessary for this state to obtain or retain certification as a state with an approved regulatory program, the department shall comply with federal requirements relating to periodic reporting of loss ratio information to the secretary of health and human services, based on a uniform methodology, as authorized by federal law. (V.T.I.C. Art. 3.74, Sec. 4(g).)

[Sections 1652.106-1652.150 reserved for expansion]

SUBCHAPTER D. CONSUMER INFORMATION AND NOTICE

Sec. 1652.151. RULES RELATING TO DISCLOSURE. The rules adopted under Sections 1652.152, 1652.153, and 1652.154 must include provisions and requirements that are at least equal to

those required by federal law, including the rules, regulations, and standards adopted under Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Secs. 5(b) (part), (f).)

Sec. 1652.152. OUTLINE OF COVERAGE. (a) To provide for full and fair disclosure in the sale of Medicare supplement benefit plans, a Medicare supplement benefit plan or certificate may not be delivered or issued for delivery in this state unless an outline of coverage that complies with this section is delivered to the applicant when the applicant applies for the coverage.

(b) The commissioner by rule shall prescribe the format and content of the outline of coverage required by Subsection (a). The rules must address the style, arrangement, and overall appearance of the outline of coverage, including the size, color, and prominence of type and the arrangement of text and captions. (V.T.I.C. Art. 3.74, Secs. 5(a), (b) (part).)

Sec. 1652.153. INFORMATIONAL BROCHURE. (a) The commissioner by rule may prescribe a standard form and the contents of an informational brochure intended to improve the ability of an individual eligible for Medicare to understand Medicare and to select the most appropriate Medicare supplement coverage.

(b) Except as provided by Subsection (c), the commissioner by rule may require that the informational brochure be provided to an individual eligible for Medicare concurrently with delivery of the outline of coverage.

(c) If the plan is a direct response Medicare supplement benefit plan, the commissioner by rule may require that the

informational brochure be provided on request to an individual eligible for Medicare at any time not later than the time the plan is delivered. (V.T.I.C. Art. 3.74, Sec. 5(c).)

Sec. 1652.154. NOTICE RELATING TO OTHER TYPES OF COVERAGE. (a) The commissioner may adopt reasonable rules for captions or notice requirements for each accident and health insurance policy, subscriber contract, or evidence of coverage sold to an individual eligible for Medicare that are determined to be in the public interest and designed to inform the individual that a particular coverage is not a Medicare supplement benefit plan. This subsection does not apply to:

(1) a Medicare supplement benefit plan;

(2) a disability income policy;

(3) a basic, catastrophic, or major medical expense policy;

(4) a single premium nonrenewable policy; or

(5) another policy, contract, or subscriber contract described by Section 1652.002(b)(1) or (2).

(b) The commissioner may adopt reasonable rules to govern the full and fair disclosure of information relating to replacing an accident and health insurance policy, a subscriber contract, or a certificate by an individual eligible for Medicare. (V.T.I.C. Art. 3.74, Secs. 5(d), (e).)

Sec. 1652.155. RIGHT TO RETURN FOR REFUND; NOTICE. (a) If an applicant is not satisfied for any reason after examining a Medicare supplement benefit plan document or certificate, the applicant is entitled to receive a refund of the premium if the

applicant returns the document or certificate not later than the 30th day after the date it is delivered.

(b) The entity issuing the plan or certificate shall refund the premium directly to the applicant in a timely manner.

(c) A Medicare supplement benefit plan or certificate must have a notice stating the substance prescribed by Subsection (a) prominently printed on the first page of or attached to the plan or certificate. (V.T.I.C. Art. 3.74, Sec. 6.)

Sec. 1652.156. ADVERTISING FILING REQUIREMENTS. (a) The commissioner shall adopt reasonable rules to require each entity described by Section 1652.003 to file with the department a copy of any advertisement relating to Medicare supplement benefit plans that the entity intends to use in this state. The rules must require that the entity file the copy not later than the 60th day before the date of intended use.

(b) At the expiration of the 60-day period provided by Subsection (a), an advertisement filed in accordance with that subsection is considered acceptable, unless before the end of that 60-day period the department notifies the entity of the advertisement's nonacceptance.

(c) An entity may not use an advertisement for Medicare supplement benefit plans that does not comply with state law, including department rules. (V.T.I.C. Art. 3.74, Sec. 9.)

[Sections 1652.157-1652.200 reserved for expansion]

SUBCHAPTER E. AGENTS

Sec. 1652.201. INFORMATION PROVIDED TO AGENTS. (a) An entity that offers a Medicare supplement benefit plan for sale in

this state shall provide to each agent authorized to sell that plan information relating to:

(1) Medicare;

(2) the Medicare supplement benefit plans offered by that entity; and

(3) the agent's ethical obligations to clients.

(b) The commissioner by rule may prescribe the information that must be provided under this section. (V.T.I.C. Art. 3.74, Sec. 9A.)

Sec. 1652.202. PERMITTED COMPENSATION ARRANGEMENTS. (a) The commissioner by rule shall limit the commission or other compensation that may be paid to an agent for the sale of a Medicare supplement benefit plan or certificate, including a replacement plan or certificate.

(b) The rules must conform to, but may not be more restrictive than, the requirements of federal law necessary for this state to obtain or retain certification as a state with an approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 9B.)

SECTION 5. TITLE 9, INSURANCE CODE. The Insurance Code is amended by adding Title 9 to read as follows:

TITLE 9. PROVISIONS APPLICABLE TO LIFE AND HEALTH COVERAGES

CHAPTER 1701. POLICY FORMS

TITLE 9. PROVISIONS APPLICABLE TO LIFE AND HEALTH COVERAGES

CHAPTER 1701. POLICY FORMS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1701.001. DEFINITION

Sec. 1701.002. APPLICABILITY OF CHAPTER TO FORMS OF

ACCIDENT AND HEALTH POLICY

CHAPTER 1701. POLICY FORMS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1701.001. DEFINITION. In this chapter, "use" includes issue and deliver. (New.)

Sec. 1701.002. APPLICABILITY OF CHAPTER TO FORMS OF CERTAIN DOCUMENTS. This chapter applies to the form of the following document:

(1) a policy, contract, or certificate of:

(A) accident or health insurance, including group accident or health insurance;

(B) medical or surgical insurance, including group medical or surgical insurance;

(C) life or term insurance, including group life or term insurance;

(D) endowment insurance;

(E) industrial life insurance; or

(F) fraternal benefit insurance;

(2) an annuity or pure endowment contract, including a group annuity contract;

(3) an application attached or required to be attached to the policy, contract, or certificate; or

(4) a rider or endorsement to be attached to, printed on, or used in connection with the policy, contract, or certificate. (V.T.I.C. Art. 3.42, Secs. (a) (part), (b) (part).)

Sec. 1701.003. APPLICABILITY OF CHAPTER TO CERTAIN INSURERS. (a) Except as provided by Subsection (b), this chapter

applies to any insurer that uses a document described by Section 1701.002 in this state, including:

(1) a life, accident, health, or casualty insurance company;

(2) a mutual life insurance company;

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

(4) a mutual or natural premium life insurance company;

(5) a general casualty company;

(6) a Lloyd's plan;

(7) a reciprocal or interinsurance exchange;

(8) a fraternal benefit society; and

(9) a group hospital service corporation.

(b) This chapter does not apply to a society, company, or other insurer whose activities are by statute exempt from department control and that is entitled by statute to a certificate from the department showing that exempt status. (V.T.I.C. Art. 3.42, Sec. (a) (part).)

Sec. 1701.004. CONSTRUCTION OF CHAPTER. This chapter may not be construed to enlarge the powers of an insurer subject to this chapter. (V.T.I.C. Art. 3.42, Sec. (a) (part).)

Sec. 1701.005. EXEMPTIONS. (a) This chapter does not apply to a rider or endorsement that:

(1) is used at the request of the holder of a policy, contract, or certificate subject to this chapter; and

(2) relates to:

(A) the manner of distribution of benefits under the policy, contract, or certificate; or

(B) the reservation of rights and benefits under the policy, contract, or certificate.

(b) The commissioner by written order may exempt a document from the requirements of this chapter for the period the commissioner considers proper if the commissioner determines that:

(1) this chapter may not practically be applied to the document;

(2) the document's preparation, use, and meaning have become routine or commonplace; or

(3) the filing and approval of the form of the document are not desirable, appropriate, required, or necessary for the protection of the public. (V.T.I.C. Art. 3.42, Secs. (b) (part), (h) (part).)

[Sections 1701.006-1701.050 reserved for expansion]

SUBCHAPTER B. FILING REQUIREMENT

Sec. 1701.051. FILING REQUIRED. (a) Except as provided by Section 1701.005, an insurer may not use a document described by Section 1701.002 in this state unless the form of the document is filed with the department in accordance with this chapter.

(b) Except as provided by Section 1701.052, the insurer must file the form of the document not later than the 60th day before the date the document is used. (V.T.I.C. Art. 3.42, Secs. (a) (part), (b) (part), (c) (part), (d) (part).)

Sec. 1701.052. FILE AND USE. (a) An insurer may use a document described by Section 1701.002 immediately after the form

of the document is filed if the form, when filed, is accompanied by a certification that meets the requirements of Subsection (b).

(b) The certification accompanying a form must:

(1) be signed by:

(A) an attorney licensed to practice law in this state;

(B) an actuary familiar with the requirements of this code and applicable rules adopted under this code;

(C) the chief executive officer of the insurer; or

(D) an individual designated by the chief executive officer of the insurer; and

(2) affirm that:

(A) the certification is made on behalf of the insurer filing the form;

(B) the insurer is bound by the certification;

(C) the individual making the certification has reviewed the form; and

(D) to the best knowledge, information, and belief of the individual making the certification, the form complies with this code and rules applicable to the form. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

Sec. 1701.053. FILING FEE. (a) The department shall collect a fee in an amount determined by the commissioner for the filing of the form of a document under this chapter.

(b) The fee may not exceed:

(1) $100 for filing the form of a new or amended

document that is not exempt from review under Section 1701.005(b); and

(2) $50 for filing the form of a new or amended document that is exempt from review under Section 1701.005(b). (V.T.I.C. Art. 3.42, Secs. (e), (f) (part).)

Sec. 1701.054. APPROVAL OF FORM. (a) A form filed under this chapter that is not affirmatively approved or disapproved in a written order of the commissioner on or before the 60th day after the date the form is filed is considered approved on the 61st day after the date of filing unless the approval period is extended under this section.

(b) An insurer may request in writing that the approval period for a form be extended for an additional period not to exceed 45 days.

(c) An extension requested under this section is considered granted on the date the department receives the request.

(d) Only one extension may be granted under this section.

(e) If an extension is granted under this section and the commissioner does not affirmatively approve or disapprove the form before the extended period expires, the form is considered approved on the day after the date the extended period expires.

(f) If the commissioner approves a form that is filed without a certification meeting the requirements of Section 1701.052(b) before the expiration of the approval period, including any extension, the remaining portion of the period is waived. (V.T.I.C. Art. 3.42, Secs. (c) (part), (d) (part).)

Sec. 1701.055. DISAPPROVAL OF FORM OR WITHDRAWAL OF

APPROVAL OR EXEMPTION. (a) Except as provided by Subsection (d), the commissioner may disapprove or, after notice and hearing, withdraw approval of a form if the form:

(1) violates this code, a rule of the commissioner, or any other law; or

(2) contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive.

(b) A form filed under this chapter that contains a coordination of benefits provision may not be approved for use in this state unless the form provides for the order of benefits determination for insured dependent children. An order of benefits determination provision may not be approved if the provision:

(1) violates this code, a rule of the commissioner, or any other law; or

(2) contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive.

(c) If necessary to accomplish the purpose of Subsection (b), the commissioner may adopt a policy provision and order the inclusion of that provision in a document subject to that subsection.

(d) If a form has been on file with the department for at least 180 days and has previously been affirmatively approved by the commissioner, been considered approved under this chapter, or been exempted from the approval requirements under this chapter, the commissioner may withdraw the approval or exemption only if:

(1) the form violates this code or a rule adopted under this code; or

(2) the commissioner finds proof of gross misrepresentation or fraud to a policyholder.

(e) An order of the commissioner disapproving or withdrawing approval for a form must state the grounds for the disapproval or withdrawal of approval and describe in adequate detail the changes that are necessary to obtain approval. (V.T.I.C. Art. 3.42, Secs. (g) (part), (i), (j), (o).)

Sec. 1701.056. USE OF DISAPPROVED FORM PROHIBITED. An insurer who receives written notice that a form filed by the insurer has been disapproved by the commissioner shall immediately stop using the form. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

Sec. 1701.057. WITHDRAWAL OF INDIVIDUAL ACCIDENT AND HEALTH INSURANCE POLICY FORM APPROVAL. (a) Except as provided by Subsection (b), the commissioner may, after notice and hearing, withdraw approval of an individual accident and health insurance policy form if, after consideration of all relevant facts, the commissioner determines that:

(1) the benefits provided under the form are unreasonable in relation to the premium charged; or

(2) the reserve required by Section 862.102 is not maintained by the insurer on the policies issued on the form.

(b) If an individual accident and health insurance policy form has been on file with the department for at least 360 days and has been affirmatively approved by the commissioner, been considered approved under this chapter, or been exempted from the approval requirements of this chapter, the commissioner may withdraw the approval or exemption only if:

(1) the form violates this code or a rule adopted under this code; or

(2) the commissioner finds proof of gross misrepresentation or fraud to a policyholder.

(c) To enable the department to determine compliance with Subsection (b), the commissioner:

(1) shall require an insurer to file the rates charged by that insurer for individual accident and health insurance policies; and

(2) may adopt and require an insurer to file in conjunction with the annual statement required under Section 841.255, 982.101, or 982.103 a form for reporting the insurer's experience on individual accident and health insurance policy forms issued by the insurer.

(d) The commissioner shall, in accordance with Section 1201.007, adopt reasonable rules necessary to establish standards under which the approval of an individual accident and health insurance policy form may be withdrawn.

(e) This section does not grant the commissioner the authority to determine, fix, prescribe, or promulgate rates to be charged for an individual accident and health insurance policy. (V.T.I.C. Art. 3.42, Secs. (k), (l), (m).)

Sec. 1701.058. RECONSIDERATION OF FORM. (a) Not later than the 45th day after the date of an order of the commissioner disapproving or withdrawing approval of a form under Section 1701.055, an insurer may correct the deficiencies described by the order and file the corrected form with the department for

reconsideration by the commissioner.

(b) If the commissioner does not approve or disapprove a form filed for reconsideration under this section on or before the 45th day after the date the form is filed, the form is considered approved on the 46th day after the date the form is filed. (V.T.I.C. Art. 3.42, Sec. (g) (part).)

Sec. 1701.059. REPLACEMENT OR AMENDMENT OF DOCUMENT. The commissioner may order an insurer to replace a document described by Section 1701.002 with a corrected document or to amend and correct the document by endorsement or rider if:

(1) the commissioner disapproves or withdraws approval of the form of the document under Section 1701.055(a); or

(2) the document is used before the form was approved under this chapter and corrections must be made to the document to bring the document into compliance with this code and rules of the commissioner before the commissioner will approve the form of the document. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

Sec. 1701.060. GENERAL RULEMAKING AUTHORITY. (a) The commissioner may, within the standards and purposes of this chapter, adopt reasonable rules necessary to implement this chapter, including, after notice and hearing, rules that establish procedures and criteria under which:

(1) each type of form submitted to the department under this chapter will be reviewed and approved by the commissioner or exempted under Section 1701.005(b); and

(2) particular types of forms designated by the commissioner may be given a summary review and approval if

considered appropriate by the commissioner to expedite review and approval of those forms.

(b) A rule adopted under this chapter may not be repealed or amended before the first anniversary of the date the rule was adopted unless the commissioner determines after notice and in a public hearing that there is a compelling public need for the rule to be repealed or amended. (V.T.I.C. Art. 3.42, Secs. (h) (part), (p) (part).)

[Sections 1701.061-1701.100 reserved for expansion]

SUBCHAPTER C. SANCTIONS; APPLICABILITY OF OTHER LAWS

Sec. 1701.101. RESTITUTION. (a) The commissioner may order an insurer to make complete restitution to each insured of this state who is financially damaged by the insurer's use of a form filed and used but not approved under this chapter if, after notice and opportunity for hearing, the commissioner determines:

(1) the form does not comply with this code and the rules of the commissioner;

(2) use of the form resulted in financial damage to an insured of this state; and

(3) the insurer intentionally used the form with the knowledge that it did not comply with this code and the rules of the commissioner.

(b) The commissioner may determine the form and amount of restitution ordered under this section and the period in which the restitution must be made. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

Sec. 1701.102. LIMIT ON SANCTIONS. Except as provided by Section 1701.101, the commissioner may not impose penalties or

other sanctions on an insurer for the issuance of a document the form of which is filed under Section 1701.052. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

Sec. 1701.103. APPLICABILITY OF OTHER LAWS. Except as provided by Section 1701.102, this chapter may not be construed to limit the applicability of any other statute. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

[Sections 1701.104-1701.150 reserved for expansion]

SUBCHAPTER D. CERTAIN POLICY APPLICATION FORMS

Sec. 1701.151. POLICY APPLICATION FORM FOR INDIVIDUAL ACCIDENT AND HEALTH POLICY. A policy application form that is required to be or that is attached to an individual accident and health policy shall comply with the rules of the commissioner adopted under Chapter 1201. (V.T.I.C. Art. 3.42, Sec. (b) (part).)

SECTION 6. TITLE 11, INSURANCE CODE. The Insurance Code is amended by adding Title 11 to read as follows:

TITLE 11. TITLE INSURANCE

SUBTITLE A. GENERAL PROVISIONS

CHAPTER 2501. GENERAL PROVISIONS

CHAPTER 2502. PROHIBITED CONDUCT

[Chapters 2503-2550 reserved for expansion]

SUBTITLE B. ORGANIZATION OF TITLE INSURANCE COMPANIES

CHAPTER 2551. TITLE INSURERS

CHAPTER 2552. ATTORNEY'S TITLE INSURANCE COMPANIES AND TITLE ATTORNEYS

CHAPTER 2553. FOREIGN OR ALIEN CORPORATIONS

[Chapters 2554-2600 reserved for expansion]

TITLE 11. TITLE INSURANCE

SUBTITLE A. GENERAL PROVISIONS

CHAPTER 2501. GENERAL PROVISIONS

Sec. 2501.007. REFERENCES TO TITLE

CHAPTER 2501. GENERAL PROVISIONS

Sec. 2501.001. SHORT TITLE. This title may be cited as the Texas Title Insurance Act. (V.T.I.C. Art. 9.01, Sec. A.)

Sec. 2501.002. PURPOSE; LEGISLATIVE INTENT. (a) The purpose of this title is to completely regulate the business of title insurance, including the direct issuance of policies and the reinsurance of any assumed risks, to:

(1) protect consumers and purchasers of title insurance policies; and

(2) provide adequate and reasonable rates of return for title insurance companies and title insurance agents.

(b) It is the express legislative intent that this title accomplish the purpose described by Subsection (a). (V.T.I.C. Art. 9.01, Sec. B.)

Sec. 2501.003. DEFINITIONS. In this title:

(1) "Abstract plant" means an abstract plant as defined by the department under Section 2501.004.

(2) "Attorney" means:

(A) a person who is licensed to practice law and is a member of the State Bar of Texas; or

(B) a Texas professional corporation organized to provide professional legal services.

(3) "Direct operation" means the operations of a title insurance company under a license issued to the company under Subchapter B, Chapter 2651. A reference in this title to a title insurance agent shall be construed to include a direct operation

unless the context indicates otherwise.

(4) "Escrow officer" means an attorney, a bona fide employee of an attorney licensed as an escrow officer, a bona fide employee of a direct operation, or a bona fide employee of a title insurance agent whose responsibilities include:

(A) countersigning title insurance forms;

(B) supervising the preparation and delivery of title insurance forms;

(C) signing escrow checks; or

(D) closing the transaction, as described by Section 2501.006.

(5) "Foreign title insurance company" means a title insurance company organized under the laws of a jurisdiction other than this state.

(6) "Joint abstract plant operation" means a joint abstract plant operation as defined by the department under Section 2501.004.

(7) "Person" includes an individual, corporation, association, partnership, or trust.

(8) "Premium" means the premium rates promulgated by the commissioner under Subchapters D and E, Chapter 2703, and includes a charge for:

(A) title examination and closing the transaction, regardless of whether the examination or closing is performed by an attorney; and

(B) issuing the policy.

(9) "Residential real property" means real property

that is improved and is designed principally for occupancy by one to four families. The term includes an individual unit of a condominium or cooperative.

(10) "Thing of value" includes any payment, advance, funds, loan, service, or other consideration.

(11) "Title examination" means the search and examination of a title to determine the conditions of the title to be insured and to evaluate the risk to be undertaken in the issuance of a title insurance policy or other title insurance form.

(12) "Title insurance" means:

(A) insurance that insures, guarantees, or indemnifies an owner of real property, or another interested in the real property, against loss or damage resulting from:

(i) a lien or encumbrance on or defect in the title to the real property; or

(ii) the invalidity or impairment of a lien on the real property; or

(B) any business that is substantially equivalent to the insurance described by Paragraph (A) and is conducted in a manner designed to evade the provisions of this title.

(13) "Title insurance agent" means a person owning or leasing and controlling an abstract plant or as a participant in a bona fide joint abstract plant operation and authorized in writing by a title insurance company to solicit insurance and collect premiums and to issue or countersign policies on the company's behalf.

(14) "Title insurance company" means:

(A) a domestic company organized under this title to engage in the business of title insurance, as described by Section 2501.005;

(B) a foreign title insurance company that:

(i) meets the requirements of this title; and

(ii) holds a certificate of authority to engage in business in this state; or

(C) any other domestic or foreign company that:

(i) meets the requirements of this title; and

(ii) holds a certificate of authority to insure a title to real property in this state. (V.T.I.C. Art. 9.02, Secs. (a), (c), (f) (part), (g), (h), (i) (part), (j), (k), (l), (m), (o), (p), (q); New.)

Sec. 2501.004. ABSTRACT PLANT; JOINT ABSTRACT PLANT OPERATION. (a) For purposes of this title, the department shall define "abstract plant" and "joint abstract plant operation."

(b) To provide for the safety and protection of policyholders, the department shall require that an abstract plant be:

(1) geographically arranged;

(2) kept current; and

(3) adequate for use in insuring titles, as determined by the department. (V.T.I.C. Art. 9.02, Secs. (f) (part), (i) (part).)

Sec. 2501.005. BUSINESS OF TITLE INSURANCE. (a) For purposes of this title, a person engages in the business of title insurance if the person:

(1) as insurer, guarantor, or surety, makes or proposes to make a contract or policy of title insurance or its equivalent;

(2) transacts or proposes to transact any phase of title insurance, including:

(A) soliciting;

(B) title examination other than an examination conducted by an attorney;

(C) closing the transaction other than a closing conducted by an attorney;

(D) executing a contract of title insurance; and

(E) insuring and transacting matters arising out of the contract after the contract is executed, including reinsurance; or

(3) makes a guaranty or warranty of a title search or a title examination, or any component of a title search or title examination, if the person is not the person who performs the search or examination.

(b) A person engages in the business of title insurance if the person engages in or proposes to engage in any business that is substantially equivalent to the business of title insurance as described by this section, regardless of whether that conduct is performed in a manner designed to evade the provisions of this title. (V.T.I.C. Art. 9.02, Sec. (b).)

Sec. 2501.006. CLOSING THE TRANSACTION. (a) For purposes of this title, "closing the transaction" describes the investigation that is made:

(1) on behalf of a title insurance company, title insurance agent, or direct operation before the title insurance policy is issued; and

(2) to determine proper execution, acknowledgment, and delivery of all conveyances, mortgage papers, and other title instruments necessary to consummate a transaction.

(b) Closing the transaction includes a determination that:

(1) all delinquent taxes have been paid;

(2) in the case of an owner title insurance policy, all current taxes, based on the latest available information, have been properly prorated between the purchaser and seller;

(3) the consideration has been passed;

(4) all proceeds have been properly disbursed;

(5) a final search of the title has been made; and

(6) all necessary papers have been filed for record. (V.T.I.C. Art. 9.02, Sec. (n).)

Sec. 2501.007. REFERENCES TO TITLE. In this title, a reference to this title includes a reference to:

(1) Chapter 223;

(2) Chapter 271;

(3) Section 171.0527, Tax Code; and

(4) Subchapter U, Chapter 171, Tax Code. (New.)

CHAPTER 2502. PROHIBITED CONDUCT

SUBCHAPTER A. PROHIBITED CONDUCT IN GENERAL

CHAPTER 2502. PROHIBITED CONDUCT

SUBCHAPTER A. PROHIBITED CONDUCT IN GENERAL

Sec. 2502.001. ENGAGING IN CERTAIN INSURANCE BUSINESS PROHIBITED. (a) A domestic or foreign corporation operating under this title may not engage in the business of any kind of insurance other than title insurance.

(b) A company may not engage in the business of title

insurance if the company engages in the business of another kind of insurance. (V.T.I.C. Art. 9.09.)

Sec. 2502.002. COVERAGE FOR UNMARKETABILITY OF TITLE PROHIBITED. (a) An insurance company may not insure against loss or damage by reason of unmarketability of title.

(b) The commissioner may not adopt a rule or form providing for coverage prohibited by this section. (V.T.I.C. Art. 9.09A.)

Sec. 2502.003. INSURING AROUND DEFINED; PROHIBITIONS AND EXCEPTIONS. (a) Except as provided by Subsection (c), a title insurance company may not wilfully issue a binder for title insurance or a title insurance policy showing no outstanding enforceable recorded liens on real property against which the company knows an outstanding enforceable recorded lien exists.

(b) A title insurance company knows that an outstanding enforceable recorded lien exists against real property if, based on an examination of the title under which the binder for title insurance or title insurance policy is issued, the company determines that the lien is valid and enforceable.

(c) The commissioner by rule may approve circumstances under which a title insurance company may issue a binder for title insurance or a title insurance policy otherwise prohibited by Subsection (a).

(d) Except as otherwise provided by this section, a title insurance company may determine the insurability of title to real property and any other matter that the company considers to be insurable under a binder for title insurance or a title insurance policy issued in connection with the property. (V.T.I.C. Art. 9.08

(part).)

Sec. 2502.004. GUARANTEE OF MORTGAGE PAYMENT PROHIBITED. (a) A title insurance company may not guarantee the payment of a mortgage on real property.

(b) A title insurance company that violates this section forfeits its authority to engage in business in this state and shall immediately surrender its certificate of authority. (V.T.I.C. Art. 9.08 (part).)

Sec. 2502.005. CIVIL PENALTY. (a) A person is liable to the state for a civil penalty of not more than $5,000 if the person:

(1) wilfully violates Section 2502.003 or 2502.004; or

(2) violates an order of the commissioner refusing to approve an application to issue a binder for title insurance or a title insurance policy prohibited by Section 2502.003(a).

(b) The department may bring an action in a Travis County district court to recover the penalty provided by this section. (V.T.I.C. Art. 9.08 (part).)

[Sections 2502.006-2502.050 reserved for expansion]

SUBCHAPTER B. REBATES AND DISCOUNTS

Sec. 2502.051. REBATES AND DISCOUNTS PROHIBITED. A commission, rebate, discount, portion of a title insurance premium, or other thing of value may not be directly or indirectly paid, allowed, or permitted by a person engaged in the business of title insurance or received or accepted by a person for engaging in the business of title insurance or for soliciting or referring title insurance business. (V.T.I.C. Art. 9.30, Sec. A.)

Sec. 2502.052. CERTAIN DIVISIONS OF REAL PROPERTY CHARGES

PROHIBITED. Other than for services actually performed, a person may not give or accept any portion, split, or percentage of a charge made or received for a settlement or closing performed in connection with a transaction involving the conveyance or mortgaging of real property located in this state. (V.T.I.C. Art. 9.30, Sec. E.)

Sec. 2502.053. CERTAIN COMPENSATORY PAYMENTS NOT PROHIBITED. This subchapter does not prohibit:

(1) payment for services actually performed by a title insurance company, title insurance agent, or direct operation in connection with title examination or with closing the transaction or furnishing title evidence if:

(A) the payment does not exceed the percentage of premium or other amount established by the commissioner for the payment; and

(B) the person receiving the payment is licensed as provided by this title;

(2) payment of bona fide compensation to a bona fide employee principally employed by a title insurance company, title insurance agent, or direct operation;

(3) reasonable payment for goods or facilities actually provided and received; or

(4) payment for services actually performed by an attorney in connection with title examination or with closing the transaction, if the payment does not exceed a reasonable charge for the services. (V.T.I.C. Art. 9.30, Secs. B (part), C.)

Sec. 2502.054. CERTAIN DIVISIONS OF PREMIUMS NOT

PROHIBITED. (a) For purposes of this section, a subsidiary is a company at least 50 percent of the voting stock of which is owned by the title insurance company or by a wholly owned subsidiary of the title insurance company.

(b) This subchapter does not:

(1) prohibit a title insurance company from:

(A) appointing as its title insurance agent for a county a person who owns or leases and operates an abstract plant for that county; and

(B) arranging for a division of premiums with the agent as set by the commissioner; or

(2) affect the division of a premium between a title insurance company and its subsidiary title insurance agent when the company directly issues a title insurance policy or contract under Section 2704.002. (V.T.I.C. Art. 9.30, Sec. B (part).)

Sec. 2502.055. CERTAIN PROMOTIONAL AND EDUCATIONAL ACTIVITIES NOT PROHIBITED. This subchapter does not prohibit legal promotional and educational activities that are not conditioned on the referral of title insurance business. (V.T.I.C. Art. 9.30, Sec. B (part).)

Sec. 2502.056. MONETARY FORFEITURE. (a) A person who pays or receives a commission, rebate, discount, or other thing of value for soliciting or referring title insurance business in violation of Section 2502.051 is engaging in the unauthorized business of insurance.

(b) After notice and opportunity for hearing, a person who makes or receives a payment described by Subsection (a) is liable

for a monetary forfeiture in an amount not less than the value of or more than three times the value of the payment.

(c) A monetary forfeiture under Subsection (b) is in addition to any other penalty provided by law. (V.T.I.C. Art. 9.30, Sec. D.)

[Chapters 2503-2550 reserved for expansion]

SUBTITLE B. ORGANIZATION OF TITLE INSURANCE COMPANIES

CHAPTER 2551. TITLE INSURERS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 2551.004-2551.050 reserved for expansion]

SUBCHAPTER B. FORMATION

[Sections 2551.057-2551.100 reserved for expansion]

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

CHAPTER 2551. TITLE INSURERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2551.001. APPLICABILITY OF TITLE AND OTHER LAW. (a) Except as provided by Subsection (c) and unless the business of title insurance or title insurance companies are expressly mentioned, the provisions of this code other than this title do not apply to:

(1) a corporation incorporated or engaging in business exclusively under this title; or

(2) any title insurance business engaged in by a corporation created under:

(A) Subdivision 57, Article 1302, Revised Statutes;

(B) Chapter 861; or

(C) any other law.

(b) A law enacted after September 7, 1951, does not apply to a title insurance company or title insurance business described by Subsection (a) unless the law expressly states that it applies.

(c) To the extent applicable, the following provisions of this code apply to a title insurance company:

(1) Articles 1.01, 1.04A, 1.09-1, 1.12, 1.13, 1.15-1.19, 21.31, 21.47, and 21.49-8;

(2) Subsection (b), Article 1.04D;

(3) Article 1.14-3, other than Section 8;

(4) Subchapter F, Chapter 5;

(5) Chapters 33, 82, 83, 84, 102, 261, 281, 541, 547, 555, 701, 801, 802, 824, and 828;

(6) Chapter 31, other than Section 31.005;

(7) Chapter 32, other than Section 32.022(b);

(8) Chapter 36, other than Sections 36.003, 36.004, and 36.101-36.106;

(9) Subchapter A, Chapter 38;

(10) Subchapters A-G, Chapter 101;

(11) Chapter 982, other than Sections 982.003, 982.051, 982.101, 982.105, 982.106(b), 982.109, and 982.113; and

(12) Sections 37.052, 39.001, 39.002, 81.002, 81.004,

201.004, 201.005, 201.051, 201.055, 521.002-521.004, 805.021, 822.001, 822.051, 822.052(1), (2), and (3), 822.053, 822.057, except Subsection (a)(4), 822.058, 822.059, 822.060, 822.155, 822.157, 822.158, except Subsection (a)(5), 841.004, 841.251, 841.252(a)-(c), and 4001.103.

(d) This title governs in any conflict between a provision listed by Subsection (c) and a provision of this title.

(e) This title does not regulate the practice of law by an attorney. The actions of an attorney in examining title or in closing a real property transaction, regardless of whether a title insurance policy is issued, does not constitute the business of title insurance, unless the attorney elects to be licensed as an escrow officer.

(f) Subsection (e) does not prohibit the commissioner from promulgating a premium for title insurance. (V.T.I.C. Art. 9.22, Sec. (b); Art. 9.47, Secs. 1, 2, 3.)

Sec. 2551.002. APPLICABILITY OF LAW GOVERNING CORPORATIONS. A title insurance company is subject to the Texas Business Corporation Act, the Texas Miscellaneous Corporation Laws Act (Article 1302-1.01 et seq., Vernon's Texas Civil Statutes), and any other law of this state that governs corporations in general, to the extent those laws are not inconsistent with this title. (V.T.I.C. Art. 9.04.)

Sec. 2551.003. RULEMAKING; AUTHORITY OF DEPARTMENT AND COMMISSIONER. (a) The commissioner may adopt and enforce rules:

(1) that prescribe underwriting standards and practices on which a title insurance contract must be issued;

(2) that define risks that may not be assumed under a title insurance contract, including risks that may not be assumed because of the insolvency of the parties to the transaction; and

(3) that the commissioner determines are necessary to accomplish the purposes of this title.

(b) With respect to a company operating under this title that engages in the kinds of business described by Section 2551.051(b)(1) or (2) in a manner that might subject the company to another regulatory statute of this state, all examination and regulation shall be exercised by the department rather than any other state agency named in the other regulatory statute, as long as the corporation engages in the business of title insurance. (V.T.I.C. Art. 9.21.)

[Sections 2551.004-2551.050 reserved for expansion]

SUBCHAPTER B. FORMATION

Sec. 2551.051. FORMATION; GENERAL PURPOSES AND POWERS. (a) A private corporation may be created and licensed under this title for the following purposes:

(1) to compile and own or lease, or to acquire and own or lease, records or abstracts of title to real property or interests in real property in this state or other jurisdictions, to insure titles to that real property or interests in that real property, and to indemnify the owners of that real property, or the holders of interests in or liens on that real property, against loss or damage resulting from an encumbrance on or defect in the title to the real property or interests in the real property; and

(2) in transactions in which title insurance is to be

or is being issued, to supervise or approve the signing of legal instruments affecting real property titles, disbursement of money, prorations, delivery of legal instruments, closing of transactions, or issuance of commitments for title insurance specifying the requirements for title insurance and the defects in title necessary to be cured or corrected.

(b) A corporation described by Subsection (a) may exercise any of the following powers by including the power in the corporation's charter:

(1) to make and sell abstracts of title in any county of this state or another state;

(2) to accumulate and lend money and to purchase, sell or deal in notes, bonds, and securities, but without banking privileges;

(3) to act as trustee under a lawful trust committed to the corporation by contract or will or by appointment by a court as trustee, receiver, or guardian; and

(4) to act as executor or guardian under the terms of a will or as an administrator of a decedent's estate under the appointment of a court.

(c) Notwithstanding any other provision of this section, a corporation described by Subsection (a) is not authorized to practice law, as that term is defined by the courts of this state. A corporation described by Subsection (a) is not authorized to prepare a legal instrument described by Subsection (a)(2). (V.T.I.C. Art. 9.03.)

Sec. 2551.052. NAME. (a) The name of a corporation

chartered or operating under this title may contain the words "Title and Trust Company."

(b) The name of a corporation chartered or operating under this title may not contain the word "Trust" alone. If the word "Trust" appears in the corporation's letterhead or literature, the corporation shall include the words "Without Banking Privileges." (V.T.I.C. Art. 9.23.)

Sec. 2551.053. STOCK AND SURPLUS REQUIREMENTS. (a) Except as provided by Section 2552.053(b), a title insurance company must have a paid-up capital of at least $1 million and a surplus of at least $1 million.

(b) The capital stock and minimum surplus requirements of a title insurance company must be maintained intact over and above all outstanding liabilities, except contingent liabilities on title insurance policies.

(c) If a title insurance company suffers the impairment of its capital stock or minimum surplus requirements, the company shall immediately report the impairment to the department. (V.T.I.C. Arts. 9.06, 9.20.)

Sec. 2551.054. PURCHASE OF OWN STOCK. (a) Subject to Section 2551.053(a) and the Texas Business Corporation Act, a title insurance company may purchase its own shares of stock. A purchase of its own shares is not considered an investment and does not constitute a violation of a provision of this code relating to admissible investments.

(b) A title insurance company that purchases its own shares must, not later than the 10th day after the date of purchase, file

with the commissioner a statement listing:

(1) the name of each shareholder from whom the shares have been purchased; and

(2) the amount paid for the shares. (V.T.I.C. Art. 9.06A.)

Sec. 2551.055. CHARTER OF CORPORATION ENGAGING IN BUSINESS OF TITLE INSURANCE. (a) The incorporators of a corporation engaging in the business of title insurance and incorporated under this title, Subdivision 57, Article 1302, Revised Statutes, Chapter 40, Acts of the 41st Legislature, Regular Session, 1929 (Article 1302a, Vernon's Texas Civil Statutes), or any other law shall file the corporation's original charter only with the department and shall certify the charter only to the department.

(b) Only the department may collect from a company described by this section any filing fees required by law.

(c) A corporation described by this section is not subject to another law to the extent that the law conflicts with this section. (V.T.I.C. Art. 9.14.)

Sec. 2551.056. REGULATION OF CERTAIN CORPORATIONS. (a) A corporation incorporated under Subdivision 57, Article 1302, Revised Statutes, before February 27, 1929, and engaging in business in this state on February 27, 1929:

(1) may continue to engage in business;

(2) is subject to this title; and

(3) shall comply with the requirements of this title regarding investments and deposits.

(b) A shareholder in a company acting under this title is

not liable in the event of default in the payment of any debt or liability of the company beyond the shareholder's subscription for stock. (V.T.I.C. Art. 9.32.)

[Sections 2551.057-2551.100 reserved for expansion]

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 2551.101. CERTIFICATE OF AUTHORITY REQUIRED. A title insurance company may not engage in the business of title insurance in this state unless the company holds a certificate of authority issued under this title. (V.T.I.C. Art. 9.15 (part).)

Sec. 2551.102. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) Subject to Subsection (c), the department shall issue a certificate of authority to engage in the business of title insurance if, following any examination the department considers proper, the department makes a determination favorable to the title insurance company with respect to:

(1) the payment of capital stock and surplus as required by this title; and

(2) the value of the assets used to pay the capital stock and surplus.

(b) The title insurance company shall pay the expense of any examination conducted under Subsection (a).

(c) Issuance of a certificate of authority to a foreign corporation is governed by Section 2553.001. (V.T.I.C. Art. 9.15 (part); New.)

[Sections 2551.103-2551.150 reserved for expansion]

SUBCHAPTER D. GENERAL POWERS AND DUTIES

Sec. 2551.151. ADMISSIBLE INVESTMENTS. (a) A title

insurance company shall hold all investments in cash or in the following:

(1) an abstract plant or plants, provided that:

(A) the corporation is organized under this title and has the right to engage in the business of title insurance;

(B) except as provided by Subsection (b), the investment is not more than 50 percent of the corporation's capital stock; and

(C) the valuation of the plant or plants is approved by the department;

(2) securities described by Article 3.39 or investments authorized for title insurance companies under the laws of any other state in which the company is authorized to engage in business;

(3) real property or any real property interest that is:

(A) required for the company's convenient accommodation in the transaction of business with reasonable regard to future needs;

(B) acquired in connection with a claim under a title insurance policy;

(C) acquired in satisfaction or on account of loans, mortgages, liens, judgments, or decrees previously owed to the company in the course of business;

(D) acquired in partial payment of the consideration of the sale of real property owned by the company if the transaction results in a net reduction in the company's

investment in real property; or

(E) reasonably necessary to maintain or enhance the sale value of real property previously acquired or held by the company under this subdivision;

(4) a first mortgage note secured by any of the following, provided that the amount of the note does not exceed 80 percent of the appraised value of the security for the note:

(A) an abstract plant and connected personal property in or outside this state;

(B) stock of a title insurance agent in or outside this state;

(C) a construction contract to build an abstract plant and connected personal property; or

(D) any two or more of the items listed in this subdivision;

(5) the shares of any federal home loan bank in an amount necessary to qualify for membership and any additional amounts approved by the commissioner;

(6) foreign securities that are substantially of the same kinds, classes, and investment grade as securities otherwise qualified for investment under this section, provided that, unless the investment is also qualified under Subdivision (2), the aggregate amount of foreign investments made under this subdivision does not exceed:

(A) five percent of the insurer's admitted assets at the end of the preceding year;

(B) two percent of the insurer's admitted assets

at the end of the preceding year invested in the securities of all entities domiciled in any one foreign country; and

(C) one-half of one percent of the insurer's admitted assets at the end of the preceding year invested in the securities of any one individual entity domiciled in a foreign country;

(7) securities lending, repurchase, reverse repurchase, and dollar roll transactions, as described by Section 4(q), Article 3.33; or

(8) money market funds, as described by Section 4(s), Article 3.33.

(b) If a corporation maintains with the department a deposit described by Subchapter E in the amount of $100,000, the corporation may invest more than 50 percent of the corporation's capital stock under Subsection (a)(1), as considered necessary by the corporation's board of directors.

(c) A corporation created or operating under this title may own or acquire more than one abstract plant in any one county, but only one abstract plant in any one county is admissible as an investment under Subsection (a)(1).

(d) A title insurance company may not hold real property acquired under Subsection (a)(3)(B), (C), or (D) for more than 10 years without written approval of the department.

(e) Any investment that does not qualify under this section and was owned by the title insurance company on October 1, 1967, continues to qualify.

(f) If any otherwise valid investment qualified under this

section exceeds in amount any of the limitations on investment provided by this section, the investment is inadmissible only to the extent that it exceeds the limitation. (V.T.I.C. Art. 9.18.)

Sec. 2551.152. ANNUAL STATEMENT. (a) Not later than March 1 of each year, each title insurance company shall file with the commissioner a verified statement.

(b) The statement must be in a form required by the commissioner and must:

(1) provide a statement of the business engaged in by the title insurance company during the preceding year; and

(2) describe the condition of the company's affairs on December 31 of the preceding year. (V.T.I.C. Art. 9.22, Sec. (a).)

Sec. 2551.153. FEES. The general laws applicable to payment of a filing fee by a corporation having capital stock apply to a corporation subject to this title. (V.T.I.C. Art. 9.13.)

Sec. 2551.154. TRANSFER OF CERTAIN BUSINESS TO STATE BANKS OR TRUST COMPANIES. (a) This section applies to a corporation chartered under Section 2551.051, or its antecedents, Article 9.01, Texas Insurance Code, or Chapter 40, Acts of the 41st Legislature, Regular Session, 1929 (Article 1302a, Vernon's Texas Civil Statutes), and empowered to act as:

(1) trustee under a lawful trust committed to the corporation by contract or will or by appointment by a court as trustee, receiver, or guardian; and

(2) executor or guardian under the terms of a will or as an administrator of a decedent's estate under the appointment of the court.

(b) A corporation described by Subsection (a) may transfer and assign to one of the following entities all of the corporation's fiduciary business in which the corporation is named or acts as guardian, trustee, executor, or administrator or in any other fiduciary capacity:

(1) a state bank created under Subtitle A, Title 3, Finance Code, or a predecessor to that law; or

(2) a state trust company created under Chapter 181, Finance Code, or a predecessor to that law.

(c) On a corporation's transfer or assignment to a state bank or trust company under this section, the state bank or trust company shall, without the necessity of any action in a court of this state or any action by the creator or beneficiary of the trust or estate:

(1) continue the guardianship, trust, executorship, administration, or other fiduciary relationship related to the trust or estate;

(2) perform all of the duties and obligations of the corporation related to the trust or estate; and

(3) exercise any powers and authority:

(A) related to the trust or estate; and

(B) exercised by the corporation at the time of the transfer or assignment.

(d) A transfer or assignment by a corporation under this section is not a resignation or refusal by the corporation to act on behalf of the guardianship, trust, executorship, administration, or other fiduciary relationship.

(e) On a corporation's transfer or assignment to a state bank or trust company under this section, the naming or designation by a testator or the creator of a living trust of the corporation to act as trustee, guardian, or executor or in any other fiduciary capacity includes the naming or designation of the state bank or trust company and authorizes the state bank or trust company to act in that capacity. (V.T.I.C. Art. 9.05, Sec. 1 (part).)

[Sections 2551.155-2551.200 reserved for expansion]

SUBCHAPTER E. REQUIRED DEPOSIT

Sec. 2551.201. DEPOSIT REQUIRED; AMOUNT. (a) Except as provided by Section 2551.202, a title insurance company shall deposit and maintain in the state treasury, or other depository in this state named by the company and approved by the department, either:

(1) cash; or

(2) securities described by Section 2551.151.

(b) A title insurance company's deposit under this section must be in an amount equal to the lesser of:

(1) one-fourth of the authorized capital of the company; or

(2) $100,000.

(c) A deposit under this section is for the benefit of all policyholders. (V.T.I.C. Art. 9.12 (part).)

Sec. 2551.202. EXCEPTION: FOREIGN TITLE INSURANCE COMPANY. (a) A foreign title insurance company is not required to make a deposit under Section 2551.201 if the company has on deposit with insurance regulatory bodies in the United States an aggregate

amount of deposit that:

(1) is equal to the amount required by Section 2551.201; and

(2) secures all policyholders of the company, regardless of their location.

(b) The foreign title insurance company must file with the department a certificate of deposit under the hand and seal of each insurance regulatory body holding a deposit of the company. (V.T.I.C. Art. 9.12 (part).)

Sec. 2551.203. WITHDRAWAL AND SUBSTITUTION OF DEPOSIT. A title insurance company may withdraw the deposit of securities made under Section 2551.201, or any portion of the deposit, after substituting other securities of a sufficient value to maintain the amount of deposit required under that section. (V.T.I.C. Art. 9.12 (part).)

Sec. 2551.204. USE OF DEPOSIT. (a) Except as otherwise provided by Subsection (e), a deposit made under this subchapter may be used only to pay an obligation connected with title insurance.

(b) On the insolvency or dissolution of a title insurance company, the company's deposit shall be used to protect title insurance policyholders even if no accrued title insurance claims exist and other unpaid obligations do exist, except as permitted by Subsection (e).

(c) A title insurance company's deposit must be applied to:

(1) the complete payment of any obligations and liabilities of the company connected with title insurance business;

and

(2) the establishment of adequate reserves or reinsurance to protect any subsequently accruing or maturing title insurance obligations and liabilities.

(d) The amount, handling, and distribution of any reserves required under Subsection (c)(2) are subject to the control and discretion of the department and are reviewable in judicial proceedings governed by rules applicable to review of rates under Subchapters D and E, Chapter 2703.

(e) Any deposit amount remaining after payments under Subsection (c) must be applied to:

(1) payment of other obligations and liabilities of the title insurance company; or

(2) distribution to shareholders. (V.T.I.C. Art. 9.12 (part).)

[Sections 2551.205-2551.250 reserved for expansion]

SUBCHAPTER F. RESERVES

Sec. 2551.251. STATUTORY PREMIUM RESERVE REQUIRED. (a) Each domestic title insurer shall establish and maintain a statutory premium reserve. The reserve is cumulative. The reserve must consist of the amounts required under Sections 2551.252-2551.260 and must be established and maintained during the period and for the uses and purposes provided by those sections.

(b) The reserve required under this section:

(1) is considered to be unearned portions of the original premium; and

(2) must be charged as a reserve liability of the title

insurer in determining the insurer's financial condition. (V.T.I.C. Art. 9.16, Sec. 1.)

Sec. 2551.252. AMOUNTS ADDED TO RESERVE FOR CALENDAR YEAR 1997; REDUCTIONS. (a) The total charges of a domestic title insurer for title insurance policies written or assumed on or after January 1, 1997, and before January 1, 1998, are computed by adding the following, as described in the insurer's annual statement:

(1) the direct premium written by the insurer;

(2) the escrow and settlement service fees paid directly to and collected by the insurer;

(3) other title fees and service charges paid directly to and collected by the insurer, including fees for closing protection letters; and

(4) premiums for any reinsurance assumed by the insurer, less premiums for reinsurance ceded by the insurer during that year.

(b) The amount a domestic title insurer must set aside in the statutory premium reserve for the 1997 calendar year is computed by multiplying the total charges computed under Subsection (a) by:

(1) 6-1/5 percent if the insurer had $250 million or more in direct premium written for the year 1996; or

(2) 3-1/2 percent if the insurer had less than $250 million in direct premium written for the year 1996.

(c) A domestic title insurer shall reduce additions to the statutory premium reserve set aside for title insurance policies written or assumed during the year 1997 over a 20-year period

beginning in the year after the year in which the policies are written or assumed, as provided by Subsection (d), by:

(1) 26 percent of the additions in the first year following the year of addition;

(2) 20 percent of the additions in the second year following the year of addition;

(3) 10 percent of the additions in the third year following the year of addition;

(4) nine percent of the additions in the fourth year following the year of addition;

(5) five percent of the additions in the fifth and sixth years following the year of addition;

(6) three percent of the additions in the seventh, eighth, and ninth years following the year of addition;

(7) two percent of the additions in the 10th through 14th years following the year of addition; and

(8) one percent of the additions in the last six years of the 20-year period.

(d) A domestic title insurer shall make the annual reductions under Subsection (c) in increments of one-fourth of the appropriate percentage of the additions each on March 31, June 30, September 30, and December 31 of each year. (V.T.I.C. Art. 9.16, Sec. 2.)

Sec. 2551.253. AMOUNTS ADDED TO RESERVE FOR CALENDAR YEARS AFTER 1997; REDUCTIONS. (a) Out of total charges for title insurance policies written or assumed on or after January 1, 1998, a domestic title insurer shall add to and set aside in the statutory

premium reserve an amount equal to the total of the following, as described in the insurer's annual statement:

(1) 25 cents per $1,000 of net retained liability if the insurer had $250 million or more in direct written premiums written for the most recent calendar year; or

(2) 30 cents per $1,000 of net retained liability if the insurer had less than $250 million in direct written premiums written for the most recent calendar year.

(b) A domestic title insurer shall reduce additions to the statutory premium reserve set aside for title insurance policies written or assumed after the year 1997 over a 20-year period beginning in the year after the year in which the policies are written or assumed in the manner and under the same percentages applied under Sections 2551.252(c) and (d). (V.T.I.C. Art. 9.16, Sec. 3.)

Sec. 2551.254. TRANSITIONAL RELEASE; TRANSITIONAL CHARGE. (a) In addition to the requirements described by Sections 2551.252 and 2551.253, each domestic title insurer shall compute a total statutory premium reserve balance for all policy years combined as of December 31, 1996.

(b) A domestic title insurer shall compute the balance under Subsection (a) as if Section 2551.252 were in effect during the 20-year period ending December 31, 1996. That balance, less the total actual statutory premium reserve balance carried by the insurer on December 31, 1996, is the insurer's transitional charge if the resulting amount is more than zero or is the insurer's transitional release if the resulting amount is zero or less.

(c) If a domestic title insurer has a transitional charge under Subsection (b), in addition to any changes to the statutory premium reserve otherwise required by this subchapter, the insurer shall add to its statutory premium reserve, on December 31 of each year for 10 consecutive years beginning on December 31, 1997, an amount equal to one-tenth of the transitional charge.

(d) If a domestic title insurer has a transitional release under Subsection (b), in addition to any changes to the statutory premium reserve otherwise required by this subchapter, the insurer shall reduce its statutory premium reserve, on December 31 of each year for 10 consecutive years beginning on December 31, 1997, by an amount equal to one-tenth of the transitional release. (V.T.I.C. Art. 9.16, Sec. 4.)

Sec. 2551.255. RUNOFF BALANCE. (a) At the end of each calendar year beginning in 1997, each domestic title insurer shall compute a total statutory premium reserve balance for all policy years before January 1, 1997, combined. The balance shall be computed as of the year-end evaluation date and as if Section 2551.252 were in effect during the 20-year period ending December 31, 1996. The balance computed under this subsection is the runoff balance.

(b) A domestic title insurer shall reduce its statutory premium reserve by an amount equal to the difference between:

(1) the runoff balance computed under Subsection (a); and

(2) the runoff balance computed for the preceding calendar year.

(c) The reduction of the statutory premium reserve under Subsection (b) is in addition to any other changes to the statutory premium reserve required by this subchapter. (V.T.I.C. Art. 9.16, Sec. 5.)

Sec. 2551.256. ACTUARIAL CERTIFICATION. (a) Each domestic or foreign title insurer shall file annually with the insurer's annual statement required under Section 2551.152 an actuarial certification made by a member in good standing of the American Academy of Actuaries.

(b) An actuarial certification must:

(1) conform to the annual statement instructions for a title insurer adopted by the National Association of Insurance Commissioners; and

(2) include the actuary's professional opinion of the insurer's reserves as of the date of the annual statement.

(c) The reserves analyzed under this section must include reserves for known claims, including adverse development on known claims, and reserves for incurred but not reported claims. (V.T.I.C. Art. 9.16, Secs. 6, 8 (part).)

Sec. 2551.257. SUPPLEMENTAL RESERVE. Each domestic or foreign title insurer shall establish a supplemental reserve in an amount equal to the amount by which the actuarially certified reserves exceed the total of the known claim reserve and statutory premium reserve as set forth in the insurer's annual statement required under Section 2551.152. (V.T.I.C. Art. 9.16, Secs. 7(a), 8 (part).)

Sec. 2551.258. REEVALUATION OF CERTAIN RESERVE

REQUIREMENTS. The commissioner may reevaluate the adequacy of the statutory premium reserves required under Section 2551.253 and may make recommendations for legislative changes as the commissioner considers appropriate. (V.T.I.C. Art. 9.16, Sec. 9.)

Sec. 2551.259. STATUTORY PREMIUM RESERVE AND SUPPLEMENTAL RESERVE FUND. The statutory premium reserve and supplemental reserve fund shall be:

(1) held in cash; or

(2) invested in first mortgage notes or other securities admissible for investment by title insurers under Section 2551.151. (V.T.I.C. Art. 9.16, Sec. 10.)

Sec. 2551.260. EFFECT OF INSOLVENCY OR DISSOLUTION. On the insolvency or dissolution of a title insurer, the statutory premium reserve and supplemental reserve fund shall be used to protect title insurance policyholders, even if no accrued title insurance claims exist and other unpaid obligations do exist. (V.T.I.C. Art. 9.16, Sec. 11.)

Sec. 2551.261. RESERVE FOR UNPAID LOSSES AND LOSS EXPENSES. (a) A title insurance company shall establish and maintain, in addition to any other reserves, a reserve against:

(1) unpaid losses; and

(2) loss expense for costs of defense of an insured and other costs expected to be paid to other parties in the defense, settlement, or processing of a claim under the terms of a title insurance policy.

(b) A title insurance company shall compute the amount of the reserve required by this section by carefully estimating any

loss and loss expense likely to be incurred on a proper disposition of each claim presented, under notice from or on behalf of the insured, of a title defect in or lien or adverse claim against a title insured by the company.

(c) The total expenses of the title insurance company are equal to the estimate under Subsection (b) for payment of loss and costs of defense of the insured and other costs expected to be paid to other parties in the defense, settlement, or processing of the claim under the terms of the title insurance policy. The title insurance company shall revise the estimate at least annually and may additionally revise the estimate as circumstances warrant.

(d) The amounts set aside in the reserve in any year shall be deducted in determining the net profits for that year of any title insurance company. (V.T.I.C. Art. 9.17.)

[Sections 2551.262-2551.300 reserved for expansion]

SUBCHAPTER G. LIABILITY AND REINSURANCE

Sec. 2551.301. MAXIMUM POLICY LIABILITY. (a) Except as provided by Subsection (b), a title insurance company may not issue a title insurance policy on any real property located in this state involving a potential policy liability of more than 50 percent of the company's capital stock and surplus as stated in the most recent annual statement of the company.

(b) A title insurance company may exceed the limit described by Subsection (a) if the excess liability is reinsured in due course in an authorized title insurance company. (V.T.I.C. Art. 9.19, Sec. A (part).)

Sec. 2551.302. REQUIREMENTS FOR REINSURING POLICIES. A

title insurance company may reinsure any of its policies and contracts issued on real property located in this state, if:

(1) the reinsuring title insurance company is authorized to engage in business in this state under this title; and

(2) the department first approves the form of the reinsurance contract. (V.T.I.C. Art. 9.19, Sec. A (part).)

Sec. 2551.303. FORM OF REINSURANCE CONTRACT. (a) If the department approves a form of reinsurance contract for a title insurance company, the company may continue using the form without submitting individual reinsurance contracts to the department for approval.

(b) The department may alter the required form of a reinsurance contract previously approved by the department after first giving written notice to each title insurance company affected by the alteration. (V.T.I.C. Art. 9.19, Sec. B.)

Sec. 2551.304. ACCEPTANCE OF REINSURANCE. A title insurance company may accept a reinsurance risk on real property located in this state only from an authorized title insurance company. (V.T.I.C. Art. 9.19, Sec. C.)

Sec. 2551.305. CERTAIN REINSURANCE ALLOWED. (a) Notwithstanding any other provision of this subchapter, the department may, on application and hearing, permit a title insurance company to acquire reinsurance on an individual policy or facultative basis from a title insurance company not authorized to engage in the business of title insurance in this state, if:

(1) the company has exhausted the opportunity to acquire reinsurance from all other authorized title insurance

companies; and

(2) the title insurance company from which the reinsurance is acquired has a combined capital and surplus of at least $1.4 million as stated in its annual statement preceding the acceptance of reinsurance.

(b) Notwithstanding any other provision of this subchapter, the department may, on application and hearing, permit a title insurance company, including an authorized reinsuring title insurance company, to retain an additional potential liability of not more than 40 percent of the company's capital stock and surplus as stated in the most recent annual statement of the company, if:

(1) the company has exhausted the opportunity to acquire reinsurance under Subsection (a); and

(2) the additional potential liability of the company is incurred only if the loss suffered by the insured under the policy exceeds the amount of insurance and reinsurance accepted by the company and its reinsuring title insurance companies under the other provisions of this subchapter. (V.T.I.C. Art. 9.19, Secs. D, E.)

[Sections 2551.306-2551.350 reserved for expansion]

SUBCHAPTER H. ENFORCEMENT AND INTERVENTION

Sec. 2551.351. FORFEITURE OF RIGHT TO ENGAGE IN BUSINESS. (a) A foreign or domestic corporation forfeits any right to engage in business in this state if the corporation:

(1) issues any form of title insurance policy, or any other adopted or approved form, on real property in this state other than a form prescribed by the department;

(2) charges any premium rate on an owner, mortgagee, or other title insurance policy, or on any other adopted or approved form, on real property in this state other than a premium rate prescribed by the commissioner; or

(3) otherwise engages in the business of title insurance in relation to real property in this state on a form or for a premium rate not prescribed by the department or commissioner.

(b) This section does not apply to a premium rate charged in connection with a reinsurance transaction between two or more title insurance companies, provided that the reinsurance contract complies with Subchapter G. (V.T.I.C. Art. 9.11.)

Sec. 2551.352. REVOCATION OF PERMIT AND FORFEITURE OF CHARTER. (a) A domestic corporation engaged in the business of title insurance that violates this title is subject to:

(1) revocation by the commissioner of the corporation's permit; and

(2) forfeiture of the corporation's charter.

(b) A foreign corporation engaged in the business of title insurance that violates this title is subject to revocation by the commissioner of the corporation's permit. (V.T.I.C. Art. 9.33, Sec. (a).)

Sec. 2551.353. PROCEDURE FOR REVOCATION OF CERTIFICATE. (a) If the commissioner determines that a domestic or foreign corporation that holds a certificate of authority to engage in business in this state has violated this title, the commissioner shall notify the company that the commissioner intends to revoke

the company's certificate of authority on the expiration of the 30-day period following the date actual notice is delivered or mailed under this section.

(b) Notice under this section must:

(1) be in writing; and

(2) be delivered to an executive officer of the company by personal service or by registered mail.

(c) If a company receiving notice under this section does not fully comply before the expiration of the period described by Subsection (a), the commissioner shall revoke the company's certificate of authority.

(d) A company whose certificate of authority is revoked under this section is ineligible for another certificate of authority until the later of:

(1) the date on which the company fully and in good faith complies; or

(2) the first anniversary of the date of the revocation. (V.T.I.C. Art. 9.28 (part).)

Sec. 2551.354. APPEAL OF COMMISSIONER ACTION. (a) A company qualified or seeking to qualify under this title and aggrieved by an action of the commissioner, including any action against the company, may file an appeal of the commissioner's action in a district court in Travis County.

(b) The appeal must be filed not later than the 30th day after the date the commissioner issues the order or ruling, except that if the order or ruling is directed against the company, whether or not directed against any other party, the company has 30 days

after the date of receipt of official notice of the commissioner's action to review the action.

(c) An appeal under this section is subject to the same standard of review as an appeal under this code in accordance with Section 36.203. (V.T.I.C. Art. 9.33, Sec. (b).)

CHAPTER 2552. ATTORNEY'S TITLE INSURANCE COMPANIES AND TITLE ATTORNEYS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 2552.008-2552.050 reserved for expansion]

SUBCHAPTER B. ORGANIZATION OF ATTORNEY'S TITLE INSURANCE COMPANY

SECURITIES

[Sections 2552.057-2552.100 reserved for expansion]

SUBCHAPTER C. TITLE ATTORNEY'S LICENSE AND RENEWAL

Sec. 2552.101. LICENSE AND OTHER GENERAL REQUIREMENTS

Sec. 2552.102. LICENSE APPLICATION

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Sec. 2552.107. LICENSE SURRENDER OR FORFEITURE

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SUBCHAPTER D. TITLE ATTORNEY GENERAL REQUIREMENTS

Sec. 2552.151. CONTRACT REQUIRED FOR APPOINTMENT

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Sec. 2552.156. INVESTIGATION BY ATTORNEY GENERAL

Sec. 2552.157. AUTHORITY TO ISSUE POLICY

Sec. 2552.158. AUTHORITY TO DELIVER BUT NOT ISSUE POLICY

[Sections 2552.159-2552.200 reserved for expansion]

SUBCHAPTER E. POWERS AND DUTIES OF ATTORNEY'S TITLE INSURANCE COMPANIES

Sec. 2552.201. ACTING AS TITLE ATTORNEY

Sec. 2552.202. LIST OF TITLE ATTORNEYS

CHAPTER 2552. ATTORNEY'S TITLE INSURANCE COMPANIES AND TITLE ATTORNEYS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2552.001. PURPOSE; LEGISLATIVE INTENT. (a) Except as otherwise expressly provided by this chapter, the purpose of this chapter is to regulate an attorney's title insurance company in the same manner as a title insurance company engaged in the business of title insurance under this title.

(b) It is the express intent of the legislature to achieve the purpose described by Subsection (a). (V.T.I.C. Art. 9.56, Sec. 1(d).)

Sec. 2552.002. DEFINITIONS. In this chapter:

(1) "Attorney's title insurance" means:

(A) insurance that:

(i) insures, guarantees, or indemnifies an owner of real property in this state, or another interested in the real property, against loss or damage resulting from:

(a) a lien or encumbrance on or defect in the title to the real property; or

(b) the invalidity of a lien on the real property; and

(ii) is issued only in connection with and as part of a real property transaction and a title opinion of a title attorney; or

(B) any business that is substantially equivalent to the insurance business described by Paragraph (A) and is conducted in a manner designed to evade the provisions of this title.

(2) "Attorney's title insurance company" means a domestic company organized and operated in accordance with this chapter for the business of attorney's title insurance.

(3) "Title attorney" means an attorney who satisfies the requirements of this chapter to act as a title attorney in this state for an attorney's title insurance company. (V.T.I.C. Art. 9.56, Secs. 1(a), 2(a), (c), (d) (part), 3 (part); New.)

Sec. 2552.003. APPLICABILITY OF TITLE 11. Except as otherwise expressly provided by this chapter:

(1) this title applies to an attorney's title

insurance company;

(2) the provisions of this title that apply to a title insurance company also apply to an attorney's title insurance company;

(3) the provisions of this title that apply to a title insurance agent also apply to a title attorney; and

(4) any rule adopted or premium promulgated by the commissioner under this title applies to an attorney's title insurance company and to a title attorney. (V.T.I.C. Art. 9.56, Secs. 1(b), (c).)

Sec. 2552.004. BUSINESS OF ATTORNEY'S TITLE INSURANCE. (a) The business of attorney's title insurance may be engaged in only by an attorney's title insurance company through a title attorney appointed by an attorney's title insurance company.

(b) For purposes of this chapter, a person engages in the business of attorney's title insurance if the person:

(1) as insurer, guarantor, or surety, makes or proposes to make a contract or policy of title insurance; or

(2) transacts or proposes to transact any phase of title insurance, including:

(A) soliciting;

(B) negotiating before executing a title insurance contract;

(C) executing a contract of title insurance; and

(D) insuring and transacting matters arising out of the contract after the contract is executed, including reinsurance.

(c) A person engages in the business of attorney's title insurance if the person engages in or proposes to engage in any business that is substantially equivalent to the business of attorney's title insurance as part of a real property transaction and title opinion of a title attorney in a manner designed to evade the applicable provisions of this title. (V.T.I.C. Art. 9.56, Secs. 2(b), 12 (part).)

Sec. 2552.005. OTHER TITLE INSURANCE COMPANIES AND AGENTS PROHIBITED. A title insurance company, title insurance agent, or escrow officer of a title insurance agent licensed under this title to engage in the business of title insurance in this state may not operate as an attorney's title insurance company or act as a title attorney under this chapter. (V.T.I.C. Art. 9.56, Sec. 12 (part).)

Sec. 2552.006. RECORD OF TITLE ATTORNEYS. The department shall maintain a record of the name and address of each title attorney in a manner that allows a person on request to conveniently ascertain and inspect the title attorneys appointed by an attorney's title insurance company authorized to engage in the business of attorney's title insurance in this state. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

Sec. 2552.007. OTHER PREMIUM OR FEE PROHIBITED. Attorney's title insurance may not be issued for any premium or fee other than the applicable prescribed premium as provided by Subchapters D and E, Chapter 2703. (V.T.I.C. Art. 9.56, Sec. 3 (part).)

[Sections 2552.008-2552.050 reserved for expansion]

SUBCHAPTER B. ORGANIZATION OF ATTORNEY'S TITLE INSURANCE COMPANY

Sec. 2552.051. ORGANIZING MEMBERS. Fifteen or more members

of the State Bar of Texas who are residents of this state may organize a private corporation to act as an attorney's title insurance company. (V.T.I.C. Art. 9.56, Sec. 3 (part).)

Sec. 2552.052. CAPITAL SHARE AND SURPLUS REQUIREMENTS GENERALLY. (a) At the time of organization, an attorney's title insurance company must have the capital and surplus required of a title insurance company under Section 2551.053(a).

(b) The capital shares of an attorney's title insurance company may be issued for a par value of $100 or more per share and in one or more classes.

(c) The capital shares, regardless of class, must be subscribed and paid for and owned by and issued to licensed members of the State Bar of Texas, each of whom is a resident of this state and is qualified to be appointed a title attorney under this chapter, subject to the right of reacquisition under Section 2552.054.

(d) Each certificate evidencing any share must have endorsed on the certificate provisions relating to limitation on the alienation of the shares indicating that the shares may be owned only by qualifying attorneys or the attorney's title insurance company issuing the shares.

(e) The requirements prescribed by Subsections (a), (c), and (d) do not apply to an attorney's title insurance company described by Section 2552.053 or to capital shares of an attorney's title insurance company owned under that section. (V.T.I.C. Art. 9.56, Secs. 3 (part), 4(b), 13(b).)

Sec. 2552.053. CAPITAL SHARE AND SURPLUS REQUIREMENTS FOR

STATE BAR ENTITY. (a) An association of the organized State Bar of Texas, the State Bar of Texas, or any foundation created by or through the State Bar of Texas, the purposes of which include the continuing legal education of the bench and bar of this state, may own any class of capital shares of an attorney's title insurance company if, at all times, at least 15 members of the State Bar of Texas who are residents of this state own capital shares, whether or not of the same class, in the attorney's title insurance company.

(b) An attorney's title insurance company created as an affiliate or subsidiary of the organized State Bar of Texas, the State Bar of Texas, or any foundation created by or through the State Bar of Texas must have a paid-up capital of at least $250,000 and a surplus of at least $150,000. (V.T.I.C. Art. 9.56, Secs. 3 (part), 4(a).)

Sec. 2552.054. REACQUISITION OF SHARES. (a) The capital shares of an attorney's title insurance company are subject to the right of reacquisition of the shares by the attorney's title insurance company in the event of:

(1) the death of the attorney shareholder;

(2) the failure of the attorney shareholder to remain a licensed member of the State Bar of Texas; or

(3) the failure of the attorney shareholder to remain appointed and qualified to be appointed a title attorney under this chapter.

(b) An attorney's title insurance company must reacquire a deceased attorney shareholder's shares within nine months of the attorney shareholder's death. (V.T.I.C. Art. 9.56, Secs. 3 (part),

13(d).)

Sec. 2552.055. REACQUISITION PLAN REQUIRED. (a) As part of the application for the approval of the charter of an attorney's title insurance company, the applicants must file with the department an acceptable plan providing for the reacquisition of all shares of stock of the attorney's title insurance company issued to a qualified attorney when the attorney is no longer qualified to own the shares or on the death of the attorney.

(b) The plan must be approved by the department.

(c) In addition to other provisions, the plan must include an express provision that the attorney's title insurance company may not reacquire under any circumstance outstanding shares of its stock as treasury stock if the reacquisition will result in reducing its capital and surplus below the minimum capital and surplus required for the initial organization of the attorney's title insurance company. (V.T.I.C. Art. 9.56, Sec. 13(c).)

Sec. 2552.056. INAPPLICABILITY OF LAWS REGULATING SECURITIES. (a) All state laws, other than this title, that provide for supervision, registration, or regulation in connection with the sale, issuance, or offering of securities do not apply to the sale, issuance, or offering of any capital stock to a person authorized under this chapter to own the capital stock.

(b) The sale, issuance, or offering of any stock described by this section is legal without any action or approval by any official or state regulatory agency authorized to license, regulate, or supervise the sale, issuance, or offering of securities. (V.T.I.C. Art. 9.56, Sec. 13(a).)

[Sections 2552.057-2552.100 reserved for expansion]

SUBCHAPTER C. TITLE ATTORNEY'S LICENSE AND RENEWAL

Sec. 2552.101. LICENSE AND OTHER GENERAL REQUIREMENTS. To act as a title attorney in this state for an attorney's title insurance company, an attorney must:

(1) be a member in good standing of the State Bar of Texas;

(2) own one or more shares of stock in the attorney's title insurance company by which the attorney is appointed;

(3) be actively engaged in the practice of law;

(4) meet the requirements prescribed by this chapter regarding an abstract plant;

(5) be appointed by an attorney's title insurance company as its title attorney authorized by the attorney's title insurance company to solicit insurance, collect premiums, and issue or countersign policies on behalf of the attorney's title insurance company;

(6) be certified as a title attorney to the department;

(7) hold a license issued by the department under this subchapter; and

(8) maintain a surety bond or deposit as required by Section 2552.154. (V.T.I.C. Art. 9.56, Secs. 2(d) (part), 5 (part).)

Sec. 2552.102. LICENSE APPLICATION. (a) Before an initial license is issued to an attorney to act as a title attorney in this state for an attorney's title insurance company, the attorney's

title insurance company must file an application for a title attorney's license with the department on forms provided by the department.

(b) The application must be:

(1) accompanied by a nonrefundable fee in an amount not to exceed $50 as prescribed by the department; and

(2) signed and sworn to by the attorney's title insurance company and the proposed title attorney.

(c) The completed application must state that:

(1) the proposed title attorney:

(A) is a licensed attorney in this state and a resident of this state;

(B) is actively engaged in the practice of law;

(C) is known to the attorney's title insurance company:

(i) to have a good business reputation;

(ii) to be a current member, in good standing, of the State Bar of Texas; and

(iii) to be worthy of the public trust; and

(D) meets the qualifications for a title attorney as prescribed by this chapter; and

(2) the attorney's title insurance company does not know of any fact or condition that would disqualify the proposed title attorney from receiving a license. (V.T.I.C. Art. 9.56, Sec. 6(a) (part).)

Sec. 2552.103. LICENSE ISSUANCE AND DELIVERY. (a) The department shall issue a title attorney's license if the department

determines, based on the application and the department's investigation, that the requirements of Section 2552.102 are satisfied.

(b) The department shall deliver the license to the attorney's title insurance company for transmittal to the title attorney. (V.T.I.C. Art. 9.56, Secs. 6(a) (part), (b) (part).)

Sec. 2552.104. DUPLICATE LICENSE. (a) The department shall collect in advance a fee from a license holder who requests a duplicate title attorney's license.

(b) The department shall prescribe the fee in an amount not to exceed $20. (V.T.I.C. Art. 9.56, Sec. 6(a) (part).)

Sec. 2552.105. LICENSE TERM. Unless a system of staggered renewal is adopted under Section 4003.002, a title attorney's license expires on June 1 following the date of issuance. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

Sec. 2552.106. AUTOMATIC TERMINATION OF LICENSE. The license of each title attorney appointed by an attorney's title insurance company that surrenders its certificate of authority or has its certificate revoked by the department is automatically terminated without notice. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

Sec. 2552.107. LICENSE SURRENDER OR FORFEITURE. (a) A title attorney may voluntarily surrender the title attorney's license at any time by giving notice to the department and to the attorney's title insurance company.

(b) A title attorney automatically forfeits the title attorney's license under the attorney's title insurance company if the title attorney terminates the title attorney's relationship

with the attorney's title insurance company.

(c) A surrender or forfeiture of a title attorney's license under this section does not affect the culpability of the license holder for conduct committed before the effective date of the surrender or forfeiture. The department may institute a disciplinary proceeding against the former license holder for conduct committed before the effective date of the surrender or forfeiture. (V.T.I.C. Art. 9.56, Secs. 8(a), (f).)

Sec. 2552.108. CONTINUATION OF LICENSE. (a) Not later than the 30th day after the date an attorney's title insurance company terminates its contract with a title attorney or gives notice of termination to the title attorney, the title attorney may apply to the department for continuation of the title attorney's license.

(b) The application must include an amendment to the license stating the name of another attorney's title insurance company for which the title attorney is or will be authorized to act. (V.T.I.C. Art. 9.56, Sec. 6(c).)

[Sections 2552.109-2552.150 reserved for expansion]

SUBCHAPTER D. TITLE ATTORNEY GENERAL REQUIREMENTS

Sec. 2552.151. CONTRACT REQUIRED FOR APPOINTMENT. (a) A title attorney must be appointed by an attorney's title insurance company by contract.

(b) The contract must make arrangements for division of premium as may be approved by the department under this title. (V.T.I.C. Art. 9.56, Sec. 2(d) (part).)

Sec. 2552.152. ABSTRACT PLANT REQUIREMENTS. (a) A title attorney must:

(1) own or lease and control a licensed abstract plant;

(2) participate in a bona fide joint abstract plant operation;

(3) contract in accordance with this subchapter to obtain title evidence from a licensed abstract plant; or

(4) use title evidence provided by an approved abstract plant owned or leased and controlled by the attorney's title insurance company.

(b) If at the time of applying for a license under Section 2552.102 an attorney does not own or lease and control a licensed abstract plant, is not a participant in a bona fide joint abstract plant operation, and is unable to contract to obtain title evidence from a licensed abstract plant located in the county in which the attorney resides, the attorney, as part of the license application, may satisfy the requirements of this section by filing with the department on a form prescribed by the department a disclosure of the inability to obtain the contract. (V.T.I.C. Art. 9.56, Sec. 2(d) (part).)

Sec. 2552.153. CONTRACT WITH LICENSED ABSTRACT PLANT. (a) A title attorney may enter into a contract with a licensed abstract plant under which the abstract plant provides title evidence to the title attorney. The contract must:

(1) be on a form prescribed by the commissioner; and

(2) state the standards for the evidence to be provided.

(b) The commissioner may change the form of the contract.

(c) The parties to the contract shall determine the portion of the premium to be paid by the title attorney to the licensed abstract plant, subject to approval by the department.

(d) The department may disapprove any division of the premium that the department determines to be excessive or inadequate. The contract is considered to be approved as to the division of the premium until the parties are notified of disapproval by the department.

(e) The portion of the premium to be paid to the licensed abstract plant is considered to be in compliance with Section 2502.053(1).

(f) The parties to the contract shall file with the department a copy of the contract not later than the 10th day after the date of execution of the contract. (V.T.I.C. Art. 9.56, Secs. 2(d) (part), 7(b).)

Sec. 2552.154. BOND OR DEPOSIT REQUIRED. (a) A title attorney shall make, file, and pay for a surety bond payable to the department in the amount of $7,500 and issued by a corporate surety company authorized to write surety bonds in this state. The bond shall obligate the principal and surety to pay any pecuniary loss that is incurred by:

(1) a participant in a real property settlement or closing in which an attorney's title insurance policy is issued by the title attorney and that is sustained through an act of fraud, dishonesty, theft, embezzlement, or wilful misapplication by a title attorney; and

(2) any party to an escrow agreement in which the title

attorney is escrowee and that is sustained through an act of fraud, dishonesty, forgery, theft, embezzlement, or wilful misapplication by the title attorney, either directly and alone or in conspiracy with another person.

(b) Instead of a surety bond, a title attorney may deposit with the department cash or securities approved by the department in the amount of $7,500, subject to the same conditions required for the bond. (V.T.I.C. Art. 9.56, Sec. 9(a).)

Sec. 2552.155. EXAMINATION OF LOSS COVERED BY BOND. (a) At any time it appears that the terms of a title attorney's bond may have been violated, the department may require the title attorney to appear in Travis County, with records the department determines to be proper, for an examination.

(b) The department shall specify a date for the examination that is not earlier than the 10th day or later than the 15th day after the date of service of notice of the requirement to appear.

(c) If after the examination the department determines that the terms of the bond have been violated, the department shall immediately notify the surety and prepare a written statement of the facts of the loss and deliver the statement to the attorney general. (V.T.I.C. Art. 9.56, Sec. 9(b) (part).)

Sec. 2552.156. INVESTIGATION BY ATTORNEY GENERAL. (a) On receipt of a written statement under Section 2552.155, the attorney general shall investigate the charges and, on determining that the terms of the bond have been violated, shall enforce the liability against cash or securities or by filing suit on the bond.

(b) A suit brought under this section shall be filed in the

name of the department in Travis County for the benefit of all parties who have suffered any loss because of the violation. (V.T.I.C. Art. 9.56, Sec. 9(b) (part).)

Sec. 2552.157. AUTHORITY TO ISSUE POLICY. A title attorney may issue a title insurance policy for an attorney's title insurance company only if the title attorney:

(1) is appointed by the attorney's title insurance company as its title attorney;

(2) bases each title opinion on separate and current title evidence, provided by a licensed abstract plant, of the records of the county in which the real property, the title to which is to be insured, is located; and

(3) pays to the licensed abstract plant the portion of the premium agreed to by the title attorney and the abstract plant and approved by the department, if the title attorney contracts to obtain the title evidence from the abstract plant as provided by Section 2552.153. (V.T.I.C. Art. 9.56, Sec. 7(a).)

Sec. 2552.158. AUTHORITY TO DELIVER BUT NOT ISSUE POLICY. A title attorney may deliver, but not issue, a title insurance policy in conformity with Subchapter A, Chapter 2704, if:

(1) the title attorney does not own or lease and control a licensed abstract plant, is not a participant in a bona fide joint abstract plant operation, and is unable to contract with a licensed abstract plant to obtain the required title evidence in the county in which the real property, the title to which is to be insured, is located; or

(2) the title insurance policy is based on a certified

abstract of title prepared by a licensed abstract plant covering the particular real property from the sovereignty of the soil to the date of the transaction. (V.T.I.C. Art. 9.56, Sec. 7(c).)

[Sections 2552.159-2552.200 reserved for expansion]

SUBCHAPTER E. POWERS AND DUTIES OF ATTORNEY'S TITLE INSURANCE COMPANIES

Sec. 2552.201. ACTING AS TITLE ATTORNEY. An attorney's title insurance company may not permit an attorney to act as its title attorney in this state, including by writing, signing, or delivering title insurance policies, unless the attorney holds a license issued under Subchapter C and maintains a surety bond or deposit as required by Section 2552.154. (V.T.I.C. Art. 9.56, Secs. 5 (part), 6(b) (part).)

Sec. 2552.202. LIST OF TITLE ATTORNEYS. (a) An attorney's title insurance company shall certify to the department the name and address of each title attorney appointed by the attorney's title insurance company.

(b) The certification required by this section must:

(1) be on a form provided by the department; and

(2) be made on or before June 1 of each year unless a system of staggered renewal is adopted under Section 4003.002. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

Sec. 2552.203. RENEWAL. An attorney's title insurance company shall apply for license renewal and pay a fee prescribed by the department in an amount not to exceed $50 for each title attorney listed under Section 2552.202. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

Sec. 2552.204. NOTICE OF TERMINATION. An attorney's title insurance company that terminates the appointment of a title attorney shall:

(1) immediately notify the department in writing of the termination and request cancellation of the title attorney's license; and

(2) notify the title attorney of the action by the attorney's title insurance company. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

[Sections 2552.205-2552.250 reserved for expansion]

SUBCHAPTER F. AUDIT AND EXAMINATION REQUIREMENTS RELATING TO TRUST FUND ACCOUNTS

Sec. 2552.251. ANNUAL AUDIT. (a) A title attorney shall have an annual audit made of trust fund accounts. The title attorney shall pay for the audit.

(b) The audit must be performed by an independent certified public accountant or licensed public accountant, or a firm composed of either, recommended by the title attorney and approved by the attorney's title insurance company represented by the title attorney.

(c) The audit must include disclosure of payments made for title evidence under a contract under Section 2552.153 and to whom the payments were made.

(d) Not later than the 90th day after January 1 of each year, the title attorney shall send by certified mail, postage prepaid, to the department one copy of the audit report with a transmittal letter. The title attorney shall also send a copy of the audit

report and transmittal letter to the attorney's title insurance company represented by the title attorney. (V.T.I.C. Art. 9.56, Secs. 7(d), 10 (part).)

Sec. 2552.252. ANALYSIS OF ANNUAL AUDIT. (a) An attorney's title insurance company shall examine and analyze the annual audit report received from each of its title attorneys under Section 2552.251.

(b) Not later than three months after the date the audit report is received, the attorney's title insurance company shall file with the department, on a form prescribed by the department, a report of the findings and results of the examination and analysis of the audit report.

(c) If an attorney's title insurance company fails to receive an audit report from a title attorney within the time required by Section 2552.251, the attorney's title insurance company shall promptly report that fact to the department.

(d) After the report of the examination and analysis is filed with the department by an attorney's title insurance company, the department may classify the report as confidential and privileged. (V.T.I.C. Art. 9.56, Sec. 10 (part).)

Sec. 2552.253. EXAMINATION OF TRUST FUND ACCOUNTS; TRANSACTION REPORTS. (a) An attorney's title insurance company, through its examiners or auditors or through independent certified public accountants commissioned by the attorney's title insurance company, may examine at any time the trust fund accounts and records relating to the accounts of any of its title attorneys.

(b) The attorney's title insurance company shall pay for the

examination of the accounts and records.

(c) An attorney's title insurance company may require from any of its title attorneys special reports regarding any of their transactions. (V.T.I.C. Art. 9.56, Sec. 11.)

Sec. 2552.254. ENFORCEMENT; HEARING. (a) After notice and hearing, the department may revoke the license of a title attorney who:

(1) fails to furnish an annual audit report within the time required by Section 2552.251; or

(2) furnishes an audit report that reveals any irregularity, including a shortage, or any practice not in keeping with sound, honest business practices.

(b) The notice must be provided to the title attorney and the attorney's title insurance company represented by the title attorney.

(c) At a hearing under this section, the title attorney and the attorney's title insurance company may offer evidence explaining or excusing a failure or irregularity. (V.T.I.C. Art. 9.56, Sec. 10 (part).)

[Sections 2552.255-2552.300 reserved for expansion]

SUBCHAPTER G. LICENSE DENIAL AND DISCIPLINARY ACTION

Sec. 2552.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION. The department may deny an application for a title attorney's license or discipline a title attorney under Sections 4005.102, 4005.103, and 4005.104 if the department determines that the applicant or license holder:

(1) has wilfully violated this title;

(2) has intentionally made a material misstatement in the license application;

(3) has obtained or attempted to obtain the license by fraud or misrepresentation;

(4) has misappropriated or converted to the applicant's or license holder's own use or illegally withheld money belonging to an attorney's title insurance company, an insured, or another person;

(5) has been guilty of fraudulent or dishonest practices;

(6) has materially misrepresented the terms and conditions of a title insurance policy or contract;

(7) has failed to maintain:

(A) a separate and distinct accounting of escrow funds; and

(B) an escrow bank account or accounts separate and apart from all other accounts;

(8) is no longer a member of the State Bar of Texas; or

(9) is no longer actively engaged in the practice of law. (V.T.I.C. Art. 9.56, Sec. 8(b).)

Sec. 2552.302. LICENSE APPLICATION AFTER DENIAL, REFUSAL, OR REVOCATION. (a) An applicant whose license application has been denied or refused or a license holder whose license has been revoked under this subchapter may not file another application for a title attorney's license before the first anniversary of:

(1) the effective date of the denial, refusal, or revocation; or

(2) the date of a final court order affirming the denial, refusal, or revocation if judicial review is sought.

(b) A license application filed after the time required by this section may be denied by the department unless the applicant shows good cause why the denial, refusal, or revocation should not be a bar to the issuance of a license. (V.T.I.C. Art. 9.56, Sec. 8(d).)

CHAPTER 2553. FOREIGN OR ALIEN CORPORATIONS

CHAPTER 2553. FOREIGN OR ALIEN CORPORATIONS

Sec. 2553.001. AUTHORITY TO ENGAGE IN BUSINESS OF TITLE INSURANCE. (a) A corporation organized under the laws of another state may engage in the business of title insurance in this state on exactly the same basis and is subject to the same rules, prices, and supervision as provided for a corporation that is organized under the laws of this state and engaged in the business of title insurance under this title.

(b) To engage in the business of title insurance in this state, a foreign corporation must file with the department:

(1) an application for a permit or certificate of authority; and

(2) a financial statement demonstrating the condition of the corporation.

(c) The department shall prescribe the form of the

application and financial statement. (V.T.I.C. Arts. 9.10, 9.24.)

Sec. 2553.002. CAPITAL AND SURPLUS REQUIREMENTS. (a) A foreign corporation may not engage in the business of title insurance in this state unless the corporation has unimpaired capital in an amount of at least $1 million and a surplus in an amount of at least $1 million.

(b) The foreign corporation must demonstrate the required capital and surplus from its financial statement and any other examination the department may want to conduct. (V.T.I.C. Art. 9.25.)

Sec. 2553.003. TAXES AND FEES. (a) A corporation organized and incorporated under the laws of another state, territory, or country for the purpose of engaging in the business of title insurance shall pay the same filing fees and occupation tax as a foreign casualty company is required to pay to obtain a permit to engage in the business of insurance in this state.

(b) A foreign title insurance company described by Subsection (a) is not required to pay a franchise tax. (V.T.I.C. Art. 9.31.)

[Chapters 2554-2600 reserved for expansion]

SUBTITLE C. FINANCIAL SOLVENCY

CHAPTER 2601. SUPERVISION, LIQUIDATION, REHABILITATION, REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES AND AGENTS

Sec. 2601.001. SUPERVISION, LIQUIDATION, REHABILITATION, REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES AND AGENTS

CHAPTER 2601. SUPERVISION, LIQUIDATION, REHABILITATION, REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES AND AGENTS

Sec. 2601.001. SUPERVISION, LIQUIDATION, REHABILITATION, REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES AND AGENTS. Each title insurance agent and title insurance company is subject to Articles 21.28 and 21.28-A. (V.T.I.C. Art. 9.29.)

CHAPTER 2602. TEXAS TITLE INSURANCE GUARANTY ASSOCIATION

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 2602.013-2602.050 reserved for expansion]

SUBCHAPTER B. GOVERNANCE OF TEXAS TITLE INSURANCE

Sec. 2602.001. SHORT TITLE. This chapter may be cited as the Texas Title Insurance Guaranty Act. (V.T.I.C. Art. 9.48, Sec. 1.)

Sec. 2602.002. PURPOSES AND FINDINGS. (a) This chapter is for:

(1) the purposes and findings stated in Section 1, Article 21.28-A; and

(2) the protection of holders of covered claims.

(b) This chapter and the powers granted and functions authorized by this chapter shall be exercised to accomplish the purposes of this chapter. (V.T.I.C. Art. 9.48, Secs. 2, 21 (part).)

Sec. 2602.003. DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an impaired title insurance company on December 31 of the year preceding the date the company becomes impaired.

(2) "Agent" includes:

(A) a title insurance agent, as defined by Section 2501.003;

(B) a title attorney, as defined by Section 2552.002; and

(C) a direct operation or a title insurance company's wholly owned subsidiary or affiliate that performs the services usually and customarily performed by a title insurance agent.

(3) "Association" means the Texas Title Insurance

Guaranty Association.

(4) "Board" means the board of directors of the association.

(5) "Impaired agent" means an agent that is:

(A) placed in:

(i) temporary or permanent receivership under a court order based on a finding of insolvency; or

(ii) conservatorship after the commissioner determines that the agent is insolvent; and

(B) designated by the commissioner as an impaired agent.

(6) "Impaired title insurance company" means a title insurance company that is:

(A) placed in:

(i) temporary or permanent receivership under a court order based on a finding of insolvency; or

(ii) conservatorship after the commissioner determines that the company is insolvent; and

(B) designated by the commissioner as an impaired title insurance company.

(7) "Net direct written premiums" means the gross amount of premiums paid by policyholders for issuance of title insurance policies insuring risks located in this state and to which this chapter applies, without deduction for premiums for reinsurance ceded to other title insurance companies and not including premiums for reinsurance accepted from other authorized title insurance companies.

(8) "Payment of covered claims" means:

(A) the actual payment of claims; or

(B) the use of money of the impaired title insurance company and money derived from assessments or guaranty fees for consummation of contracts of reinsurance or assumption of liabilities or contracts of substitution to provide for liabilities arising from covered claims.

(9) "Trust funds or escrow accounts" includes accounts subject to annual audit under Subchapter D, Chapter 2651.

(10) "Unauthorized insurer" means a person, firm, association, or corporation that has engaged in activities prohibited by Subchapter C, Chapter 101, while engaging in the business of title insurance. (V.T.I.C. Art. 9.48, Secs. 5(4), (5), (6), (7), (8), (9), (11), (12), (13), (14).)

Sec. 2602.004. DESCRIPTION OF CONTROL. (a) For purposes of this chapter, control is the power to direct, or cause the direction of, the management and policies of a person, other than power that results from an official position with or corporate office held by the person. The power may be possessed directly or indirectly by any means, including through the ownership of voting securities or by contract, other than a commercial contract for goods or nonmanagement services.

(b) A person is presumed to control another person if the person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities of the other person. This presumption may be rebutted by a showing that the person does not in fact control the

other person. (V.T.I.C. Art. 9.48, Sec. 5(15).)

Sec. 2602.005. APPLICABILITY; CONFLICT WITH OTHER LAWS. (a) This chapter applies to:

(1) a title insurance company engaging in business under this title;

(2) all title insurance, direct or reinsurance, written by a title insurance company engaging in business under this title; and

(3) trust funds or escrow accounts of:

(A) title insurance companies engaging in business under this title; or

(B) agents authorized to engage in business in this state and engaging in business under and governed by this title.

(b) If this chapter conflicts with another law relating to the subject matter of this chapter or its application, other than Article 21.28 or 21.28-A, this chapter controls. If this chapter conflicts with Article 21.28 or 21.28-A, that article controls. (V.T.I.C. Art. 9.48, Secs. 3 (part), 21 (part).)

Sec. 2602.006. CONSTRUCTION. (a) This chapter shall be liberally construed to implement the purposes of this chapter described by Section 2602.002, which shall be used to aid and guide interpretation of this chapter.

(b) This chapter does not:

(1) expand or diminish a right or obligation between or among policyholders, title insurance companies, or agents; or

(2) require a person to assign, waive, or relinquish a

claim, right, or cause of action arising under Chapter 541 of this code or Subchapter E, Chapter 17, Business & Commerce Code. (V.T.I.C. Art. 9.48, Secs. 3 (part), 4.)

Sec. 2602.007. PROHIBITED USE OF PROTECTION PROVIDED BY CHAPTER. (a) A title insurance company or agent may not advertise or refer to this chapter as an inducement to the purchase of title insurance.

(b) The use by a person of the protection provided by this chapter in the sale of insurance is unfair competition and an unfair practice under Chapter 541. (V.T.I.C. Art. 9.48, Secs. 16, 19(b).)

Sec. 2602.008. IMMUNITY. (a) Liability does not exist and a cause of action does not arise against any of the following persons for a good faith action or omission of the person in exercising the person's powers and performing the person's duties under this chapter:

(1) the commissioner or the commissioner's representative;

(2) the association or the association's agent or employee;

(3) a title insurance company or the company's agent or employee;

(4) a board member; and

(5) a special deputy receiver or the special deputy receiver's agent or employee.

(b) The attorney general shall defend any action to which Subsection (a) applies that is brought against a person listed in that subsection, including an action instituted after the

defendant's service with the association, commissioner, or department has terminated. This subsection does not require the attorney general to defend a person or entity with respect to an issue other than the applicability or effect of the immunity created by Subsection (a). The attorney general is not required to defend a person listed in Subsection (a)(2), (3), (4), or (5) against an action regarding the disposition of a claim filed with the association under this chapter or any issue other than the applicability or effect of the immunity created by Subsection (a). The association may contract with the attorney general under Chapter 771, Government Code, for legal services not covered by this subsection.

(c) A title insurance company that reinsures or assumes the policies of an impaired title insurance company is not liable, and a cause of action does not arise against that company:

(1) for an action or omission by the impaired title insurance company or an officer, director, employee, attorney, or agent of the impaired title insurance company;

(2) by subrogation; or

(3) under any type of indemnity agreement. (V.T.I.C. Art. 9.48, Secs. 10(i) (part), 17.)

Sec. 2602.009. ASSOCIATION AND TITLE INSURANCE COMPANIES AS INTERESTED PARTIES. The association and each title insurance company assessed under this chapter are interested parties under Sections 3(h) and 12(b), Article 21.28. (V.T.I.C. Art. 9.48, Sec. 14(e)(8).)

Sec. 2602.010. RULES. The commissioner shall adopt

reasonable rules as necessary to implement and supplement this chapter and its purposes. (V.T.I.C. Art. 9.48, Sec. 18.)

Sec. 2602.011. INFORMATION PROVIDED BY AND TO COMMISSIONER. (a) The commissioner shall notify the association of the existence of an impaired title insurance company not later than the third day after the date on which the commissioner gives notice of the designation of impairment. The association is entitled to a copy of any complaint seeking an order of receivership with a finding of insolvency against a title insurance company at the time the complaint is filed with a court.

(b) The commissioner shall notify the board when the commissioner receives a report from the commissioner of insurance or other analogous officer of another state that indicates that a title insurance company has been designated impaired in another state. The report to the board must contain all significant details of the action taken or the report received.

(c) The commissioner shall report to the board when the commissioner has reasonable cause to believe from a completed or continuing examination of any title insurance company that the company may be an impaired title insurance company. The board may use this information in performing its duties under this chapter. The board shall keep the report and the information contained in the report confidential until it is made public by the commissioner or other lawful authority.

(d) On the board's request, the commissioner shall provide the association with a statement of the net direct written premiums of each title insurance company.

(e) The commissioner may require that the association notify the insureds of the impaired title insurance company and any other interested party of the designation of impairment and of the person's rights under this chapter. Notification by publication in a newspaper of general circulation is sufficient notice under this section. (V.T.I.C. Art. 9.48, Sec. 15A.)

Sec. 2602.012. APPEALS. (a) A title insurance company may appeal to the commissioner an action or ruling of the association relating to an assessment.

(b) An action or ruling of the commissioner under this chapter may be appealed as provided by Subchapter D, Chapter 36.

(c) A title insurance company appealing an assessment shall pay the assessment. The association may use the money to meet its obligations while the appeal is pending. If the appeal on the assessment is upheld, the association shall return to the company the amount paid in error or excess.

(d) Venue in a suit relating to an action or ruling under this chapter is in Travis County. Each party to the action may appeal, and the appeal is at once returnable to the appellate court and has precedence over all cases of a different character pending before the court. The commissioner or association is not required to give an appeal bond in an appeal of a cause of action arising under this chapter. (V.T.I.C. Art. 9.48, Sec. 20.)

[Sections 2602.013-2602.050 reserved for expansion]

SUBCHAPTER B. GOVERNANCE OF TEXAS TITLE INSURANCE GUARANTY ASSOCIATION

Sec. 2602.051. ASSOCIATION AS LEGAL ENTITY; SUPERVISION;

MEMBERSHIP. (a) The Texas Title Insurance Guaranty Association is a nonprofit legal entity.

(b) The association is subject to the applicable insurance laws of this state and the immediate supervision of the commissioner.

(c) A title insurance company may not engage in the business of title insurance in this state unless the company is a member of the association. (V.T.I.C. Art. 9.48, Sec. 14(a) (part).)

Sec. 2602.052. BOARD OF DIRECTORS. (a) The association's powers are exercised through a board of directors consisting of nine individuals appointed by the commissioner.

(b) Three board members must be officers or employees of title insurance companies. Two board members must be officers or employees of agents. Four board members must be public representatives.

(c) Board members other than public representatives shall be chosen to give fair representation to all title insurance companies and agents, considering the following categories:

(1) premium income;

(2) geographical location; and

(3) segments of the industry represented in this state. (V.T.I.C. Art. 9.48, Secs. 14(a) (part), (b)(1) (part).)

Sec. 2602.053. ELIGIBILITY TO SERVE AS PUBLIC REPRESENTATIVE. (a) In this section, "immediate family" includes parents, a spouse, children, brothers, and sisters residing in the same household.

(b) To be eligible to serve as a public representative on

the board, an individual must have resided in this state during the five years preceding appointment and may not be:

(1) licensed by or subject to the regulation of the department;

(2) financially involved in an organization subject to the regulation of the department other than by ownership of an insurance policy or contract;

(3) a member of the immediate family of an individual who is financially involved in an organization subject to the regulation of the department;

(4) engaged in or employed by an entity having a contract with an organization subject to the regulation of the department;

(5) employed by, on the board of directors of, or a holder of an elective office by or under the authority of a unit of federal, state, or local government or an organization that receives a significant part of its funding from a unit of federal, state, or local government;

(6) employed by or associated with an organization formed to represent license holders of the department or organizations or individuals subject to the regulation of the department; or

(7) required to register as a lobbyist under Chapter 305, Government Code, because of activities on behalf of an organization representing the regulated industry. (V.T.I.C. Art. 9.48, Sec. 14(b)(1) (part).)

Sec. 2602.054. TERM; VACANCY. (a) Board members serve

staggered six-year terms, with the terms of three members expiring each odd-numbered year. A member may serve more than one term.

(b) A member shall serve until a successor is appointed.

(c) If a member other than a public representative ceases to be an officer or employee of a title insurance company or agent, the member's office becomes vacant.

(d) The commissioner shall appoint an individual to fill a vacancy on the board for the unexpired term. (V.T.I.C. Art. 9.48, Sec. 14(b)(1) (part).)

Sec. 2602.055. COMPENSATION OF BOARD MEMBERS. A board member may not receive compensation for the member's services but is entitled to reimbursement for actual expenses incurred in performing the member's duties. (V.T.I.C. Art. 9.48, Sec. 14(b)(2).)

Sec. 2602.056. FINANCIAL STATEMENT OF BOARD MEMBER. Each board member shall file with the Texas Ethics Commission a financial statement as provided by Subchapter B, Chapter 572, Government Code. (V.T.I.C. Art. 9.48, Secs. 14(b)(3), (c) (part).)

Sec. 2602.057. RIGHTS OF TITLE INSURANCE COMPANY WITH REPRESENTATIVE ON BOARD. (a) A title insurance company is not prohibited, because the company has an officer, director, or employee serving as a board member, from negotiating for or entering into a contract of reinsurance or assumption of liability or a contract of substitution to provide for liabilities for covered claims with the receiver or conservator of an impaired title insurance company or agent.

(b) A conflict of interest does not arise from entering into

a contract described by this section. (V.T.I.C. Art. 9.48, Sec. 14(e)(7).)

[Sections 2602.058-2602.100 reserved for expansion]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF ASSOCIATION

Sec. 2602.101. GENERAL POWERS AND DUTIES. (a) In addition to the other powers and duties provided by this chapter, the association may:

(1) borrow money as necessary to implement this chapter according to the plan of operation;

(2) lend money to an impaired title insurance company;

(3) sue and be sued, including taking any legal action necessary or proper to recover an unpaid assessment;

(4) enter into contracts as necessary or proper to implement this chapter;

(5) ensure payment of the policy obligations of an impaired title insurance company;

(6) negotiate and contract with a rehabilitator, conservator, receiver, or ancillary receiver to exercise the powers and perform the duties of the association;

(7) guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, a policy or contract of an impaired title insurance company;

(8) take legal action necessary to avoid the payment of improper claims or to settle claims or potential claims against an impaired title insurance company or the association; and

(9) perform any other acts as necessary or proper to implement this chapter.

(b) The association has standing to appear before a court in this state with jurisdiction over an impaired title insurance company or agent concerning which the association is or may become obligated under this chapter. (V.T.I.C. Art. 9.48, Sec. 14(c) (part).)

Sec. 2602.102. PLAN OF OPERATION. (a) The association shall perform its functions under a plan of operation. The plan of operation must contain provisions necessary or proper for the execution of the association's powers and duties. The plan of operation must, in addition to the other requirements of this chapter:

(1) establish:

(A) procedures for handling the assets of the association;

(B) the amount and method of reimbursing board members;

(C) regular places and times for board meetings;

(D) procedures for maintaining records of all financial transactions of the association, its agents, and the board; and

(E) procedures for determining the amount of guaranty fees, for collecting those fees, and for assessments; and

(2) contain additional provisions necessary or proper for the execution of the association's powers and duties.

(b) The association shall submit to the commissioner any amendment to the plan of operation necessary or suitable to ensure the fair, reasonable, and equitable administration of the

association. The amendment takes effect on the commissioner's written approval.

(c) If the association does not submit a suitable amendment to the plan of operation, the commissioner after notice and hearing may adopt reasonable rules as necessary or advisable to implement this chapter. A rule continues in effect until modified by the commissioner or superseded by an amendment submitted by the association and approved by the commissioner.

(d) Each title insurance company shall comply with the plan of operation. (V.T.I.C. Art. 9.48, Secs. 14(a) (part), (d)(1), (2) (part), (3), (4).)

Sec. 2602.103. EMPLOYEES AND EXPERTS. (a) The association may employ or retain persons to perform the functions necessary or proper under this chapter, including persons necessary to handle the association's financial transactions.

(b) On the commissioner's request, the association shall retain one or more persons to:

(1) audit and review agent escrow and trust accounts, financial condition, and compliance with applicable statutes and rules; and

(2) report to the commissioner on the accounts, condition, and compliance.

(c) A person retained under Subsection (b) acts solely under the direction of and as assigned by the commissioner.

(d) From the guaranty fee account, the association shall compensate a person retained under Subsection (b) and reimburse the person for the person's reasonable and necessary expenses.

(V.T.I.C. Art. 9.48, Sec. 14(c) (part).)

Sec. 2602.104. 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 exercising its powers and performing its duties under this chapter.

(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 title insurance company;

(2) termination of the impairment or insolvency of the title insurance company; or

(3) order of a court.

(c) This section does not limit the association's duty to report on its activities under this chapter. (V.T.I.C. Art. 9.48, Sec. 23(a).)

Sec. 2602.105. MEETING BY CONFERENCE CALL. Notwithstanding Chapter 551, Government Code, the board may hold an open meeting by telephone conference call if immediate action is required and convening of a quorum of the board at a single location is not reasonable or practical. The meeting is subject to the notice requirements that apply to other meetings. The notice of the meeting must specify as the location of the meeting the location at which meetings of the board are usually held, and each part of the meeting that is required to be open to the public must be audible to the public at that location and must be tape-recorded. The tape

recording shall be made available to the public for 30 days after the meeting date. (V.T.I.C. Art. 9.48, Sec. 14(g).)

Sec. 2602.106. ACCOUNTS. For purposes of administration and assessment, the board shall establish:

(1) an administrative account;

(2) a title account; and

(3) a guaranty fee account. (V.T.I.C. Art. 9.48, Sec. 14(a) (part).)

Sec. 2602.107. 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) The association shall assess title insurance companies as provided by Subchapter E for any additional money needed for the administrative account. (V.T.I.C. Art. 9.48, Sec. 7(e).)

Sec. 2602.108. DEPOSIT OF FEES AND ASSESSMENTS. The association may deposit fees and assessments it 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. 9.48, Sec. 6A.)

Sec. 2602.109. USE OF EXCESS MONEY IN ACCOUNTS. (a) If the association determines that money in the title account exceeds the amount reasonably necessary for efficient future operation under this chapter, the association shall return the excess money pro rata to the holders of participation receipts on which an

outstanding balance exists after deducting any credits against premium taxes taken under Section 2602.210. The amount deducted for those credits shall be deposited with the comptroller for credit to the general revenue fund. The association shall transfer to the guaranty fee account any excess money remaining in the title account after the distribution.

(b) If the association determines that money in the administrative account exceeds the amount reasonably necessary for efficient future operation under this chapter, the association shall transfer the excess money to the guaranty fee account. (V.T.I.C. Art. 9.48, Secs. 9(b), (c).)

Sec. 2602.110. EXPENSES OF RECEIVERSHIP OR CONSERVATORSHIP. The association may advance money necessary to pay the expenses of administering the receivership or conservatorship estate of an impaired title insurance company or agent, on terms the association negotiates, if the company's or agent's assets are insufficient to pay those expenses. (V.T.I.C. Art. 9.48, Sec. 5(2)C (part).)

Sec. 2602.111. DELEGATION OF POWERS AND DUTIES. (a) The plan of operation may provide that, on approval of the board and the commissioner, a power or duty of the association may be delegated to a corporation or other organization that:

(1) performs or will perform in two or more states functions similar to those of the association or its equivalent; and

(2) provides protection not substantially less favorable and effective than that provided by this chapter.

(b) A power or duty under Section 2602.101(a)(1) or (4), 2602.107, 2602.201, 2602.202, 2602.203, or 2602.205 may not be delegated under this section.

(c) The corporation or other organization shall be:

(1) reimbursed as a servicing facility would be reimbursed; and

(2) paid for its performance of any other functions of the association. (V.T.I.C. Art. 9.48, Sec. 14(f).)

Sec. 2602.112. EXEMPTION FROM TAXATION. The association is exempt from payment of all fees and all taxes levied by this state or a subdivision of this state, except taxes levied on real or personal property. (V.T.I.C. Art. 9.48, Sec. 20A.)

Sec. 2602.113. DETECTION AND PREVENTION OF IMPAIRMENT. (a) The board may make recommendations to the commissioner for detecting and preventing title insurance company or agent impairments. The board shall advise and counsel with the commissioner on matters relating to the solvency of title insurance companies and agents.

(b) The board may report and make recommendations to the commissioner relating to any matter germane to the solvency, liquidation, rehabilitation, or conservation of a title insurance company or agent. A report or recommendation under this subsection is not a public document until a title insurance company is designated impaired.

(c) The board shall notify the commissioner of any information indicating that a title insurance company or agent may be unable or potentially unable to fulfill its contractual

obligations and shall request a meeting with the commissioner. The board may request appropriate investigation and action by the commissioner. The commissioner may investigate and act as the commissioner considers appropriate. (V.T.I.C. Art. 9.48, Secs. 14(e)(2), (3) (part), (4), (5).)

Sec. 2602.114. MEETING OF BOARD ON IMPAIRED TITLE INSURANCE COMPANY OR AGENT. (a) The commissioner:

(1) shall call a meeting of the board when the commissioner determines that a title insurance company or agent is insolvent or impaired; and

(2) may call a meeting of the board when the commissioner determines that a title insurance company or agent is in danger of becoming insolvent or impaired.

(b) The meeting is not open to the public. Only board members, the commissioner, and persons the commissioner authorizes may attend the meeting.

(c) The commissioner may require an officer, director, or employee of the title insurance company or agent to appear before the board for conference or to give testimony.

(d) At the meeting the commissioner may disclose to the board information that the commissioner possesses and may disclose department records, including an examination report or a preliminary report from an examiner that relates to the title insurance company or agent.

(e) A board member may not disclose information received in the meeting unless authorized by the commissioner or required as witness in court. A board member and the meeting are subject to the

confidentiality standard imposed on an examiner under Article 1.18, except that a bond is not required of a board member. (V.T.I.C. Art. 9.48, Sec. 14(e)(3) (part).)

Sec. 2602.115. ASSOCIATION AND BOARD ADVICE AND ASSISTANCE. (a) On the commissioner's request, the board shall attend hearings before the commissioner and meet with and advise the commissioner or the receiver or the conservator appointed by the commissioner on matters relating to:

(1) the affairs of an impaired title insurance company or agent;

(2) action that the commissioner, receiver, or conservator may take to best protect the interest of holders of covered claims against the company or agent; and

(3) the marshalling of assets.

(b) On the commissioner's request, the association may assist and advise the commissioner concerning rehabilitation, payment of claims, continuation of coverage, or the performance of other contractual obligations of an impaired title insurance company or agent. (V.T.I.C. Art. 9.48, Secs. 14(c) (part), (e)(3) (part).)

Sec. 2602.116. BOARD ACCESS TO RECORDS. The receiver or statutory successor of an impaired title insurance company shall give the board or its representative:

(1) access to the company's records as necessary for the board to perform its functions under this chapter relating to covered claims; and

(2) copies of those records on the board's request and

at the board's expense. (V.T.I.C. Art. 9.48, Sec. 20B (part).)

Sec. 2602.117. BOARD REPORT AT CONCLUSION OF IMPAIRMENT. At the conclusion of a title insurance company or agent impairment in which the association exercised its powers or performed its duties under this chapter, the board shall prepare, from information available to the association, and submit to the commissioner a report on the history and causes of the impairment. (V.T.I.C. Art. 9.48, Sec. 14(e)(6).)

[Sections 2602.118-2602.150 reserved for expansion]

SUBCHAPTER D. POLICY GUARANTY FEES

Sec. 2602.151. PAYMENT OF FEE. (a) An agent or, if there is no agent, the title insurance company shall pay the association a quarterly guaranty fee for each owner or mortgagee title insurance policy that the agent or company is required to report on its statistical report to the department.

(b) The fee is due:

(1) May 1, for the quarter ending March 31;

(2) August 1, for the quarter ending June 30;

(3) November 1, for the quarter ending September 30; and

(4) February 1, for the quarter ending December 31.

(c) The association shall deposit the fee in the guaranty fee account.

(d) Except as provided by Section 2602.109, money in the guaranty fee account shall be derived only from guaranty fees as provided by this subchapter. (V.T.I.C. Art. 9.48, Secs. 6(a) (part), (b), 7(c) (part).)

Sec. 2602.152. AMOUNT OF FEE. Annually or more frequently, the board shall determine the amount of the guaranty fee, not to exceed $5, considering the amount of money to be maintained in the guaranty fee account that is reasonably necessary for efficient future operation under this chapter. (V.T.I.C. Art. 9.48, Sec. 6(a) (part).)

Sec. 2602.153. USE OF FEE. (a) The association shall collect, receive, retain, and disburse the guaranty fees only as specifically provided by this chapter.

(b) The following covered claims shall be paid from guaranty fees only and may not be paid from assessments:

(1) claims against trust funds or an escrow account of an impaired agent under Section 2602.252; and

(2) conservator and receiver expenses under Section 2602.254.

(c) Administrative expenses with respect to the estate of an impaired agent under Section 2602.110 may be paid only from the guaranty fee account.

(d) Guaranty fees may be used only for payment of:

(1) covered claims described by Subsection (b) or (c); and

(2) audit and review expenses under Section 2602.103(b). (V.T.I.C. Art. 9.48, Secs. 5(2)A (part), C (part), D (part), 6(c), 14(c) (part).)

Sec. 2602.154. ENFORCEMENT OF FEE. (a) After notice and opportunity for hearing, the commissioner may suspend or revoke the certificate of authority or license to engage in business in this

state of a title insurance company or agent that does not comply with this subchapter.

(b) The commissioner shall adopt rules that implement the program created under this subchapter. (V.T.I.C. Art. 9.48, Secs. 6(d), (e).)

[Sections 2602.155-2602.200 reserved for expansion]

SUBCHAPTER E. ASSESSMENTS

Sec. 2602.201. MAKING OF ASSESSMENT. (a) If the commissioner determines that a title insurance company or agent has become impaired, the association shall promptly estimate the amount of additional money needed to supplement the assets of the impaired title insurance company or agent to pay all covered claims and administrative expenses.

(b) The association shall assess title insurance companies in writing an amount as determined under Section 2602.202. A title insurance company does not incur real or contingent liability under this chapter until the association actually makes the written assessment. (V.T.I.C. Art. 9.48, Secs. 7(a), (b) (part), (f).)

Sec. 2602.202. AMOUNT OF ASSESSMENT; PRORATION OF PAYMENT. (a) The association shall assess title insurance companies the amount necessary to pay:

(1) the association's obligations under this chapter and the expenses of handling covered claims subsequent to an impairment; and

(2) other expenses authorized by this chapter.

(b) The assessment of each title insurance company must be in the proportion that the net direct written premiums of that

company for the calendar year preceding the assessment bear to the net direct written premiums of all title insurance companies for that year.

(c) The total assessment of a title insurance company in a year may not exceed an amount equal to two percent of the company's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment and the association's other assets are insufficient in any one year to make all necessary payments, the money available shall be prorated and the unpaid portion shall be paid as soon as money becomes available. (V.T.I.C. Art. 9.48, Sec. 7(b) (part).)

Sec. 2602.203. NOTICE AND PAYMENT. (a) Not later than the 30th day before the date an assessment is due, the association shall notify the title insurance company.

(b) Not later than the 30th day after the date an assessment is made, the title insurance company shall pay the association the amount of the assessment. (V.T.I.C. Art. 9.48, Secs. 7(b) (part), (d) (part).)

Sec. 2602.204. EXEMPTION FOR IMPAIRED TITLE INSURANCE COMPANY. A title insurance company is exempt from assessment during the period beginning on the date the commissioner designates the company as an impaired title insurance company and ending on the date the commissioner determines that the company is no longer an impaired title insurance company. (V.T.I.C. Art. 9.48, Sec. 7(g).)

Sec. 2602.205. DEFERMENT. (a) The association may defer in whole or in part an assessment of a title insurance company that would cause the company's financial statement to show amounts of

capital or surplus less than the minimum amount required for a certificate of authority in any jurisdiction in which the company is authorized to engage in the business of insurance.

(b) The title insurance company shall pay the deferred assessment when payment will not reduce capital or surplus below required minimums. The payment shall be refunded to or credited against future assessments of any title insurance company receiving a larger assessment because of the deferment, as elected by that company.

(c) During a period of deferment, the title insurance company may not pay a dividend to shareholders or policyholders. (V.T.I.C. Art. 9.48, Sec. 7(c) (part).)

Sec. 2602.206. PARTICIPATION RECEIPTS. (a) On receipt from a title insurance company of payment of an assessment or partial assessment, the association shall provide the company with a participation receipt. A participation receipt creates liability against the impaired title insurance company.

(b) The holder of the receipt is a general creditor of the impaired title insurance company, except that if the amount of assessments the association receives exceeds the amount paid for covered claims, the holders of participation receipts have preference over other general creditors to, and are entitled to share pro rata in, the excess. (V.T.I.C. Art. 9.48, Sec. 9(a) (part).)

Sec. 2602.207. ACCOUNTING; REPORTS; REFUND. (a) The association shall adopt accounting procedures to show how money received from assessments or partial assessments is used.

(b) The association shall make interim accounting reports as the commissioner requires.

(c) The association shall make a final report to the commissioner showing how money received from assessments or partial assessments has been used, including a statement of any final balance of that money. As soon as practicable after completion of the final report, the association shall refund the remaining balance to the holders of participation receipts as required by Section 2602.206(b). (V.T.I.C. Art. 9.48, Sec. 9(a) (part).)

Sec. 2602.208. USE OF ASSESSMENTS. (a) Money from assessments is considered to supplement the marshalling of an impaired title insurance company's assets to make payments on the impaired title insurance company's behalf. The association may assess title insurance companies or use money from assessments to pay covered claims before the receiver exhausts the impaired title insurance company's assets.

(b) The association may use money from assessments to negotiate and consummate contracts of reinsurance or assumption of liabilities or contracts of substitution to provide for outstanding liabilities of covered claims.

(c) Except as provided by Section 2602.109, money from assessments may not be used for the guaranty fee account. (V.T.I.C. Art. 9.48, Secs. 7(c) (part), 7A, 10(i) (part).)

Sec. 2602.209. FAILURE TO PAY; COLLECTION BY COMMISSIONER. (a) The association shall promptly report to the commissioner a failure of a title insurance company to pay an assessment when due.

(b) On failure of a title insurance company to pay an

assessment when due, the commissioner may either:

(1) suspend or revoke, after notice and hearing, the company's certificate of authority to engage in business in this state; or

(2) assess an administrative penalty as provided by Chapter 84 in an amount not to exceed the greater of five percent of the unpaid assessment each month or $100 each month.

(c) A title insurance company whose certificate of authority is canceled or surrendered is liable for any unpaid assessments made before the date of the cancellation or surrender.

(d) The commissioner may collect an assessment on behalf of the association through a suit brought for that purpose. (V.T.I.C. Art. 9.48, Secs. 7(d) (part), 8.)

Sec. 2602.210. RECOVERY OF ASSESSMENT IN RATES; TAX CREDIT. (a) A title insurance company is entitled to recover in its rates for the succeeding calendar year amounts paid in assessments not to exceed one percent of the company's net direct written premiums. In promulgating or establishing rates the commissioner shall consider assessments and refunds of assessments and shall adjust the rates to allow for recovery under this subsection.

(b) Unless the department determines that all amounts paid as assessments by each title insurance company have been recovered under Subsection (a), for any amount not recovered the title insurance company is entitled to a credit against its premium tax under Chapter 223. The credit may be taken at a rate of 20 percent each year for five successive years following the date of assessment and, if the title insurance company elects, may be taken

over an additional number of years.

(c) An amount of a tax credit allowed by this section that is unclaimed may be shown in the title insurance company's books and records as an admitted asset for all purposes, including an annual statement under Section 862.001. (V.T.I.C. Art. 9.48, Sec. 15.)

[Sections 2602.211-2602.250 reserved for expansion]

SUBCHAPTER F. COVERED CLAIMS

Sec. 2602.251. COVERED CLAIMS IN GENERAL. An unpaid claim is a covered claim if:

(1) the claim is made by an insured under a title insurance policy to which this chapter applies;

(2) the claim arises out of the policy and is within the coverage and applicable limits of the policy;

(3) the title insurance company that issued the policy or assumed the policy under an assumption certificate is an impaired title insurance company; and

(4) the insured real property or a lien on the property is located in this state. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

Sec. 2602.252. CLAIM AGAINST TRUST FUNDS OR ESCROW ACCOUNT. An unpaid claim is a covered claim if the claim:

(1) is against trust funds or an escrow account of an impaired title insurance company or agent; and

(2) is unpaid because of a shortage of those funds or in that account. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

Sec. 2602.253. CLAIM IN CONNECTION WITH FIDELITY OF AGENT. An unpaid claim is a covered claim if an impaired title insurance company is liable for the claim in connection with the fidelity of

the company's agent as authorized by Subchapter A, Chapter 2702. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

Sec. 2602.254. CERTAIN CONSERVATOR AND RECEIVER EXPENSES COVERED. Reasonable and necessary administrative expenses incurred by a conservator appointed by the commissioner or a receiver appointed by a court for an unauthorized insurer operating in this state are covered claims if the commissioner has notified the association or the association has otherwise become aware that:

(1) the unauthorized insurer has insufficient liquid assets to pay those expenses; and

(2) insufficient money is available from:

(A) abandoned money under Section 8, Article 21.28; and

(B) department appropriations for use in paying those expenses. (V.T.I.C. Art. 9.48, Sec. 5(2)D (part).)

Sec. 2602.255. CLAIMS NOT COVERED. The following are not covered claims:

(1) an amount due a reinsurer, title insurance company, insurance pool, or underwriting association as a subrogation recovery or otherwise;

(2) a supplementary payment obligation incurred before a determination is made under this chapter that a title insurance company or agent is impaired, including:

(A) adjustment fees or expenses;

(B) attorney's fees or expenses;

(C) court costs;

(D) interest;

(E) enhanced damages, sought as a recovery against the insured, the impaired title insurance company or agent, or the association, that arise under Chapter 541 of this code or Subchapter E, Chapter 17, Business & Commerce Code; and

(F) bond premiums;

(3) a shortage of trust funds or in an escrow account resulting from the insolvency of a financial institution;

(4) exemplary, extracontractual, or bad faith damages awarded against an insured or title insurance company by a court judgment;

(5) a claim under Section 2602.252 by a claimant who has a lien against the real property that was the subject of the transaction from which the claim arises, unless the lien is held to be invalid as a matter of law;

(6) a claim under Section 2602.251, 2602.252, or 2602.253 by a claimant who caused or substantially contributed to the claimant's loss by the claimant's action or omission; and

(7) a claim filed with the association after the final date set by the court for the filing of claims against a receiver of an impaired title insurance company or agent. (V.T.I.C. Art. 9.48, Secs. 5(2)B, 10(c).)

Sec. 2602.256. AMOUNT OF COVERED CLAIM; LIMIT. (a) A covered claim under Section 2602.251 or 2602.253 may not exceed the lesser of $250,000 for each claimant or $250,000 for each policy.

(b) A covered claim under Section 2602.252 may not exceed the lesser of $250,000 for each claimant or the amount of money actually delivered to the impaired title insurance company or agent

as trust funds or an escrow account for each claimant in a transaction from which the claim arises, except that the cumulative amount of covered claims arising from a single transaction may not exceed $250,000. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

Sec. 2602.257. EXHAUSTION OF OTHER RIGHTS REQUIRED. (a) A person having a covered claim that is also a claim against a title insurance company under law or under an insurance policy other than a policy of an impaired title insurance company must exhaust the person's rights under law or the policy before asserting the covered claim under this chapter.

(b) The amount payable on the covered claim is reduced by the amount of any recovery under law or the policy.

(c) Notwithstanding any other provision, to avoid undue hardship to a claimant the association may authorize payment of a covered claim against an impaired agent without regard to the liability of any title insurance company or coverage under any insurance policy, subject to the approval of the receivership court or commissioner, as applicable. On payment, the association is in all respects subrogated to the rights and claims of the claimant. (V.T.I.C. Art. 9.48, Sec. 12.)

Sec. 2602.258. CERTAIN MONEY AUTHORIZED FOR USE IN PAYING COVERED CLAIM; LIMIT. (a) Money from assessments or guaranty fees is liable only for the difference between the amount of covered claims and the amount of assets marshalled by a receiver or conservator for payment to holders of covered claims.

(b) In an ancillary receivership in this state, money from assessments is liable only for the difference between the amount of

covered claims and the amount of assets marshalled by receivers in other states for payment of covered claims in this state. (V.T.I.C. Art. 9.48, Secs. 11(a), (b) (part).)

Sec. 2602.259. STAY OF PROCEEDINGS; CERTAIN DECISIONS NOT BINDING. (a) To permit the receiver or association to properly defend a pending cause of action, a proceeding in which an impaired title insurance company is a party or is obligated to defend a party in a court in this state, other than a proceeding directly related to the receivership or instituted by the receiver, is stayed for:

(1) a six-month period beginning on the later of the date of the designation of impairment or the date an ancillary proceeding is brought in this state; and

(2) any subsequent period as determined by the court.

(b) If a covered claim arises from a judgment, order, verdict, finding, or other decision based on the default of an impaired title insurance company or its failure to defend an insured, the association on its own behalf or on behalf of the insured may apply to the court or administrator that made the decision to have the decision set aside and may defend the claim on its merits.

(c) In a proceeding considering a covered claim, a judgment against an insured taken after the date the delinquency proceeding begins or a conservator is appointed is not evidence of liability or of the amount of damages, and a default or consent judgment against an insured or the impaired title insurance company or a settlement, release, or judgment entered into by the insured or the impaired title insurance company does not bind the association and is not

evidence of liability or of the amount of damages in connection with a claim brought against the association or another party under this chapter. (V.T.I.C. Art. 9.48, Secs. 11(c) (part), 20B (part).)

Sec. 2602.260. ADMISSIBILITY OF PAYMENT. In a lawsuit brought by a conservator or receiver of an impaired title insurance company or agent to recover assets of the company or agent, the fact that a claim against the company or agent has been or will be paid under this chapter is not admissible and may not be placed before a jury by evidence, argument, or reference. (V.T.I.C. Art. 9.48, Sec. 19(a).)

[Sections 2602.261-2602.300 reserved for expansion]

SUBCHAPTER G. ASSOCIATION POWERS AND DUTIES RELATING TO COVERED CLAIMS

Sec. 2602.301. GENERAL POWERS AND DUTIES OF ASSOCIATION IN CONNECTION WITH PAYMENT OF COVERED CLAIMS. (a) The association shall:

(1) investigate a claim brought against the association, the commissioner, or a special deputy receiver appointed under Article 21.28 if the claim involves or may involve the association's rights and obligations under this chapter; and

(2) adjust, compromise, settle, and pay a covered claim to the extent of the association's obligation, and deny all other claims.

(b) The association may review a settlement, release, or judgment to which an impaired title insurance company or agent or its insured was a party to determine the extent to which the settlement, release, or judgment is contested. (V.T.I.C. Art.

9.48, Sec. 10(e).)

Sec. 2602.302. PAYMENT OF COVERED CLAIMS. (a) The association shall pay covered claims:

(1) existing before the determination of impairment; or

(2) arising on or before:

(A) the date of cancellation of the impaired title insurance company's policies; or

(B) the claim deadline for covered claims against an impaired agent.

(b) The court in which the receivership proceedings are pending shall set, as applicable:

(1) the date of cancellation of the policies, which may not be later than the fifth anniversary of the date of determination of impairment; or

(2) the claim deadline, which may not be later than the first anniversary of the date of determination of impairment.

(c) Subject to the approval of the commissioner, the association shall establish:

(1) procedures for filing claims with the association; and

(2) acceptable forms of proof of covered claims.

(d) The association shall pay claims in the order the association considers reasonable, including payment as claims are received from the claimants or in groups or categories of claims.

(e) The association may not pay a claimant an amount exceeding the amount of the claimant's covered claim. (V.T.I.C.

Art. 9.48, Secs. 10(a), (b), (f), (g) (part).)

Sec. 2602.303. SERVICING FACILITY. (a) The association may handle claims through its employees or through one or more title insurance companies or other persons designated, subject to the approval of the commissioner, as a servicing facility.

(b) A title insurance company may decline designation as a servicing facility.

(c) The association shall reimburse a servicing facility for:

(1) obligations of the association paid by the facility; and

(2) expenses incurred by the facility in handling claims for the association. (V.T.I.C. Art. 9.48, Sec. 10(h).)

Sec. 2602.304. ADVANCE AS LOAN. Money advanced by the association under this chapter is considered a special fund loan to the impaired title insurance company or agent for payment of covered claims and does not become an asset of the title insurance company or agent. The loan is repayable to the extent money from the title insurance company or agent is available. (V.T.I.C. Art. 9.48, Sec. 10(j).)

Sec. 2602.305. ASSOCIATION IN PLACE OF IMPAIRED TITLE INSURANCE COMPANY OR AGENT. (a) To the extent of the association's obligation on a covered claim, the association stands in the place of the impaired title insurance company or agent and has all the rights, duties, and obligations of the company or agent as if the company or agent were not impaired.

(b) In performing its obligations under this chapter, the

association is not considered:

(1) to be engaged in the business of insurance;

(2) to have assumed or succeeded to a liability of the impaired title insurance company or agent; or

(3) to otherwise stand in the place of the impaired title insurance company or agent, including as to whether the association is subject to personal jurisdiction of the courts of another state. (V.T.I.C. Art. 9.48, Sec. 10(d).)

Sec. 2602.306. ASSIGNMENT OF CLAIMANT'S RIGHTS. (a) Any cause of action or other right of the holder of a covered claim arising from the occurrence on which the claim is based is assigned to the association on the holder's acceptance of:

(1) the association's payment of the claim; or

(2) a benefit of a contract by the association providing for reinsurance or assumption of liabilities or for substitution.

(b) Rights are assigned to the association under Subsection (a) to the extent of the amount accepted or the value of the benefit provided.

(c) The association may assign the rights acquired under this section to the title insurance company executing the reinsurance, assumption, or substitution agreement. (V.T.I.C. Art. 9.48, Sec. 11(d).)

Sec. 2602.307. SETTLEMENT BY ASSOCIATION BINDING; PRIORITY OF CLAIM AND EXPENSES. (a) The settlement of a covered claim by the association binds the receiver or statutory successor of an impaired title insurance company.

(b) The court shall give the covered claim the same priority against assets of the impaired title insurance company that the claim would have had in the absence of this chapter.

(c) The association's expenses in handling claims have the same priority as the receiver's expenses. (V.T.I.C. Art. 9.48, Sec. 11(e).)

Sec. 2602.308. REPORT TO RECEIVER. The association shall periodically file with the receiver of an impaired title insurance company a statement of covered claims paid by the association and an estimate of claims anticipated against the association. The statement preserves the rights of the association against the assets of the company. (V.T.I.C. Art. 9.48, Sec. 11(f).)

[Sections 2602.309-2602.350 reserved for expansion]

SUBCHAPTER H. CONSERVATOR OR RECEIVER POWERS AND DUTIES RELATING TO COVERED CLAIMS

Sec. 2602.351. DETERMINATION OF CONSERVATOR CONCERNING REINSURANCE, ASSUMPTION, OR SUBSTITUTION. A conservator appointed to handle the affairs of an impaired title insurance company or agent shall determine whether covered claims should or can be provided for in whole or in part by reinsurance, assumption, or substitution. (V.T.I.C. Art. 9.48, Sec. 11(b) (part).)

Sec. 2602.352. NOTICE OF DETERMINATION CONCERNING ACTUAL PAYMENT. (a) On determination by the conservator that covered claims should be actually paid, the conservator shall give notice of the determination to holders of covered claims.

(b) The conservator shall mail the notice to each holder of a covered claim at the most recent address shown in the impaired

title insurance company's or agent's records, except that if those records do not show the claimant's address the conservator may give notice by publication in a newspaper of general circulation.

(c) The notice must state a date, not earlier than the 91st day after the date of the mailing or publication of the notice, before which the claimant must file a claim with the conservator. (V.T.I.C. Art. 9.48, Sec. 11(b) (part).)

Sec. 2602.353. FILING OF COVERED CLAIM. The conservator may require in whole or in part that claimants file:

(1) sworn claim forms; and

(2) additional information or evidence reasonably necessary for the conservator to determine the legality of or amount due under a covered claim. (V.T.I.C. Art. 9.48, Sec. 11(b) (part).)

Sec. 2602.354. CLAIM BY PERSON WITH CAUSE OF ACTION AGAINST INSURED. (a) On determination by the conservator that covered claims should be actually paid or on order of the court to the receiver to give notice for the filing of claims, a person having a cause of action that constitutes a covered claim against an insured of the impaired title insurance company under a title insurance policy issued or assumed by the company may file the claim with the receiver or conservator, regardless of whether the claim is unliquidated or undetermined.

(b) A claim under this section may be approved as a covered claim if:

(1) it may be reasonably inferred from the proof presented that the claimant would be able to obtain a judgment on

the cause of action against the insured;

(2) the claimant provides suitable proof that no valid claim exists against the impaired title insurance company arising from the cause of action other than claims already made; and

(3) the total liability of the impaired title insurance company to all claimants under the same title insurance policy does not exceed the amount of the company's total liability if the company were not in liquidation, rehabilitation, or conservation. (V.T.I.C. Art. 9.48, Sec. 11(c) (part).)

Sec. 2602.355. REPORT TO ASSOCIATION. (a) A receiver of an impaired title insurance company or agent shall periodically submit a list of claims to the association or a similar organization in another state.

(b) Notice of a claim to the receiver is considered notice to the association. (V.T.I.C. Art. 9.48, Sec. 10(g) (part).)

[Sections 2602.356-2602.400 reserved for expansion]

SUBCHAPTER I. OPERATION OF IMPAIRED TITLE INSURANCE COMPANY OR AGENT

Sec. 2602.401. ISSUANCE OR RENEWAL OF POLICIES. (a) If an assessment has been made under this chapter for an impaired title insurance company or association funds have been provided for the company, the company, on release from the conservatorship or receivership, may not issue a new or renewal insurance policy until the company:

(1) has repaid pro rata in full to each holder of a participation receipt the assessment amount paid by the receipt holder or its assignee; and

(2) has repaid in full the amount of guaranty fees paid by the association.

(b) If an assessment has been made under this chapter for an impaired agent or guaranty fees have been provided for the agent, the agent, on release from the conservatorship or receivership, may not issue a new or renewal insurance policy until the agent has repaid in full the amount of guaranty fees paid by the association.

(c) Notwithstanding Subsections (a) and (b), on application of the association and after hearing, the commissioner may permit the impaired title insurance company or agent to issue new policies as provided by a plan of operation for repayment. In approving the plan, the commissioner may restrict the issuance of new or renewal policies as the commissioner considers necessary to implement the plan.

(d) Not later than the 11th day before the date of a hearing under Subsection (c), the commissioner shall give notice of the hearing to the association. The commissioner shall give 10 days' notice of the hearing to title insurance companies to whom participation receipts were issued for an assessment made for the benefit of the released title insurance company. The association and title insurance companies are entitled to appear at and participate in the hearing.

(e) Money recovered against an impaired title insurance company under this section shall be repaid to the title insurance companies that paid assessments in relation to the impaired title insurance company on return of the participation receipt. (V.T.I.C. Art. 9.48, Secs. 13, 23(i).)

Sec. 2602.402. DISTRIBUTIONS TO SHAREHOLDERS AND AFFILIATES. (a) An impaired or insolvent title insurance company may not make a distribution to shareholders until the association has recovered the total amount of valid claims for money spent in exercising the association's powers and performing the association's duties under this chapter with respect to that company, plus interest on that amount.

(b) Except as otherwise provided by this section, the receiver appointed under an order of receivership of a title insurance company domiciled in this state may recover on behalf of the company from an affiliate that controlled the company the amount of a distribution, other than a stock dividend the company paid on its common stock, made during the five years preceding the date of the petition for liquidation or rehabilitation.

(c) A person who was an affiliate that controlled the title insurance company when the distribution described by Subsection (b) was paid is liable for the amount of the distribution received. A person who was an affiliate that controlled the title insurance company when the distribution was declared is liable for the amount of the distribution the affiliate would have received if the distribution had been paid immediately. Two or more persons liable for the same distribution are jointly and severally liable. If a person liable under this subsection is insolvent, all of the affiliates that controlled the insolvent person when the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent person.

(d) The maximum amount recoverable under Subsections (b) and (c) is the amount needed in excess of all other available assets of the insolvent title insurance company to pay the company's contractual obligations.

(e) The receiver may not recover a distribution under Subsection (b) if the title insurance company shows that:

(1) the distribution was lawful and reasonable on the date of payment; and

(2) the company did not know and could not reasonably have known that the distribution might adversely affect the ability of the company to fulfill its contractual obligations. (V.T.I.C. Art. 9.48, Secs. 23(c), (d), (e), (f), (g), (h).)

Sec. 2602.403. ASSETS ATTRIBUTABLE TO COVERED POLICIES. (a) For the purposes of this section, assets attributable to covered policies are the proportion of the assets that the reserves that should have been established for the covered policies bear to the reserves that should have been established for all insurance policies written by the impaired or insolvent title insurance company.

(b) To perform its obligations under this chapter, the association is considered a creditor of the impaired or insolvent title insurance company to the extent of assets attributable to covered policies, less any amount that the association recovers as a subrogee under this chapter.

(c) Assets of the impaired or insolvent title insurance company attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the

impaired or insolvent company as required by this chapter. (V.T.I.C. Art. 9.48, Sec. 23(b).)

[Chapters 2603-2650 reserved for expansion]

SUBTITLE D. TITLE INSURANCE PROFESSIONALS

CHAPTER 2651. TITLE INSURANCE AGENTS AND DIRECT OPERATIONS

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[Sections 2651.012-2651.050 reserved for expansion]

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CHAPTER 2651. TITLE INSURANCE AGENTS AND DIRECT OPERATIONS

SUBCHAPTER A. TITLE INSURANCE AGENT'S LICENSE

Sec. 2651.001. LICENSE AND BOND OR DEPOSIT REQUIRED. (a) An individual, firm, association, or corporation may not act in this state as a title insurance agent for a title insurance company unless the individual or entity:

(1) holds a license as an agent issued by the department; and

(2) maintains a surety bond or deposit required under Subchapter C.

(b) A title insurance company may not allow or permit an

individual, firm, association, or corporation to act as its agent in this state unless the individual or entity complies with this section. (V.T.I.C. Art. 9.35.)

Sec. 2651.002. LICENSE APPLICATION. (a) Before an initial license is issued to an individual, firm, association, or corporation to act as an agent in this state for a title insurance company, the company must file an application for an agent's license with the department on forms provided by the department.

(b) The application must be:

(1) accompanied by a nonrefundable license fee; and

(2) signed and sworn to by the title insurance company and by the proposed agent.

(c) The completed application must state that:

(1) the proposed agent is:

(A) an individual who is a bona fide resident of this state;

(B) an association or firm composed only of Texas residents; or

(C) a Texas corporation or a foreign corporation authorized to engage in business in this state;

(2) the proposed agent, including a corporation's managerial personnel, if applicable, has reasonable experience or instruction in the field of title insurance;

(3) the title insurance company:

(A) knows that the proposed agent has a good business reputation and is worthy of the public trust; and

(B) is unaware of any fact or condition that

disqualifies the proposed agent from receiving a license; and

(4) the proposed agent qualifies as a title insurance agent under this chapter. (V.T.I.C. Art. 9.36, Sec. 1(a) (part).)

Sec. 2651.003. LICENSE AND RENEWAL FEES. (a) The department shall prescribe the license fee in an amount not to exceed $50.

(b) License fees, and renewal fees collected under this subchapter, shall be deposited to the credit of the Texas Department of Insurance operating account to be used by the department to enforce this chapter and any other law of this state that regulates title insurance agents. (V.T.I.C. Art. 9.36, Sec. 1(a) (part).)

Sec. 2651.004. LICENSE ISSUANCE. The department shall issue a license if the department determines, based on the application and the department's investigation, that the requirements of Section 2651.002 are satisfied. (V.T.I.C. Art. 9.36, Sec. 1(b).)

Sec. 2651.005. DUPLICATE LICENSE. (a) The department shall collect in advance a fee from a title insurance agent who requests a duplicate license.

(b) The department shall prescribe the fee in an amount not to exceed $20. (V.T.I.C. Art. 9.36, Sec. 1(c).)

Sec. 2651.006. LICENSE TERM. Unless a system of staggered license renewal is adopted under Section 4003.002, a license issued under this subchapter expires on June 1 after the second anniversary of the date of issuance. (V.T.I.C. Art. 9.36, Sec. 2(b).)

Sec. 2651.007. LICENSE RENEWAL. (a) A title insurance agent may renew a license by:

(1) filing a completed license renewal application form with the department; and

(2) paying the nonrefundable license renewal fee to the department.

(b) The department shall prescribe the license renewal application form.

(c) The department shall prescribe the license renewal fee in an amount not to exceed $50. (V.T.I.C. Art. 9.36, Sec. 2(a).)

Sec. 2651.008. RECORDS OF AGENTS. The department shall maintain a record of the name and address of each title insurance agent licensed by the department in a manner that ensures that the agents appointed by any company authorized to engage in the business of title insurance in this state may be conveniently ascertained and inspected by any person on request. (V.T.I.C. Art. 9.36, Sec. 2(c).)

Sec. 2651.009. MULTIPLE APPOINTMENTS. (a) A licensed title insurance agent may be appointed to represent additional title insurance companies.

(b) Any additional title insurance company must notify the department of the appointment in the manner prescribed by the department. The agent must include with the notice a nonrefundable fee for each additional appointment. The department shall prescribe the fee in an amount not to exceed $16.

(c) The appointment is effective on the eighth day following the date the department receives the completed notice of

appointment and the fee, unless the department rejects the appointment. If the department rejects the appointment, the department shall state in writing the reasons for rejection not later than the seventh day after the date on which the department receives the completed notice of appointment.

(d) A title insurance company may not permit an agent appointed by the company to write, sign, or deliver title insurance until the agent's appointment is effective.

(e) The appointment remains effective, without the necessity of renewal, until the appointment:

(1) is terminated by the title insurance company as provided by this section; or

(2) is otherwise terminated under this subchapter.

(f) A renewal license issued to an agent authorizes the agent to represent and act for the title insurance companies for which the agent holds appointments until the appointments are terminated, and the agent is considered to be the agent of the appointing companies for purposes of this subchapter.

(g) When a title insurance company terminates the appointment of an agent, the company shall immediately file with the department a statement that contains:

(1) the facts relating to the termination of the appointment; and

(2) the effective date and reason for the termination.

(h) On receipt of the statement, the department shall terminate the appointment of the agent to represent that title insurance company in this state. (V.T.I.C. Art. 9.36, Secs. 3(a),

(b), (c).)

Sec. 2651.010. SUSPENSION OF LICENSE. The department shall suspend the license of a title insurance agent during any period in which the agent does not have a valid appointment. The department shall end the suspension when the department receives an acceptable notice of a valid appointment. (V.T.I.C. Art. 9.36, Sec. 4.)

Sec. 2651.011. PRIVILEGED COMMUNICATIONS. Any information, including a document, record, or statement, required to be made or disclosed to the department under this subchapter, other than Section 2651.001, is:

(1) a privileged communication; and

(2) not admissible in evidence in a court action or proceeding except under a subpoena issued by a court of record. (V.T.I.C. Art. 9.36, Sec. 3(d).)

[Sections 2651.012-2651.050 reserved for expansion]

SUBCHAPTER B. DIRECT OPERATION LICENSE

Sec. 2651.051. LICENSE REQUIRED. (a) A title insurance company may not own or lease and operate an abstract plant or participate in a bona fide joint abstract plant operation in a county in this state unless the company holds a license as a direct operation issued by the department for that county.

(b) A title insurance company may not write, sign, or deliver title insurance in a county in which the company operates an abstract plant until the department has issued a direct operation license to the company. (V.T.I.C. Art. 9.36A, Secs. A, C (part).)

Sec. 2651.052. LICENSE APPLICATION. (a) Before a direct operation license is issued to a title insurance company, the

company must file an application for a direct operation license on forms provided by the department.

(b) The application must be:

(1) accompanied by a nonrefundable license fee; and

(2) signed and sworn to by the title insurance company.

(c) The completed application must state that:

(1) the title insurance company is a Texas corporation or a foreign corporation holding a certificate of authority to insure titles to real property in this state and meets the requirements of this title; and

(2) the abstract plant to be licensed:

(A) complies with department requirements relating to abstract plants; and

(B) has been approved by the department. (V.T.I.C. Art. 9.36A, Sec. B (part).)

Sec. 2651.053. LICENSE AND RENEWAL FEES. (a) The department shall prescribe the license fee in an amount not to exceed $50.

(b) License fees, and renewal fees collected under this subchapter, shall be deposited to the credit of the Texas Department of Insurance operating account to be used by the department to enforce this chapter and the laws of this state that regulate title insurance agents and title insurance companies. (V.T.I.C. Art. 9.36A, Sec. B (part).)

Sec. 2651.054. LICENSE TERM. Unless a system of staggered license renewal is adopted, a license issued under this subchapter

expires on the second June 1 following the date of issuance. (V.T.I.C. Art. 9.36A, Sec. C (part).)

Sec. 2651.055. LICENSE RENEWAL. (a) On or before the expiration date of a license issued under this subchapter, a title insurance company may renew the license by:

(1) certifying to the department each county and address at which the company operates the abstract plant for each license to be renewed;

(2) filing a completed renewal application; and

(3) paying a nonrefundable license renewal fee for each license.

(b) The department shall provide the forms used under this section.

(c) The department shall prescribe the license renewal fee in an amount not to exceed $50.

(d) If a license has been expired for 90 days or less, the license holder may renew the license by paying to the department the required nonrefundable renewal fee and a nonrefundable fee equal to one-half of the original license fee.

(e) If a license has been expired for more than 90 days, the license may not be renewed. (V.T.I.C. Art. 9.36A, Sec. C (part).)

Sec. 2651.056. CEASING OPERATION OF ABSTRACT PLANT; REQUEST FOR LICENSE CANCELLATION. If a title insurance company ceases to operate a licensed abstract plant, the company shall immediately notify the department in writing and request cancellation of the license. (V.T.I.C. Art. 9.36A, Sec. C (part).)

Sec. 2651.057. AUTOMATIC TERMINATION OF LICENSES. If a

title insurance company surrenders the company's certificate of authority or if the certificate of authority is revoked by the department, all licenses of the company's abstract plants automatically terminate. (V.T.I.C. Art. 9.36A, Sec. C (part).)

Sec. 2651.058. RECORDS OF DIRECT OPERATIONS. The department shall maintain a record of the county and address of each location at which a title insurance company operates an abstract plant in a manner that ensures that the abstract plants may be conveniently ascertained and inspected by any person on request. (V.T.I.C. Art. 9.36A, Sec. C (part).)

Sec. 2651.059. USE OF AGENTS NOT PROHIBITED. This subchapter does not prohibit a title insurance company from issuing title insurance through a licensed title insurance agent. (V.T.I.C. Art. 9.36A, Sec. C (part).)

[Sections 2651.060-2651.100 reserved for expansion]

SUBCHAPTER C. BOND AND DEPOSIT REQUIREMENTS

Sec. 2651.101. BOND REQUIRED. (a) Each licensed title insurance agent and direct operation shall make, file, and pay for a surety bond payable to the department and issued by a corporate surety company authorized to write surety bonds in this state. The bond shall obligate the principal and surety to pay for any pecuniary loss sustained by:

(1) any participant in an insured real property transaction through an act of fraud, dishonesty, theft, embezzlement, or wilful misapplication by a title insurance agent or direct operation; or

(2) the department as a result of any administrative

expense incurred in a receivership of a title insurance agent or direct operation.

(b) The amount of the bond must be the greater of:

(1) $10,000; or

(2) an amount equal to 10 percent of the gross premium written by the title insurance agent or direct operation in accordance with the latest statistical report to the department but not to exceed $100,000. (V.T.I.C. Art. 9.38, Sec. (a) (part).)

Sec. 2651.102. ALTERNATIVE TO BOND. (a) Instead of the bond required by Section 2651.101, a title insurance agent or direct operation may deposit with the department:

(1) cash;

(2) irrevocable letters of credit issued by a financial institution in this state that is insured by an agency of the United States; or

(3) securities approved by the department.

(b) The cash, letters of credit, or securities deposited under this section are subject to the conditions required for a bond under Section 2651.101. (V.T.I.C. Art. 9.38, Sec. (a) (part).)

Sec. 2651.103. EXAMINATION OF LOSS COVERED BY BOND OR DEPOSIT. (a) At any time it appears that a loss covered by a bond or deposit has occurred, the department may require the title insurance agent or direct operation to appear in Travis County, with records the department determines to be proper, for an examination.

(b) The department shall specify a date for the examination

that is not earlier than the 10th day or later than the 15th day after the date of service of notice of the requirement to appear.

(c) If after the examination the department determines that a loss covered by the bond or deposit has occurred, the department shall immediately notify the surety on the bond, if applicable, and prepare a written statement of the facts of the loss and deliver the statement to the attorney general. (V.T.I.C. Art. 9.38, Sec. (b) (part).)

Sec. 2651.104. INVESTIGATION BY ATTORNEY GENERAL. (a) On receipt of a written statement under Section 2651.103, the attorney general shall investigate the charges and, on determining that a loss covered by the bond or deposit has occurred, shall enforce the liability by collecting against the deposited cash or securities or by filing suit on the bond.

(b) A suit brought under this section shall be filed in the name of the department in Travis County for the benefit of all parties who have suffered any loss covered by the bond or deposit. (V.T.I.C. Art. 9.38, Sec. (b) (part).)

[Sections 2651.105-2651.150 reserved for expansion]

SUBCHAPTER D. ANNUAL AUDIT

Sec. 2651.151. ANNUAL AUDIT OF TRUST FUND ACCOUNTS: TITLE INSURANCE AGENTS AND DIRECT OPERATIONS. (a) Each title insurance agent and direct operation shall have an annual audit made of trust fund accounts. The agent or direct operation shall pay for the audit.

(b) Not later than the 90th day after the date of the end of the agent's or direct operation's fiscal year, the agent or direct

operation shall send by certified mail, postage prepaid, to the department one copy of the audit report with a transmittal letter. The agent shall also send a copy of the audit report and transmittal letter to each title insurance company that the agent represents. (V.T.I.C. Art. 9.39, Sec. (a).)

Sec. 2651.152. ANNUAL AUDIT OF TRUST FUND ACCOUNTS: TITLE INSURANCE COMPANIES. (a) Each title insurance company shall have an annual audit made of trust fund accounts for each county in which it operates in its own name. The company shall pay for the audit.

(b) Not later than the 90th day after the date of the end of the title insurance company's fiscal year, the company shall send by certified mail, postage prepaid, to the department one copy of the audit report. (V.T.I.C. Art. 9.39, Sec. (b).)

Sec. 2651.153. RULES. The commissioner by rule shall adopt:

(1) the standards for an audit; and

(2) the form of the required audit report. (V.T.I.C. Art. 9.39, Sec. (c).)

Sec. 2651.154. PERFORMANCE OF AUDIT BY PUBLIC ACCOUNTANT. An audit required under this subchapter must be performed by an independent certified public accountant or licensed public accountant, or a firm composed of either. (V.T.I.C. Art. 9.39, Sec. (d).)

Sec. 2651.155. CONFIDENTIALITY OF AUDIT. The commissioner may classify an audit report that is filed with the department by a title insurance company under this subchapter as confidential and privileged. (V.T.I.C. Art. 9.39, Sec. (f).)

Sec. 2651.156. FAILURE TO RECEIVE AUDIT REPORT FROM AGENTS OR DIRECT OPERATIONS. If a title insurance company fails to receive an audit report from any of the company's agents or direct operations in the specified period required by Section 2651.151, the company shall report that failure to the department not later than the 30th day after the expiration of the specified period. (V.T.I.C. Art. 9.39, Sec. (e).)

Sec. 2651.157. ENFORCEMENT; HEARING. (a) After notice and hearing, the department may revoke the license or certificate of authority of a title insurance agent, direct operation, or title insurance company that:

(1) fails to furnish an audit report in the time required; or

(2) furnishes an audit report that reveals any irregularity, including a shortage, or any practice not in keeping with sound, honest business practices.

(b) The notice must be provided to the agent, the direct operation, or each title insurance company involved.

(c) At a hearing under this section, the agent, direct operation, or title insurance company may offer evidence explaining or excusing a failure or irregularity. (V.T.I.C. Art. 9.39, Sec. (g).)

[Sections 2651.158-2651.200 reserved for expansion]

SUBCHAPTER E. GENERAL REGULATION OF TITLE INSURANCE AGENTS AND DIRECT OPERATIONS

Sec. 2651.201. LICENSE SURRENDER OR FORFEITURE. (a) A title insurance agent or direct operation may voluntarily surrender

at any time a license issued under this chapter by giving notice to:

(1) the department; and

(2) the affected title insurance company.

(b) A title insurance agent or direct operation that terminates the agency contract with a title insurance company automatically forfeits the license under that company.

(c) A surrender or forfeiture of a license under this section does not affect the culpability of the license holder for conduct committed before the effective date of the surrender or forfeiture. The department may institute a disciplinary proceeding against the former license holder for conduct committed before the effective date of the surrender or forfeiture. (V.T.I.C. Art. 9.37, Secs. A, F.)

Sec. 2651.202. TRUST FUND ACCOUNT DISBURSEMENTS. (a) A title insurance company, title insurance agent, or direct operation may not disburse funds from a trust fund account until good funds related to the transaction have been received and deposited in the account in amounts sufficient to fund any disbursements from the transaction.

(b) A title insurance company, title insurance agent, or direct operation is not liable for a violation of this section if the violation:

(1) was not intentional; and

(2) resulted from a bona fide error despite the maintenance of procedures reasonably adopted to avoid the error.

(c) The commissioner shall adopt rules and definitions to implement this section. (V.T.I.C. Art. 9.39A, Secs. (a) (part),

(b), (c) (part).)

Sec. 2651.203. DISCLOSURE OF OWNERSHIP AND PREMIUM INFORMATION. (a) A title insurance agent who receives a portion of a premium shall disclose to each purchaser of a title insurance policy or other title insurance form the following:

(1) each shareholder, owner, or partner owning or controlling at least one percent of the agent;

(2) each shareholder, owner, or partner owning or controlling at least 10 percent of an entity that owns or controls at least one percent of the agent;

(3) each person who is not a full-time employee of the agent and who receives a portion of the premium for services performed on behalf of the agent in connection with the issuance of a title insurance form; and

(4) the amount of premium that a person disclosed in Subdivision (3) receives.

(b) The department shall prescribe the form of the disclosure required by this section. (V.T.I.C. Art. 9.38, Sec. (c).)

Sec. 2651.204. CONTINUING EDUCATION. (a) To protect the public and to preserve and improve the competence of license holders, the department shall require as a condition of holding a title insurance agent license that the license holder enroll in and attend or teach continuing education consisting of class instruction, lectures, seminars, or other forms of education approved by the department for title insurance agents.

(b) The department shall prescribe the required number of

hours of continuing education, not to exceed 15 hours in each two-year license period.

(c) Continuing education instruction must be designed to refresh the license holder's understanding of:

(1) basic principles and coverages relating to title insurance;

(2) recent and prospective changes in those principles and coverages;

(3) applicable rules of the commissioner and laws;

(4) the proper conduct of the license holder's business; and

(5) the duties and responsibilities of the license holder.

(d) The department may permit a license holder to complete an equivalent course of study and instruction by mail if, because of the remote location of the license holder's residence or business, the license holder is unable to attend educational sessions with reasonable convenience.

(e) On written request by the license holder, the department may extend the time for the license holder to comply with the requirements of this section or may exempt the license holder from all or part of the requirements for a license period if the department determines that the license holder is unable to comply with the requirements because of illness, medical disability, or another extenuating circumstance beyond the control of the license holder. The commissioner shall prescribe the criteria for an extension or exemption by rule.

(f) The commissioner shall adopt rules to administer this section. (V.T.I.C. Art. 9.58, Secs. A (part), B, C, D, E.)

[Sections 2651.205-2651.250 reserved for expansion]

SUBCHAPTER F. TITLE INSURANCE COMPANY POWERS AND DUTIES REGARDING TITLE INSURANCE AGENTS

Sec. 2651.251. EXAMINATION OF TRUST FUND ACCOUNTS BY TITLE INSURANCE COMPANY. (a) A title insurance company may examine, at any time, the trust fund accounts and related records of the company's title insurance agents through the company's examiners or auditors or through independent certified public accountants commissioned by the company.

(b) The title insurance company shall pay for each examination. (V.T.I.C. Art. 9.40 (part).)

Sec. 2651.252. SPECIAL REPORTS. A title insurance company may require special reports from the company's title insurance agents regarding any of its transactions. (V.T.I.C. Art. 9.40 (part).)

Sec. 2651.253. AUDIT OF UNUSED FORMS. (a) A title insurance company shall periodically audit the unused forms in the possession of each of the company's title insurance agents to determine that all used forms have been reported to the company.

(b) A title insurance company shall conduct an audit required by this section at least once every two years.

(c) A report of each audit conducted under this section shall be made to the department. (V.T.I.C. Art. 9.40 (part).)

[Sections 2651.254-2651.300 reserved for expansion]

SUBCHAPTER G. LICENSE DENIAL AND DISCIPLINARY ACTION

Sec. 2651.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION. The department may deny an application for a license or discipline a title insurance agent or direct operation under Sections 4005.102, 4005.103, and 4005.104 if the department determines that the applicant or license holder has:

(1) wilfully violated this title;

(2) intentionally made a material misstatement in the license application;

(3) obtained or attempted to obtain the license by fraud or misrepresentation;

(4) misappropriated or converted to the applicant's or license holder's own use or illegally withheld money belonging to a title insurance company, an insured, or another person;

(5) been guilty of fraudulent or dishonest practices;

(6) materially misrepresented the terms and conditions of a title insurance policy or contract; or

(7) failed to maintain:

(A) a separate and distinct accounting of escrow funds; and

(B) an escrow bank account or accounts separate and apart from all other accounts. (V.T.I.C. Art. 9.37, Sec. B.)

Sec. 2651.302. LICENSE APPLICATION AFTER DENIAL, REFUSAL, OR REVOCATION. (a) An applicant whose license application has been denied or refused or a license holder whose license has been revoked under this subchapter may not file another application for a license as a title insurance agent or direct operation before the first anniversary of:

(1) the effective date of the denial, refusal, or revocation; or

(2) the date of a final court order affirming the denial, refusal, or revocation if judicial review is sought.

(b) A license application filed after the time required by this section may be denied by the department unless the applicant shows good cause why the denial, refusal, or revocation should not be a bar to the issuance of a license. (V.T.I.C. Art. 9.37, Sec. D.)

CHAPTER 2652. ESCROW OFFICERS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 2652.007-2652.050 reserved for expansion]

SUBCHAPTER B. LICENSE APPLICATION AND RENEWAL

[Sections 2652.059-2652.100 reserved for expansion]

CHAPTER 2652. ESCROW OFFICERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2652.001. LICENSE AND BOND OR DEPOSIT REQUIRED. An individual may not act as an escrow officer unless the individual:

(1) holds a license issued by the department; and

(2) maintains a surety bond or deposit required under Subchapter C. (V.T.I.C. Art. 9.41, Sec. A (part); New.)

Sec. 2652.002. EMPLOYMENT OF ESCROW OFFICER. (a) A title

insurance agent or direct operation may not employ an individual as an escrow officer unless the individual holds a license and maintains a surety bond or deposit as required by this chapter.

(b) A title insurance agent or direct operation may not permit an individual to act as an escrow officer in this state before the agent or direct operation has complied with Sections 2652.151 and 2652.152 with respect to the individual. (V.T.I.C. Art. 9.41, Sec. A (part); Art. 9.42, Sec. 1(a) (part); New.)

Sec. 2652.003. ATTORNEY ACTING AS ESCROW OFFICER. (a) Notwithstanding Section 2652.001, an attorney is not required to be licensed as an escrow officer to perform the duties of an escrow officer as defined by Section 2501.003.

(b) An attorney may hold a license to act as an escrow officer. An employee of an attorney licensed as an escrow officer also may hold a license to act as an escrow officer. An attorney licensed as an escrow officer shall comply with the provisions of this code that apply to escrow officers and trust funds as if the attorney were a title insurance agent.

(c) Notwithstanding any other provision of this chapter, a title insurance company or title insurance agent may not permit an attorney to conduct the attorney's business in the name of the company or agent unless the attorney and the attorney's bona fide employees who close transactions are licensed escrow officers. (V.T.I.C. Art. 9.41, Secs. B, C.)

Sec. 2652.004. TRUST FUND ACCOUNT DISBURSEMENTS. (a) An escrow officer may not disburse funds from a trust fund account until good funds related to the transaction have been received and

deposited in the account in amounts sufficient to fund any disbursements from the transaction.

(b) An escrow officer is not liable for a violation of this section if the violation:

(1) was not intentional; and

(2) resulted from a bona fide error despite the maintenance of procedures reasonably adopted to avoid the error.

(c) The commissioner shall adopt rules and definitions to implement this section. (V.T.I.C. Art. 9.39A, Secs. (a) (part), (b), (c) (part).)

Sec. 2652.005. ESCROW ACCOUNT AUDIT. Each escrow account used by a licensed escrow officer for closing a transaction is subject to the audit requirements of Subchapter D, Chapter 2651. (V.T.I.C. Art. 9.41, Sec. D.)

Sec. 2652.006. RECORD OF ESCROW OFFICERS. The department shall maintain a record of the name and address of each escrow officer licensed by the department in a manner that ensures that the escrow officers employed by any title insurance agent or direct operation in this state may be conveniently determined. (V.T.I.C. Art. 9.42, Sec. 1(c).)

[Sections 2652.007-2652.050 reserved for expansion]

SUBCHAPTER B. LICENSE APPLICATION AND RENEWAL

Sec. 2652.051. LICENSE APPLICATION. (a) Before an initial license is issued to an individual to act as an escrow officer in this state for a title insurance agent or direct operation, the title insurance agent or direct operation must file an application for an escrow officer's license with the department on forms

provided by the department.

(b) The application must be:

(1) accompanied by a nonrefundable license fee; and

(2) signed and sworn to by the title insurance agent or direct operation and by the proposed escrow officer.

(c) The completed application must state that:

(1) the proposed escrow officer is an individual who is a bona fide resident of this state;

(2) the proposed escrow officer is an attorney or is a bona fide employee of:

(A) an attorney licensed as an escrow officer; or

(B) a title insurance agent or direct operation;

(3) the proposed escrow officer has reasonable experience or instruction in the field of title insurance; and

(4) the title insurance agent or direct operation does not know of any fact or condition that disqualifies the proposed escrow officer from receiving a license. (V.T.I.C. Art. 9.43, Secs. A (part), B.)

Sec. 2652.052. LICENSE AND RENEWAL FEES. (a) The department shall prescribe the license fee in an amount not to exceed $50.

(b) License fees, and renewal fees collected under Section 2652.152, shall be deposited to the credit of the Texas Department of Insurance operating account to be used by the department to enforce this chapter and any other law of this state that regulates escrow officers for title insurance agents or direct operations. (V.T.I.C. Art. 9.43, Sec. A (part).)

Sec. 2652.053. LICENSE ISSUANCE. The department shall issue a license if the department determines, based on the application and the department's investigation, that the requirements of Section 2652.051 are satisfied. (V.T.I.C. Art. 9.43, Sec. C.)

Sec. 2652.054. DUPLICATE LICENSE. (a) The department shall collect in advance a fee from a title insurance agent or direct operation that requests a duplicate license.

(b) The department shall prescribe the fee in an amount not to exceed $20. (V.T.I.C. Art. 9.43, Sec. D.)

Sec. 2652.055. LICENSE TERM. Unless a system of staggered license renewal is adopted under Section 4003.002, a license expires on the second June 1 following the date of issuance. (V.T.I.C. Art. 9.42, Sec. 1(b) (part).)

Sec. 2652.056. AUTOMATIC TERMINATION OF LICENSE. The license of each escrow officer employed by a title insurance agent or direct operation that surrenders its license or has its license revoked by the department is automatically terminated without notice. (V.T.I.C. Art. 9.42, Sec. 1(b) (part).)

Sec. 2652.057. LICENSE SURRENDER OR FORFEITURE. (a) An escrow officer may voluntarily surrender the escrow officer's license at any time by giving notice to the department.

(b) An escrow officer automatically forfeits the escrow officer's license if the officer is not employed as an escrow officer.

(c) A surrender or forfeiture of a license under this section does not affect the culpability of the license holder for

conduct committed before the effective date of the surrender or forfeiture. The department may institute a disciplinary proceeding against the former license holder for conduct committed before the effective date of the surrender or forfeiture. (V.T.I.C. Art. 9.44, Secs. 1, 6.)

Sec. 2652.058. CONTINUING EDUCATION. (a) To protect the public and to preserve and improve the competence of license holders, the department shall require as a condition of holding an escrow officer license that the license holder enroll in and attend or teach continuing education consisting of class instruction, lectures, seminars, or other forms of education approved by the department for escrow officers.

(b) The department shall prescribe the required number of hours of continuing education, not to exceed 15 hours in each two-year license period.

(c) Continuing education instruction must be designed to refresh the license holder's understanding of:

(1) basic principles and coverages relating to title insurance;

(2) recent and prospective changes in those principles and coverages;

(3) applicable rules of the commissioner and laws;

(4) the proper conduct of the license holder's business; and

(5) the duties and responsibilities of the license holder.

(d) The department may permit a license holder to complete

an equivalent course of study and instruction by mail if, because of the remote location of the license holder's residence or business, the license holder is unable to attend educational sessions with reasonable convenience.

(e) On written request by the license holder, the department may extend the time for the license holder to comply with the requirements of this section or may exempt the license holder from all or part of the requirements for a license period if the department determines that the license holder is unable to comply with the requirements because of illness, medical disability, or another extenuating circumstance beyond the control of the license holder. The commissioner shall prescribe the criteria for an extension or exemption by rule.

(f) The commissioner shall adopt rules to administer this section. (V.T.I.C. Art. 9.58, Secs. A (part), B, C, D, E.)

[Sections 2652.059-2652.100 reserved for expansion]

SUBCHAPTER C. BOND AND DEPOSIT REQUIREMENTS

Sec. 2652.101. BOND REQUIRED. (a) A title insurance agent or direct operation shall obtain, at its own expense, a bond for its escrow officers payable to the department. The bond shall obligate the principal and surety to pay for any pecuniary loss sustained by the title insurance agent or direct operation through an act of fraud, dishonesty, forgery, theft, embezzlement, or wilful misapplication by an escrow officer, either directly and alone or in conspiracy with another person.

(b) The bond must be:

(1) of a type approved by the department; and

(2) issued by a surety licensed by the department to do business in this state. (V.T.I.C. Art. 9.45, Sec. (a) (part).)

Sec. 2652.102. ALTERNATIVE TO BOND. (a) Instead of the bond required by Section 2652.101, a title insurance agent or direct operation may deposit with the department:

(1) cash;

(2) irrevocable letters of credit issued by a financial institution insured by an agency of the United States; or

(3) securities approved by the department.

(b) The cash, letters of credit, or securities deposited under this section are subject to the conditions required for a bond under Section 2652.101. (V.T.I.C. Art. 9.45, Sec. (a) (part).)

Sec. 2652.103. AMOUNT OF BOND OR DEPOSIT. The amount of the bond or deposit required under this subchapter is determined by multiplying the number of escrow officers employed by the title insurance agent or direct operation by $5,000, except that the maximum amount of the bond or deposit required under this subchapter is $50,000. (V.T.I.C. Art. 9.45, Sec. (a) (part).)

Sec. 2652.104. EXAMINATION OF LOSS COVERED BY BOND OR DEPOSIT. (a) At any time it appears that a loss covered by a bond or deposit has occurred, the department may require the escrow officer to appear in Travis County, with records the department determines to be proper, for an examination.

(b) The department shall specify a date for the examination that is not earlier than the 10th day or later than the 15th day after the date of service of notice of the requirement to appear. Copies of the notice shall be sent to any title insurance agent or

direct operation concerned.

(c) If after the examination the department determines that a loss covered by the bond or deposit has occurred, the department shall immediately notify the appropriate title insurance agent or direct operation and the surety on the bond, if applicable, and prepare a written statement of the facts of the loss and deliver the statement to the attorney general. (V.T.I.C. Art. 9.45, Sec. (b) (part).)

Sec. 2652.105. INVESTIGATION BY ATTORNEY GENERAL. (a) On receipt of a written statement under Section 2652.104, the attorney general shall investigate the charges and, on determining that a loss covered by the bond or deposit has occurred, shall enforce the liability by collecting against the deposited cash or securities or by filing suit on the bond.

(b) A suit brought under this section shall be filed in the name of the department in Travis County for the benefit of all parties who have suffered any loss covered by the bond or deposit. (V.T.I.C. Art. 9.45, Sec. (b) (part).)

[Sections 2652.106-2652.150 reserved for expansion]

SUBCHAPTER D. DUTIES OF TITLE INSURANCE AGENTS AND DIRECT OPERATIONS REGARDING ESCROW OFFICERS

Sec. 2652.151. LIST OF ESCROW OFFICERS. (a) A title insurance agent or direct operation shall certify to the department, not later than the expiration date of the title insurance agent's or direct operation's license, the name and address of each individual employed by the title insurance agent or direct operation to serve as an escrow officer in this state.

(b) The certification required by this section must be on a form provided by the department. (V.T.I.C. Art. 9.42, Sec. 1(a) (part).)

Sec. 2652.152. RENEWAL. A title insurance agent or direct operation shall apply for renewal and pay a nonrefundable license renewal fee prescribed by the department in an amount not to exceed $50 for each escrow officer listed by the title insurance agent or direct operation under Section 2652.151. (V.T.I.C. Art. 9.42, Sec. 1(a) (part).)

Sec. 2652.153. NOTICE OF TERMINATION. A title insurance agent or direct operation that terminates the employment of a licensed escrow officer shall:

(1) immediately notify the department in writing of the termination and request cancellation of the license; and

(2) notify the escrow officer of the action by the title insurance agent or direct operation. (V.T.I.C. Art. 9.42, Sec. 1(a) (part).)

[Sections 2652.154-2652.200 reserved for expansion]

SUBCHAPTER E. LICENSE DENIAL AND DISCIPLINARY ACTION

Sec. 2652.201. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION. The department may deny an application for a license or discipline an escrow officer under Sections 4005.102, 4005.103, and 4005.104 if the department determines that the applicant or license holder has:

(1) wilfully violated this title;

(2) intentionally made a material misstatement in the license application;

(3) obtained or attempted to obtain the license by fraud or misrepresentation;

(4) misappropriated or converted to the escrow officer's own use or illegally withheld money belonging to a title insurance agent, direct operation, or another person;

(5) been guilty of fraudulent or dishonest practices;

(6) materially misrepresented the terms and conditions of a title insurance policy or contract; or

(7) failed to complete all educational requirements. (V.T.I.C. Art. 9.44, Sec. 2.)

Sec. 2652.202. LICENSE APPLICATION AFTER DENIAL, REFUSAL, OR REVOCATION. (a) An applicant whose license application has been denied or refused or a license holder whose license has been revoked under this subchapter may not file another application for a license as an escrow officer before the first anniversary of:

(1) the effective date of the denial, refusal, or revocation; or

(2) the date of a final court order affirming the denial, refusal, or revocation if judicial review is sought.

(b) A license application filed after the time required by this section may be denied by the department unless the applicant shows good cause why the denial, refusal, or revocation should not be a bar to the issuance of a license. (V.T.I.C. Art. 9.44, Sec. 4.)

[Chapters 2653-2700 reserved for expansion]

SUBTITLE E. THE BUSINESS OF TITLE INSURANCE

CHAPTER 2701. GENERAL PROVISIONS

Sec. 2701.001. ABSTRACT OF TITLE DISTINGUISHED; PROHIBITION

ON REGULATION OF ABSTRACT OF TITLE

Sec. 2701.002. CONSTRUCTION OF CHAPTER 39, BUSINESS & COMMERCE CODE

CHAPTER 2701. GENERAL PROVISIONS

Sec. 2701.001. ABSTRACT OF TITLE DISTINGUISHED; PROHIBITION ON REGULATION OF ABSTRACT OF TITLE. (a) In this section, "commitment for title insurance" means a title insurance form under which a title insurance company offers to issue a title insurance policy subject to stated exceptions, requirements, and terms. The term includes a mortgagee title policy binder on an interim construction loan.

(b) A commitment for title insurance constitutes a statement of the terms and conditions on which a title insurance company is willing to issue its policy. A title insurance policy or other title insurance form constitutes a statement of the terms and conditions of the indemnity under the policy or form.

(c) An abstract of title prepared from an abstract plant for a chain of title to real property described in the abstract of title is not title insurance, a commitment for title insurance, or any other title insurance form. A commitment for title insurance, title insurance policy, or other title insurance form is not an abstract of title.

(d) The commissioner may not adopt rules relating to abstracts of title. (V.T.I.C. Art. 9.07B.)

Sec. 2701.002. CONSTRUCTION OF CHAPTER 39, BUSINESS & COMMERCE CODE. Chapter 39, Business & Commerce Code, is a consumer protection law when construed in connection with a title insurance

policy issued in this state. (V.T.I.C. Art. 9.50.)

CHAPTER 2702. CLOSING AND SETTLEMENT

SUBCHAPTER A. INSURED CLOSING AND SETTLEMENT LETTERS

Sec. 2702.001. INSURED CLOSING AND SETTLEMENT LETTER: LOANS

Sec. 2702.002. INSURED CLOSING AND SETTLEMENT LETTER: CERTAIN BUYERS OR SELLERS

Sec. 2702.003. EFFECT OF FAILURE TO ISSUE INSURED CLOSING AND SETTLEMENT LETTER

[Sections 2702.004-2702.050 reserved for expansion]

SUBCHAPTER B. UNIFORM CLOSING AND SETTLEMENT STATEMENTS

Sec. 2702.051. APPLICABILITY

Sec. 2702.052. DUTY TO PRESCRIBE UNIFORM CLOSING AND SETTLEMENT STATEMENT FORMS

Sec. 2702.053. CONTENT OF CLOSING AND SETTLEMENT STATEMENT

Sec. 2702.054. USE OF ALTERNATE SETTLEMENT STATEMENT FORM PERMITTED

[Sections 2702.055-2702.100 reserved for expansion]

SUBCHAPTER C. ADVANCE DISCLOSURE OF CLOSING AND SETTLEMENT COSTS IN TRANSACTIONS INVOLVING RESIDENTIAL REAL PROPERTY

Sec. 2702.101. APPLICABILITY

Sec. 2702.102. DUTY TO PROVIDE ADVANCE DISCLOSURE OF CLOSING AND SETTLEMENT COSTS

Sec. 2702.103. TITLE INSURANCE COMPANY OR TITLE INSURANCE AGENT NOT SUBJECT TO REQUIREMENTS APPLICABLE TO LENDERS

CHAPTER 2702. CLOSING AND SETTLEMENT

SUBCHAPTER A. INSURED CLOSING AND SETTLEMENT LETTERS

Sec. 2702.001. INSURED CLOSING AND SETTLEMENT LETTER: LOANS. (a) On request, a title insurance company may issue insured closing and settlement letters in connection with the closing and settlement by a title insurance agent or direct operation of loans relating to real property located in this state.

(b) Insured closing and settlement letters must be issued in the form prescribed by the commissioner.

(c) A title insurance company may not impose a charge for issuing insured closing and settlement letters under this section. (V.T.I.C. Art. 9.49, Sec. (a) (part).)

Sec. 2702.002. INSURED CLOSING AND SETTLEMENT LETTER: CERTAIN BUYERS OR SELLERS. (a) On written request, a title insurance company may issue to the buyer or seller of real property located in this state, the sales price of which exceeds the maximum covered claim specified by Chapter 2602, an insured closing and settlement letter in connection with the closing and settlement of the transaction by a title insurance agent or direct operation. Only the title insurance company that is to issue an owner title insurance policy in connection with the transaction may issue the insured closing and settlement letter.

(b) An insured closing and settlement letter must be issued:

(1) at or before closing; and

(2) in the form and manner prescribed by the commissioner.

(c) The commissioner may adopt a charge for the issuance of an insured closing and settlement letter under this section and

prescribe the form and manner in which the charge must be made. (V.T.I.C. Art. 9.49, Sec. (b) (part).)

Sec. 2702.003. EFFECT OF FAILURE TO ISSUE INSURED CLOSING AND SETTLEMENT LETTER. The failure of a title insurance company to issue an insured closing and settlement letter does not affect the company's liability under an issued title insurance policy. (V.T.I.C. Art. 9.49, Secs. (a) (part), (b) (part).)

[Sections 2702.004-2702.050 reserved for expansion]

SUBCHAPTER B. UNIFORM CLOSING AND SETTLEMENT STATEMENTS

Sec. 2702.051. APPLICABILITY. This subchapter does not apply to the closing or settlement of:

(1) a residential real property transaction regulated by the Real Estate Settlement Procedures Act of 1974 (Pub. L. No. 93-533); or

(2) a real property transaction if the closing or settlement is not actually handled by:

(A) a title insurance company, a title insurance agent, or an attorney for a title insurance company or title insurance agent; or

(B) a representative of a title insurance company, a title insurance agent, or an attorney for a title insurance company or title insurance agent. (V.T.I.C. Art. 9.53 (part).)

Sec. 2702.052. DUTY TO PRESCRIBE UNIFORM CLOSING AND SETTLEMENT STATEMENT FORMS. (a) The department, after notice and hearing, shall prescribe uniform closing and settlement statement forms to be used in connection with the closing and settlement of a

transaction involving:

(1) the conveyance or mortgage of real property; and

(2) the issuance of a title insurance policy by a title insurance company or title insurance agent.

(b) The department may prescribe separate forms under this section for transactions involving improved residential real property and for all other real property transactions.

(c) The department shall design the forms under this section to enable each party to the transaction to be provided with a dual or separate form identifying only the charges made to that party. (V.T.I.C. Art. 9.53 (part).)

Sec. 2702.053. CONTENT OF CLOSING AND SETTLEMENT STATEMENT. (a) Each closing and settlement statement provided to a party to a transaction described by Section 2702.052(a) must state the name of any person receiving any amount from that party.

(b) Notwithstanding Subsection (a), the title insurance company or title insurance agent is required to include in the closing and settlement statement only those items of disbursement that are actually disbursed by the company or agent.

(c) If an attorney, other than a full-time employee of the title insurance company or title insurance agent, examines a title or provides any closing or settlement services, the closing and settlement statement must include:

(1) the amount of the fee for the services, shown as included in the premium; and

(2) the name of the attorney or, if applicable, the name of the firm to which the fee was paid.

(d) The closing and settlement statement must conspicuously and clearly itemize the charges imposed on the party in connection with the closing and settlement.

(e) If a charge for title insurance is made to the party, the closing and settlement statement must state whether the title insurance premium included in the charge covers the mortgagee's interest in the real property, the borrower's interest, or both. (V.T.I.C. Art. 9.53 (part).)

Sec. 2702.054. USE OF ALTERNATE SETTLEMENT STATEMENT FORM PERMITTED. A title insurance company or title insurance agent may use the uniform settlement statement form prepared under the Real Estate Settlement Procedures Act of 1974 (Pub. L. No. 93-533) instead of the uniform closing and settlement statement form prescribed by the department under this subchapter. (V.T.I.C. Art. 9.53 (part).)

[Sections 2702.055-2702.100 reserved for expansion]

SUBCHAPTER C. ADVANCE DISCLOSURE OF CLOSING AND SETTLEMENT COSTS IN TRANSACTIONS INVOLVING RESIDENTIAL REAL PROPERTY

Sec. 2702.101. APPLICABILITY. This subchapter does not apply to the closing or settlement of a real property transaction if the closing or settlement is not actually handled by:

(1) a title insurance company, a title insurance agent, or an attorney for a title insurance company or title insurance agent; or

(2) a representative of a title insurance company, a title insurance agent, or an attorney for a title insurance company or title insurance agent. (V.T.I.C. Art. 9.54 (part).)

Sec. 2702.102. DUTY TO PROVIDE ADVANCE DISCLOSURE OF CLOSING AND SETTLEMENT COSTS. (a) Except as provided by Subsection (c), on the written request of the buyer, seller, or borrower before the closing and settlement of a transaction involving improved residential real property, a title insurance company or title insurance agent shall, in connection with the issuance of any kind of title insurance policy guaranteeing a lien on or the title to the property, provide to the requesting party an itemized disclosure of each charge to be made to that party that arises in connection with the closing and settlement.

(b) The itemized disclosure must be provided on a closing and settlement statement form prescribed or permitted under Subchapter B.

(c) The title insurance company or title insurance agent is required to provide the itemized disclosure only to the extent that information is available concerning each charge to be made to the party. If information concerning a charge is not available, the title insurance company or title insurance agent shall:

(1) make a notation that the charge is to be made but that the information is not available or that the amount shown is an estimate of the charge; and

(2) advise the party in writing as to the identity of the person or organization responsible for the charge. (V.T.I.C. Art. 9.54 (part).)

Sec. 2702.103. TITLE INSURANCE COMPANY OR TITLE INSURANCE AGENT NOT SUBJECT TO REQUIREMENTS APPLICABLE TO LENDERS. (a) Notwithstanding Section 2702.102, a title insurance company or

title insurance agent is not required to disclose a cost or charge that a lender is required by law to disclose to a party.

(b) Section 2702.102 does not impose on a title insurance company or title insurance agent any obligation imposed on a lender by the Real Estate Settlement Procedures Act of 1974 (Pub. L. No. 93-533). (V.T.I.C. Art. 9.54 (part).)

CHAPTER 2703. POLICY FORMS AND PREMIUM RATES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2703.001. COMPLIANCE WITH TITLE AND RULES

Sec. 2703.002. USE OF FORMS IN GENERAL

Sec. 2703.003. PAYMENT OF PREMIUMS

[Sections 2703.004-2703.050 reserved for expansion]

SUBCHAPTER B. POLICY PROVISIONS

Sec. 2703.051. CERTAIN PROVISIONS REQUIRED

Sec. 2703.052. DUTY OF TITLE INSURANCE COMPANY

Sec. 2703.053. ESTABLISHMENT OF STANDARDS AND SCHEDULES

Sec. 2703.054. AUTHORITY OF COMMISSIONER IN IMPLEMENTING SUBCHAPTER

[Sections 2703.055-2703.100 reserved for expansion]

SUBCHAPTER C. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY

Sec. 2703.101. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY

[Sections 2703.102-2703.150 reserved for expansion]

SUBCHAPTER D. FIXING AND PROMULGATING PREMIUM RATES

Sec. 2703.151. FIXING AND PROMULGATING PREMIUM RATES

Sec. 2703.152. FACTORS CONSIDERED IN FIXING PREMIUM RATES

CHAPTER 2703. POLICY FORMS AND PREMIUM RATES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2703.001. COMPLIANCE WITH TITLE AND RULES. (a) This section applies to a corporation organized under this title, a foreign corporation, and, to the extent that the corporation is engaged in the business of title insurance, a corporation organized under another law, including:

(1) Subdivision 57, Article 1302, Revised Statutes, before repeal of that statute; and

(2) Chapter 861.

(b) A corporation operates in this state under the control and supervision of the commissioner and under uniform rules adopted

by the commissioner relating to:

(1) forms of policies and underwriting contracts;

(2) premiums for those policies and contracts; and

(3) underwriting standards and practices.

(c) With respect to real property located in this state, a corporation may not issue any kind of title insurance coverage, any kind of guarantee, or reinsurance of a risk assumed under a title insurance policy, except as provided by Section 2551.305(a), unless the corporation is authorized to engage in the business of title insurance under this title and otherwise complies with this title. In engaging in the business of title insurance with respect to real property located in this state, the corporation shall comply with this title and rules described by Subsection (b), including when:

(1) issuing any kind of title insurance policy or an underwriting contract;

(2) reinsuring any portion of a risk assumed under a title insurance policy; and

(3) deleting a title insurance policy exclusion.

(d) Title insurance coverage, reinsurance, or a guarantee issued in violation of Subsection (c) is invalid. (V.T.I.C. Art. 9.07, Sec. (a) (part).)

Sec. 2703.002. USE OF FORMS IN GENERAL. A title insurance company or title insurance agent may not use a form required under this title to be prescribed or approved until the commissioner has prescribed or approved the form. (V.T.I.C. Art. 9.07, Sec. (a) (part).)

Sec. 2703.003. PAYMENT OF PREMIUMS. The premium for a title

insurance policy or for another form prescribed or approved by the commissioner shall be paid in the due and ordinary course of business. (V.T.I.C. Art. 9.07, Sec. (b) (part).)

[Sections 2703.004-2703.050 reserved for expansion]

SUBCHAPTER B. POLICY PROVISIONS

Sec. 2703.051. CERTAIN PROVISIONS REQUIRED. A title insurance policy delivered or issued for delivery in this state to insure an owner of real property must include certain provisions, the form and content of which shall be prescribed by the commissioner, in accordance with this subchapter. (V.T.I.C. Art. 9.57, Sec. (a).)

Sec. 2703.052. DUTY OF TITLE INSURANCE COMPANY. (a) On a report to a title insurance company made by an insured after a title insurance policy has been issued that a lien, encumbrance, or title defect exists that is not excepted under the policy or otherwise excluded from coverage, the company shall promptly investigate to determine whether the lien or encumbrance is valid and not barred by statute or other law.

(b) A title insurance company that concludes that a valid lien or encumbrance that is not barred by statute or other law exists or that a title defect exists shall:

(1) institute all necessary legal proceedings to clear the title to the property;

(2) indemnify the insured according to the terms of the policy;

(3) reinsure at current value the title to the property without making exception to the lien, encumbrance, or

defect or indemnify another insurer for reinsuring the title without making exception to the lien, encumbrance, or defect;

(4) secure a release of the lien, encumbrance, or defect; or

(5) take a combination of the actions described by this subsection. (V.T.I.C. Art. 9.57, Sec. (b).)

Sec. 2703.053. ESTABLISHMENT OF STANDARDS AND SCHEDULES. The commissioner by rule shall establish standards and time schedules for implementing and handling claims by title insurance companies in accordance with this subchapter. (V.T.I.C. Art. 9.57, Sec. (d).)

Sec. 2703.054. AUTHORITY OF COMMISSIONER IN IMPLEMENTING SUBCHAPTER. (a) The commissioner may adopt, by amendment to an owner title insurance policy or by separate endorsement to an owner title insurance policy, language to implement this subchapter in a manner consistent with the terms, provisions, conditions, and stipulations of the policy or the exceptions to coverage contained in the schedules to the policy.

(b) This subchapter does not prohibit the commissioner from adopting for use in this state one or more policies in a simplified, generally more understandable, and usable form. (V.T.I.C. Art. 9.57, Sec. (c).)

[Sections 2703.055-2703.100 reserved for expansion]

SUBCHAPTER C. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY

Sec. 2703.101. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY. (a) The commissioner shall prescribe an owner title insurance policy form to be issued in connection with a transaction involving

residential real property in this state.

(b) A title insurance company or title insurance agent shall use the form prescribed by the commissioner in issuing to an individual an owner title insurance policy relating to residential real property in this state.

(c) Unless authorized by rule adopted by the commissioner, an insurer may not enter into a contract or other agreement concerning an individual title insurance policy if the contract or other agreement is not expressed in the policy. A contract or agreement prohibited by this subsection is void.

(d) An endorsement prescribed by the commissioner may be attached to the title insurance policy form as authorized by rule adopted by the commissioner.

(e) The commissioner may not prescribe an owner title insurance policy form for residential real property or an endorsement to the policy if the policy form or endorsement is not written in plain language. For purposes of this subsection, a policy form or endorsement is written in plain language if it achieves the minimum score established by the commissioner on the Flesch reading ease test or an equivalent test selected by the commissioner or, at the commissioner's option, if it conforms to the language requirements in a National Association of Insurance Commissioners model act relating to plain language. This subsection does not apply to policy language required by state or federal law.

(f) For an owner title insurance policy on residential real property that is issued to an individual, the commissioner may

adopt coverages that insure against ad valorem taxes, including penalties and interest, to be paid with respect to the property for a previous tax year:

(1) that are delinquent on the effective date of the policy because of sale, diversion, or change of use, unless excluded because the insured has actual knowledge of the delinquent taxes; or

(2) that result from an exemption granted to a previous owner of the property under Section 11.13, Tax Code, or from an improvement not assessed for a previous tax year, unless excluded because the insured has actual knowledge of the taxes. (V.T.I.C. Art. 9.07A.)

[Sections 2703.102-2703.150 reserved for expansion]

SUBCHAPTER D. FIXING AND PROMULGATING PREMIUM RATES

Sec. 2703.151. FIXING AND PROMULGATING PREMIUM RATES. (a) Except as provided by Subsection (b), the commissioner shall fix and promulgate the premium rates to be charged by a title insurance company or by a title insurance agent for title insurance policies or for other forms prescribed or approved by the commissioner.

(b) The commissioner may not fix or promulgate the premium rates for reinsurance between title insurance companies. Title insurance companies may establish the premium rates in amounts to which the companies agree.

(c) Except for a premium charged for reinsurance, a premium may not be charged for a title insurance policy or for another prescribed or approved form at a rate different than the rate fixed and promulgated by the commissioner. (V.T.I.C. Art. 9.07, Sec. (b)

(part).)

Sec. 2703.152. FACTORS CONSIDERED IN FIXING PREMIUM RATES. (a) In fixing premium rates, the commissioner shall consider all relevant income and expenses of title insurance companies and title insurance agents attributable to engaging in the business of title insurance in this state.

(b) The premium rates fixed by the commissioner must be:

(1) reasonable as to the public; and

(2) nonconfiscatory as to title insurance companies and title insurance agents. (V.T.I.C. Art. 9.07, Sec. (b) (part).)

Sec. 2703.153. COLLECTION OF DATA FOR FIXING PREMIUM RATES. (a) Each title insurance company and title insurance agent engaged in the business of title insurance in this state shall submit to the department, as required by the department to collect data to use to fix premium rates, all information relating to:

(1) loss experience;

(2) expense of operation; and

(3) other material matters.

(b) The information must be submitted in the form prescribed by the department. (V.T.I.C. Art. 9.07, Sec. (b) (part).)

[Sections 2703.154-2703.200 reserved for expansion]

SUBCHAPTER E. PROCEDURES REGARDING PREMIUM RATES, POLICY FORMS, AND OTHER RELATED MATTERS

Sec. 2703.201. HEARING REQUIRED FOR FIXING PREMIUM RATE. Before a premium rate may be fixed and a premium charged, the department must provide reasonable notice and a hearing must be afforded to title insurance companies, title insurance agents, and

the public. (V.T.I.C. Art. 9.07, Sec. (a) (part).)

Sec. 2703.202. HEARING REQUIRED FOR CHANGE IN PREMIUM RATE. (a) A premium rate previously fixed by the commissioner may not be changed until after the commissioner holds a public hearing.

(b) At the request of a title insurance company or the office of public insurance counsel, the commissioner shall order a public hearing to consider changing a premium rate. (V.T.I.C. Art. 9.07, Sec. (d) (part).)

Sec. 2703.203. BIENNIAL HEARING. The commissioner shall hold a biennial public hearing not earlier than July 1 of each even-numbered year to consider adoption of premium rates and other matters relating to regulating the business of title insurance that an association, title insurance company, title insurance agent, or member of the public requests to be considered or that the commissioner determines necessary to consider. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

Sec. 2703.204. ADMISSION AS PARTY TO BIENNIAL HEARING. An individual or association or other entity recommending adoption of a premium rate or another matter relating to regulating the business of title insurance shall be admitted as a party to the biennial hearing. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

Sec. 2703.205. PHASES OF BIENNIAL HEARING. (a) The biennial hearing consists of:

(1) a rulemaking phase to consider rules, forms, endorsements, and related matters that do not have rate implications; and

(2) a ratemaking phase to consider fixing of premium

rates and other matters that have rate implications.

(b) The commissioner shall certify which matters have rate implications to be considered in the ratemaking phase of the hearing.

(c) Except as provided by Subsection (d), the commissioner shall conduct both phases of the hearing.

(d) At the direction of the commissioner or at the written request of a person seeking admission as a party to the ratemaking phase of the hearing, the State Office of Administrative Hearings shall conduct the ratemaking phase of the hearing in accordance with Chapter 40. A request under this subsection must be made at the time a person seeks to be admitted as a party to the hearing but may not be made later than the 10th day after the date notice of the hearing is provided under Section 2703.207.

(e) The ratemaking phase of the hearing shall be conducted as a contested case in accordance with Chapter 2001, Government Code.

(f) A party's presentation of relevant, admissible oral testimony may not be limited.

(g) Each matter in each phase of the hearing shall be considered by the commissioner and decisions on the matters made in an open meeting. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

Sec. 2703.206. COMMISSIONER AUTHORITY TO HOLD HEARINGS AS NECESSARY. At any time, the commissioner may order a public hearing to consider adoption of premium rates and other matters relating to regulating the business of title insurance as the commissioner determines necessary or proper. (V.T.I.C. Art. 9.07, Sec. (e)

(part).)

Sec. 2703.207. NOTICE OF CERTAIN HEARINGS. Not later than the 60th day before the date of a hearing under Section 2703.202, 2703.203, or 2703.206, notice of the hearing and of each item to be considered at the hearing shall be:

(1) sent directly to all title insurance companies and title insurance agents; and

(2) provided to the public in a manner that gives fair notice concerning the hearing. (V.T.I.C. Art. 9.07, Secs. (c) (part), (d) (part), (e) (part).)

Sec. 2703.208. ADDITIONS OR AMENDMENTS TO MANUAL. (a) An addition or amendment to the Basic Manual of Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas may be proposed and adopted by reference by publishing notice of the proposal or adoption by reference in the Texas Register.

(b) Notice under this section must include:

(1) a brief summary of the substance of the matter to be added or amended; and

(2) a statement that the full text of the matter is available for review in the office of the chief clerk of the department. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

CHAPTER 2704. ISSUANCE OF POLICY OR CONTRACT; DETERMINATION OF INSURABILITY

SUBCHAPTER A. GENERAL PROVISIONS

OPERATION

Sec. 2704.004. EXCEPTIONS TO APPLICABILITY OF CHAPTER

[Sections 2704.005-2704.050 reserved for expansion]

SUBCHAPTER B. ISSUANCE OF OWNER AND MORTGAGEE POLICIES FOR RESIDENTIAL REAL PROPERTY

Sec. 2704.051. ISSUANCE OF OWNER POLICY REQUIRED IN CONNECTION WITH ISSUANCE OF MORTGAGEE POLICY

Sec. 2704.052. REJECTION OF ISSUANCE OF OWNER POLICY

[Sections 2704.053-2704.100 reserved for expansion]

SUBCHAPTER C. TITLE INSURANCE COVERING AREAS AND BOUNDARIES

Sec. 2704.101. DEFINITION

Sec. 2704.102. RULES AUTHORIZING ACCEPTANCE OF EXISTING SURVEY

Sec. 2704.103. CERTAIN DISCRIMINATION PROHIBITED

Sec. 2704.104. INDEMNITY PROHIBITED

CHAPTER 2704. ISSUANCE OF POLICY OR CONTRACT; DETERMINATION OF INSURABILITY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2704.001. ISSUANCE OF POLICY OR CONTRACT. A title insurance policy or contract may not be written unless:

(1) Sections 2502.053, 2502.054, and 2502.055 have been complied with;

(2) the policy or contract is based on an examination of title made from title evidence prepared from an abstract plant owned, or leased and operated by a title insurance agent or direct operation for the county in which the real property is located,

except as provided by Section 2704.002;

(3) insurability of title has been determined in accordance with sound title underwriting practices; and

(4) evidence thereof is preserved and retained in the files of the title insurance company, title insurance agent, or direct operation for a period of not less than 15 years after the date of issuance of the policy or contract. (V.T.I.C. Art. 9.34 (part).)

Sec. 2704.002. DIRECT ISSUANCE OF POLICY OR CONTRACT. A title insurance company may directly issue a title insurance policy or contract based on the best title evidence available if:

(1) a title insurance agent or direct operation does not exist for the county in which the real property is located; or

(2) each title insurance agent and direct operation for that county refuses to provide title evidence:

(A) in a reasonable period as determined by the department; and

(B) in compliance with Section 2502.053(1). (V.T.I.C. Art. 9.34 (part).)

Sec. 2704.003. COPY OF POLICY OR CONTRACT TO AGENT OR DIRECT OPERATION. In a reasonable period as determined by the department, a copy of each title insurance policy or contract issued in a real property transaction shall be provided to each title insurance agent or direct operation providing the title evidence on which the policy or contract is issued. (V.T.I.C. Art. 9.34 (part).)

Sec. 2704.004. EXCEPTIONS TO APPLICABILITY OF CHAPTER. This chapter does not apply to a company that:

(1) does not assume primary liability in a reinsurance contract; or

(2) acts as coinsurer, if at least one of the other coinsurers has complied with this chapter. (V.T.I.C. Art. 9.34 (part).)

[Sections 2704.005-2704.050 reserved for expansion]

SUBCHAPTER B. ISSUANCE OF OWNER AND MORTGAGEE POLICIES FOR RESIDENTIAL REAL PROPERTY

Sec. 2704.051. ISSUANCE OF OWNER POLICY REQUIRED IN CONNECTION WITH ISSUANCE OF MORTGAGEE POLICY. (a) In this section, "mortgagee title insurance policy" means a mortgagee policy of title insurance or another agreement or the equivalent that constitutes the business of title insurance.

(b) Except as provided by Section 2704.052, a title insurance company or title insurance agent that issues a mortgagee title insurance policy in connection with a lien on improved residential real property in this state that is sold shall also issue an owner title insurance policy to the owner of the property.

(c) The title insurance company or title insurance agent issuing the owner title insurance policy shall charge the required premium promulgated by the commissioner. (V.T.I.C. Art. 9.55 (part).)

Sec. 2704.052. REJECTION OF ISSUANCE OF OWNER POLICY. At or before closing and settlement, the person acquiring title may reject the issuance of the owner title insurance policy required under Section 2704.051 by executing a written and acknowledged rejection in the form prescribed, after notice and hearing, by the

commissioner. (V.T.I.C. Art. 9.55 (part).)

[Sections 2704.053-2704.100 reserved for expansion]

SUBCHAPTER C. TITLE INSURANCE COVERING AREAS AND BOUNDARIES

Sec. 2704.101. DEFINITION. In this subchapter, "area and boundary coverage" means title insurance coverage relating to discrepancies, conflicts, or shortages in area or boundary lines, or any encroachments or protrusions, or any overlapping of improvements. (V.T.I.C. Art. 9.07C, Sec. (a).)

Sec. 2704.102. RULES AUTHORIZING ACCEPTANCE OF EXISTING SURVEY. (a) The commissioner by rule may authorize a title insurance company providing area and boundary coverage to accept an existing real property survey as provided by this section.

(b) A title insurance company may accept an existing real property survey rather than requiring a new survey if, notwithstanding the age of the survey or the identity of the person for whom the survey was prepared, the company is willing to accept:

(1) evidence of the existing survey; and

(2) an affidavit prescribed by the commissioner that verifies the existing survey. (V.T.I.C. Art. 9.07C, Sec. (b).)

Sec. 2704.103. CERTAIN DISCRIMINATION PROHIBITED. A title insurance company may not discriminate in providing area and boundary coverage in connection with residential real property solely because:

(1) the real property is platted or unplatted; or

(2) a municipality did not accept a subdivision plat relating to the real property before September 1, 1975. (V.T.I.C. Art. 9.07C, Sec. (c).)

Sec. 2704.104. INDEMNITY PROHIBITED. A title insurance company may not require an indemnity from a seller, buyer, borrower, or lender to provide area and boundary coverage. (V.T.I.C. Art. 9.07C, Sec. (d).)

SECTION 7. TITLE 13, INSURANCE CODE. The Insurance Code is amended by adding Title 13 to read as follows:

TITLE 13. REGULATION OF PROFESSIONALS

SUBTITLE A. GENERAL PROVISIONS

CHAPTER 4001. AGENT LICENSING IN GENERAL
CHAPTER 4002. EXAMINATION OF LICENSE APPLICANTS
CHAPTER 4003. LICENSE EXPIRATION AND RENEWAL
CHAPTER 4004. CONTINUING EDUCATION
CHAPTER 4005. CONDUCT, DISCIPLINARY ACTIONS, AND SANCTIONS
CHAPTER 4006. DISABILITY PROBATION OF AGENTS

[Chapters 4007-4050 reserved for expansion]

SUBTITLE B. AGENTS

CHAPTER 4051. PROPERTY AND CASUALTY AGENTS
CHAPTER 4052. LIFE AND HEALTH INSURANCE COUNSELORS
CHAPTER 4053. MANAGING GENERAL AGENTS
CHAPTER 4054. LIFE, ACCIDENT, AND HEALTH AGENTS
CHAPTER 4055. SPECIALTY AGENTS
CHAPTER 4056. NONRESIDENT AGENTS

[Chapters 4057-4100 reserved for expansion]

SUBTITLE C. ADJUSTERS

CHAPTER 4101. INSURANCE ADJUSTERS

[Chapters 4102-4150 reserved for expansion]

CHAPTER 4001. AGENT LICENSING IN GENERAL

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4001.001. PURPOSE. It is the intent of the legislature to:

(1) simplify and reform the regulation of agents and other persons regulated under this title in this state by consolidating the kinds of licenses issued to those persons under

this title; and

(2) promote uniformity in the licensing, examination, continuing education, and disciplinary requirements for those persons in this state and with other states. (V.T.I.C. Art. 21.01, Sec. 1.)

Sec. 4001.002. APPLICABILITY. (a) Except as otherwise provided by this code, this title applies to each person licensed under:

(1) Subchapter H, Chapter 885;

(2) Subchapter F, Chapter 911;

(3) Section 912.251;

(4) Subchapter E, Chapter 981;

(5) Subchapter D, Chapter 1152;

(6) Subchapter C or D of this chapter;

(7) Subtitle B, C, or D of this title;

(8) Article 23.23A; or

(9) Subsection (c), Article 5.13-1.

(b) This title does not apply to:

(1) a resident of this state who arbitrates in the adjustment of losses between an insurer and an insured, a marine adjuster who adjusts particular or general average losses of vessels or cargoes if the adjuster paid an occupation tax of $200 for the year in which the adjustment is made, or a practicing attorney at law in this state, acting in the regular transaction of the person's business as an attorney at law, who is not a local agent and is not acting as an adjuster for an insurer;

(2) a full-time home office salaried employee of an

insurer authorized to engage in the business of insurance in this state, other than an employee who solicits or receives an application for the sale of insurance through an oral, written, or electronic communication in accordance with Subchapter G, Chapter 4051;

(3) an attorney in fact or the traveling salaried representative of a reciprocal or interinsurance exchange admitted to engage in the business of insurance in this state as to business transacted through the attorney in fact or salaried representative;

(4) the attorney in fact for a Lloyd's plan;

(5) the group motor vehicle insurance business or the group motor vehicle department of a company engaged in that business; or

(6) a salaried employee who is not involved in soliciting or negotiating insurance in the office of an agent and who devotes the employee's full time to clerical and administrative services, including the incidental taking of information from customers and receipt of premiums in the office of an agent, if:

(A) the employee does not receive any commissions; and

(B) the employee's compensation is not varied by the volume of premiums taken and received. (V.T.I.C. Art. 21.01, Sec. 3; Art. 21.02, Sec. (a) (part); Art. 21.07, Sec. 1(b).)

Sec. 4001.003. DEFINITIONS. Unless the context clearly indicates otherwise, in this title:

(1) "Agent" means a person who is an authorized agent of an insurer or health maintenance organization, a subagent, and

any other person who performs the acts of an agent, whether through an oral, written, electronic, or other form of communication, by soliciting, negotiating, procuring, or collecting a premium on an insurance or annuity contract, or who represents or purports to represent a health maintenance organization, including a health maintenance organization offering only a single health care service plan, in soliciting, negotiating, procuring, or effectuating membership in the health maintenance organization. The term does not include:

(A) a regular salaried officer or employee of an insurer, health maintenance organization, or agent who:

(i) devotes substantially all of the officer's or employee's time to activities other than the solicitation of applications for insurance, annuity contracts, or memberships;

(ii) does not receive a commission or other compensation directly dependent on the business obtained; and

(iii) does not solicit or accept from the public applications for insurance, annuity contracts, or memberships;

(B) an employer or an employer's officer or employee or a trustee of an employee benefit plan, to the extent that the employer, officer, employee, or trustee is engaged in the administration or operation of an employee benefits program involving the use of insurance or annuities issued by an insurer or memberships issued by a health maintenance organization, if the employer, officer, employee, or trustee is not directly or

indirectly compensated by the insurer or health maintenance organization issuing the insurance or annuity contracts or memberships;

(C) except as otherwise provided by this code, a depository institution, or an officer or employee of a depository institution, to the extent that the depository institution or officer or employee collects and remits premiums or charges by charging those premiums or charges against accounts of depositors on the orders of those depositors; or

(D) a person or the employee of a person who has contracted to provide administrative, management, or health care services to a health maintenance organization and who is compensated for those services by the payment of an amount computed as a percentage of the revenues, net income, or profit of the health maintenance organization, if that method of compensation is the sole basis for subjecting that person or the employee of the person to this title.

(2) "Control" means the power to direct or cause the direction of the management and policies of a license holder, whether directly or indirectly. For the purposes of this title, a person is considered to control:

(A) a corporate license holder if the person, individually or acting with others, directly or indirectly, holds with the power to vote, owns, or controls, or holds proxies representing, at least 10 percent of the voting stock or voting rights of the corporate license holder; or

(B) a partnership if the person through a right

to vote or through any other right or power exercises rights in the management, direction, or conduct of the business of the partnership.

(3) "Corporation" means a legal entity that is organized under the business corporation laws or limited liability company laws of this state or another state and that has as one of its purposes the authority to act as an agent.

(4) "Depository institution" means:

(A) a bank or savings association as defined by 12 U.S.C. Section 1813, as amended;

(B) a foreign bank that maintains a branch, agency, or commercial lending company in the United States;

(C) a federal or state credit union as defined by 12 U.S.C. Section 1752, as amended;

(D) a bank branch; or

(E) a bank subsidiary, as defined by state or federal law.

(5) "Individual" means a natural person. The term includes a resident or a nonresident of this state.

(6) "Insurer" means an insurance company or insurance carrier regulated by the department. The term includes:

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

(B) a mutual life, health, or accident insurance company;

(C) a stock fire or casualty insurance company;

(D) a mutual fire or casualty insurance company;

(E) a Mexican casualty insurance company;

(F) a Lloyd's plan;

(G) a reciprocal or interinsurance exchange;

(H) a fraternal benefit society;

(I) a stipulated premium company;

(J) a nonprofit or for-profit legal services corporation;

(K) a statewide mutual assessment company;

(L) a local mutual aid association;

(M) a local mutual burial association;

(N) an association exempt under Section 887.102;

(O) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 842;

(P) a health maintenance organization;

(Q) a county mutual insurance company; and

(R) a farm mutual insurance company.

(7) "Partnership" means an association of two or more persons organized under the partnership laws or limited liability partnership laws of this state or another state. The term includes a general partnership, limited partnership, limited liability partnership, and limited liability limited partnership.

(8) "Person" means an individual, partnership, corporation, or depository institution.

(9) "Subagent" means a person engaging in activities described under Subdivision (1) who acts for or on behalf of an agent, whether through an oral, written, electronic, or other form of communication, by soliciting, negotiating, or procuring an

insurance or annuity contract or health maintenance organization membership, or collecting premiums or charges on an insurance or annuity contract or health maintenance organization membership, without regard to whether the subagent is designated by the agent as a subagent or by any other term. A subagent is an agent for all purposes of this title, and a reference to an agent in this title, Chapter 21, or a provision listed in Section 4001.009 includes a subagent without regard to whether a subagent is specifically mentioned. (V.T.I.C. Art. 21.07, Secs. 1A(1), (2), (3) (part), (4), (5), (6), (7), (8), (9).)

Sec. 4001.004. LIMITED LIABILITY COMPANIES. The licensing and regulation of a limited liability company are subject to each provision of this title that applies to a corporation licensed under this title. (V.T.I.C. Art. 21.07, Sec. 1A(3) (part).)

Sec. 4001.005. RULES. The commissioner may adopt rules necessary to implement this title and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.01, Sec. 4.)

Sec. 4001.006. FEES. (a) The department shall collect from each agent of an insurer writing insurance in this state under this code:

(1) a nonrefundable license fee; and

(2) a nonrefundable appointment fee for each appointment of the agent by an insurer.

(b) The department shall deposit the fees described by Subsection (a), together with other license fees, examination fees, and license renewal fees, to the credit of the Texas Department of

Insurance operating account.

(c) The department shall set the fees in amounts reasonable and necessary to implement this title and may use any portion of those fees to enforce this title. (V.T.I.C. Art. 21.07, Secs. 6C(a), (b) (part), (c).)

Sec. 4001.007. INVESTIGATION OF ALLEGED VIOLATIONS. (a) The department may:

(1) employ persons as the department considers necessary to investigate and make reports regarding alleged violations of this code and misconduct on the part of agents; and

(2) pay the salaries and expenses of those persons and office employees and other expenses necessary to enforce this title from the fees described by Section 4001.006.

(b) A person employed by the department under this section may:

(1) administer the oath to, and examine under oath, any person considered necessary in gathering information and evidence; and

(2) have that information and evidence reduced to writing if considered necessary.

(c) All expenses related to the activities described by Subsection (b) shall be paid from the fees described by Section 4001.006. (V.T.I.C. Art. 21.07, Sec. 6C(b) (part).)

Sec. 4001.008. COMMISSIONER AGENT FOR SERVICE OF PROCESS. In the manner provided by Subchapter C, Chapter 804, the commissioner is a corporation's or partnership's agent for service of process in a legal proceeding against the corporation or

partnership if:

(1) the corporation or partnership is licensed to engage in business in this state and does not appoint or maintain an agent for service in this state;

(2) an agent for service cannot be found with reasonable diligence; or

(3) the license of the corporation or partnership is revoked. (V.T.I.C. Art. 21.07, Sec. 2(r).)

Sec. 4001.009. REFERENCES TO OTHER LAW. (a) As referenced in Section 4001.003(9), a reference to an agent in the following laws includes a subagent without regard to whether a subagent is specifically mentioned:

(1) Chapters 281, 523, 541-556, 558, 702, 703, 705, 821, 823-825, 827, 828, 844, 1108, 1205-1209, 1352, 1353, 1357, 1358, 1360-1363, 1369, 1453-1455, and 1503;

(2) Subchapter C, Chapter 521;

(3) Subchapter A, Chapter 557;

(4) Subchapter B, Chapter 805;

(5) Subchapter D, Chapter 1103;

(6) Subchapters B, C, D, and E, Chapter 1204, excluding Sections 1204.153 and 1204.154;

(7) Subchapter B, Chapter 1366;

(8) Subchapters B, C, and D, Chapter 1367, excluding Section 1367.053(c);

(9) Subchapters A, C, D, E, F, H, and I, Chapter 1451;

(10) Subchapter B, Chapter 1452;

(11) Sections 982.001, 982.002, 982.004, 982.052,

982.102, 982.103, 982.104, 982.106, 982.107, 982.108, 982.110, 982.111, and 982.112;

(12) Subchapters D, E, and F, Chapter 982;

(13) Section 1101.003(a); and

(14) Chapter 107, Occupations Code.

(b) As referenced in Section 4001.051(b), a person is the agent of the insurer for which the act is done or risk is taken in the manner provided by that subsection for purposes of the liabilities, duties, requirements, and penalties provided by a law listed in Subsection (a). (New.)

[Sections 4001.010-4001.050 reserved for expansion]

SUBCHAPTER B. ACTS CONSTITUTING ACTING AS AGENT; CONSEQUENCES OF AGENT'S ACTIONS

Sec. 4001.051. ACTS CONSTITUTING ACTING AS AGENT. (a) This section applies regardless of whether an insurer is incorporated under the laws of this state or another state or a foreign government.

(b) Regardless of whether the act is done at the request of or by the employment of an insurer, broker, or other person, a person is the agent of the insurer for which the act is done or risk is taken for purposes of the liabilities, duties, requirements, and penalties provided by this title, Chapter 21, or a provision listed in Section 4001.009 if the person:

(1) solicits insurance on behalf of the insurer;

(2) receives or transmits other than on the person's own behalf an application for insurance or an insurance policy to or from the insurer;

(3) advertises or otherwise gives notice that the person will receive or transmit an application for insurance or an insurance policy;

(4) receives or transmits an insurance policy of the insurer;

(5) examines or inspects a risk;

(6) receives, collects, or transmits an insurance premium;

(7) makes or forwards a diagram of a building;

(8) takes any other action in the making or consummation of an insurance contract for or with the insurer other than on the person's own behalf; or

(9) examines into, adjusts, or aids in adjusting a loss for or on behalf of the insurer.

(c) This section does not authorize an agent to orally, in writing, or otherwise alter or waive a term or condition of an insurance policy or an application for an insurance policy.

(d) The referral by an unlicensed person of a customer or potential customer to an agent is not an act of an agent under this section unless the unlicensed person discusses specific insurance policy terms or conditions with the customer or potential customer. (V.T.I.C. Art. 21.02, Secs. (a) (part), (b).)

Sec. 4001.052. SOLICITOR OF APPLICATION FOR INSURANCE CONSIDERED AGENT OF INSURER. (a) A person who solicits an application for life, accident, or health insurance or property or casualty insurance is considered the agent of the insurer issuing a policy on the application and not the agent of the insured in any

controversy between the insurer and the insured, the insured's beneficiary, or the insured's dependents.

(b) The agent may not alter or waive a term or condition of the application or policy. (V.T.I.C. Art. 21.04.)

Sec. 4001.053. PERSONAL LIABILITY FOR ACTING AS AGENT. A person who takes an action listed in Section 4001.051 for or on behalf of an insurer before the insurer complies with the requirements of the laws of this state is personally liable to the holder of any insurance policy with respect to which the action was taken for any loss covered by the insurance policy. (V.T.I.C. Art. 21.02, Sec. (a) (part).)

Sec. 4001.054. LIABILITY OF AGENT AND INSURER FOR TAXES. (a) If a person takes an action in this state listed in Section 4001.051 for or on behalf of an insurer, the insurer is considered to be engaged in the business of insurance in this state and is subject to the same state, county, and municipal taxes as an insurer that has been legally qualified and admitted to engage in the business of insurance in this state.

(b) Taxes shall be assessed against and collected from an insurer under this section in the same manner as taxes are assessed against and collected from insurers that are legally qualified and admitted to engage in the business of insurance in this state.

(c) A person who takes an action by means of which an insurer is considered to be engaged in the business of insurance in this state under this section is personally liable for any taxes assessed against the insurer under this section. (V.T.I.C. Art. 21.03.)

[Sections 4001.055-4001.100 reserved for expansion]

SUBCHAPTER C. LICENSE REQUIREMENTS

Sec. 4001.101. LICENSE OR CERTIFICATE OF AUTHORITY REQUIRED. (a) Unless the person holds a license or certificate of authority issued by the department, a person may not:

(1) solicit or receive an application for insurance in this state; or

(2) aid in the transaction of the business of an insurer.

(b) A person may not act as an agent of a health maintenance organization or other type of insurer authorized to engage in business in this state unless the person holds a license issued by the department as provided by this title.

(c) An insurer described by Subsection (b) may not appoint a person to act as its agent unless the person holds a license under this title.

(d) This subchapter does not permit an employee or agent of a corporation or partnership to perform an act of an agent under this title without obtaining a license. (V.T.I.C. Art. 21.01, Sec. 2; Art. 21.07, Secs. 1(a) (part), 2(j).)

Sec. 4001.102. LICENSE APPLICATION. (a) To become an agent for an insurer or health maintenance organization, a person must submit to the department a completed license application in the form required by the department.

(b) The commissioner by rule shall prescribe the requirements for a properly completed application. (V.T.I.C. Art. 21.07, Secs. 2(a), (b).)

Sec. 4001.103. FAILURE TO PROVIDE COMPLETE SET OF FINGERPRINTS: GROUND FOR DENIAL OF APPLICATION. (a) In this section, "authorization" means any authorization issued by the department to engage in an activity regulated under this title, including a license or permit.

(b) The department may deny an application for an authorization if the applicant fails to provide a complete set of fingerprints on request by the department. (V.T.I.C. Art. 1.10C (part).)

Sec. 4001.104. ISSUANCE OF LICENSE: INTENT TO ACTIVELY ENGAGE IN BUSINESS OF INSURANCE FOR GENERAL PUBLIC. (a) The department may not issue a license as an agent to write any line of insurance unless the department determines that:

(1) the applicant is or intends to be actively engaged in the soliciting or writing of insurance for the general public and is to be actively engaged in the business of insurance; and

(2) the application is not made to evade the laws against rebating and discrimination, either for the applicant or for another person.

(b) This subchapter does not prohibit an applicant from insuring property that the applicant owns or in which the applicant has an interest. It is the intent of this subchapter to prohibit coercion of insurance and to preserve to each individual the right to choose that individual's own agent or insurer and to prohibit the licensing of an applicant to engage in the business of insurance principally to handle business that the applicant controls only through ownership, mortgage, sale, family relationship, or

employment. An applicant for an original license must have a bona fide intention to engage in business in which, in any calendar year, at least 25 percent of the total volume of premiums is derived from persons other than the applicant and from property other than that on which the applicant controls the placing of insurance through ownership, mortgage, sale, family relationship, or employment.

(c) The department may not deny a license application solely on the ground that the applicant will act only part-time as an agent. (V.T.I.C. Art. 21.07, Secs. 2(c), (d), (e).)

Sec. 4001.105. ISSUANCE OF LICENSE TO INDIVIDUAL. The department shall issue a license to an individual to engage in business as an agent if the department determines that the individual:

(1) is at least 18 years of age;

(2) has passed the licensing examination required under this code within the past 12 months;

(3) has not committed an act for which a license may be denied under Subchapter C, Chapter 4005; and

(4) has submitted the application, appropriate fees, and any other information required by the department. (V.T.I.C. Art. 21.07, Sec. 2(f).)

Sec. 4001.106. ISSUANCE OF LICENSE TO CORPORATION OR PARTNERSHIP. (a) In this section, "customer" means a person or firm to which a corporation or partnership sells or attempts to sell an insurance policy or from which a corporation or partnership accepts an application for insurance.

(b) The department shall issue a license to a corporation or

partnership if the department determines that:

(1) the corporation or partnership is:

(A) organized under the laws of this state or another state;

(B) admitted to engage in business in this state by the secretary of state, if required; and

(C) authorized by its articles of incorporation or its partnership agreement to act as an agent;

(2) at least one officer of the corporation or one active partner of the partnership and all other persons performing any acts of an agent on behalf of the corporation or partnership in this state are individually licensed by the department separately from the corporation or partnership;

(3) the corporation or partnership will have the ability to pay any amount up to $25,000 that it might become legally obligated to pay under a claim made against it by a customer and caused by a negligent act, error, or omission of the corporation or partnership or a person for whose acts the corporation or partnership is legally liable in the conduct of its business under this code;

(4) if engaged in the business of insurance, the corporation or partnership intends to be actively engaged in that business as required under Section 4001.104(a);

(5) each location from which the corporation or partnership will engage in business in this state under authority of a license issued by the department is registered separately with the department;

(6) the corporation or partnership has submitted the application, appropriate fees, and any other information required by the department; and

(7) an officer, director, member, manager, partner, or other person who has the right or ability to control the corporation or partnership has not:

(A) had a license suspended or revoked or been the subject of any other disciplinary action by a financial or insurance regulator of this state, another state, or the United States; or

(B) committed an act for which a license may be denied under Subchapter C, Chapter 4005.

(c) A corporation or partnership shall maintain the ability to pay a claim described by Subsection (b)(3) by obtaining:

(1) an errors and omissions policy insuring the corporation or partnership against errors and omissions in at least the amount of $250,000, with a deductible of not more than 10 percent of the full amount of the policy, issued by:

(A) an insurer authorized to engage in the business of insurance in this state; or

(B) if a policy cannot be obtained from an insurer authorized to engage in the business of insurance in this state, a surplus lines insurer under Chapter 981; or

(2) a bond in the principal amount of $25,000 that is:

(A) executed by the corporation or partnership as principal and a surety company authorized to engage in business in this state as surety;

(B) payable to the department for the use and benefit of customers of the corporation or partnership; and

(C) conditioned that the corporation or partnership shall pay any final judgment recovered against it by a customer.

(d) A binding commitment to issue a policy or bond described by Subsection (c) is sufficient in connection with an application for a license. (V.T.I.C. Art. 21.07, Sec. 2(i) (part).)

Sec. 4001.107. ISSUANCE OF LICENSE TO DEPOSITORY INSTITUTION. The department shall issue a license to a depository institution in the manner provided by this subchapter for the licensing of a corporation. (V.T.I.C. Art. 21.07, Sec. 2(m).)

Sec. 4001.108. ISSUANCE OF LICENSE TO ENTITY CHARTERED BY FEDERAL FARM CREDIT ADMINISTRATION. The department may license an entity chartered by the federal Farm Credit Administration under the farm credit system established under 12 U.S.C. Section 2001 et seq., as amended, to solicit insurance in this state as provided by 12 U.S.C. Section 2218, as amended. The department shall issue the license in the manner provided by this subchapter for the licensing of a corporation. (V.T.I.C. Art. 21.07, Sec. 2(v).)

Sec. 4001.109. LICENSING OF SUBAGENT. A subagent must be licensed to write each line of insurance that the subagent is employed to write, but is not required to hold each kind of license issued to the agent for whom the subagent acts. (V.T.I.C. Art. 21.07, Sec. 2(u).)

[Sections 4001.110-4001.150 reserved for expansion]

SUBCHAPTER D. TEMPORARY LICENSE

Sec. 4001.151. AUTHORITY TO ISSUE TEMPORARY LICENSE. The department may issue a temporary agent's license to an applicant for a license under Section 4001.102 who is being considered for appointment as an agent by another agent, an insurer, or a health maintenance organization. (V.T.I.C. Art. 21.07, Sec. 3A(a) (part).)

Sec. 4001.152. EXAMINATION NOT REQUIRED. An applicant is not required to pass a written examination to obtain a temporary license. (V.T.I.C. Art. 21.07, Sec. 3A(a) (part).)

Sec. 4001.153. APPLICATION FOR AND ISSUANCE OF TEMPORARY LICENSE. The department shall issue a temporary license immediately on receipt of a properly completed application executed by the applicant in the form required by Section 4001.102 and accompanied by:

(1) the nonrefundable filing fee set by the department; and

(2) a certificate signed by an officer or properly authorized representative of an agent, insurer, or health maintenance organization stating that:

(A) the applicant is being considered for appointment by the agent, insurer, or health maintenance organization as its full-time agent;

(B) the agent, insurer, or health maintenance organization desires that the applicant be issued a temporary license; and

(C) the applicant will complete training as prescribed by Section 4001.160 under the agent's, insurer's, or

health maintenance organization's supervision. (V.T.I.C. Art. 21.07, Sec. 3A(a) (part).)

Sec. 4001.154. AUTHORITY TO ACT AS AGENT PENDING RECEIPT OF TEMPORARY LICENSE. If a temporary license is not received from the department before the eighth day after the date the application, nonrefundable fee, and certificate are delivered or mailed to the department and the appropriate agent, insurer, or health maintenance organization has not been notified that the application is denied, the agent, insurer, or health maintenance organization may assume that the temporary license will be issued and the applicant may proceed to act as an agent. (V.T.I.C. Art. 21.07, Sec. 3A(b).)

Sec. 4001.155. TERM OF TEMPORARY LICENSE. A temporary license is valid for 90 days after the date of issuance. (V.T.I.C. Art. 21.07, Sec. 3A(a) (part).)

Sec. 4001.156. RESTRICTION ON ISSUANCE OR RENEWAL OF TEMPORARY LICENSE. (a) A temporary license may not be issued to or renewed by the same person more than once in a consecutive six-month period.

(b) A temporary license may not be issued to a person who does not intend to apply for a license to sell insurance or memberships to the general public. (V.T.I.C. Art. 21.07, Secs. 3A(c), (d).)

Sec. 4001.157. OBTAINING CERTAIN COMMISSIONS PROHIBITED. (a) A temporary license holder may not obtain a commission on a sale made to a person who has a family, employment, or business relationship with the temporary license holder.

(b) An agent, insurer, or health maintenance organization may not knowingly pay, directly or indirectly, to a temporary license holder, and a temporary license holder may not receive or accept, a commission on the sale of a contract of insurance or membership covering:

(1) the temporary license holder;

(2) a person related to the temporary license holder by consanguinity or affinity;

(3) a person who is or has been during the past six months the temporary license holder's employer, either as an individual or as a member of a partnership, association, firm, or corporation; or

(4) a person who is or has been during the past six months an employee of the temporary license holder. (V.T.I.C. Art. 21.07, Sec. 3A(e).)

Sec. 4001.158. REPLACEMENT OF EXISTING LIFE INSURANCE OR ANNUITY CONTRACT PROHIBITED. (a) A temporary license holder who is acting under the authority of that license may not:

(1) engage in an insurance solicitation, sale, or other agency transaction that the license holder knows or should know will result or is intended to result in:

(A) the purchase of a new life insurance or annuity contract; and

(B) any of the following actions with regard to an existing individual life insurance or annuity contract as a result of that purchase:

(i) termination of the contract by lapse,

forfeiture, surrender, or other means;

(ii) conversion of the contract to reduced paid-up insurance, continuation of the contract as extended term insurance, or reduction in value of the contract by the use of nonforfeiture benefits or other policy values;

(iii) amendment of the contract to reduce:

(a) benefits; or

(b) the term for which coverage would otherwise remain in force or for which benefits would be paid;

(iv) reissuance of the contract with a reduction in cash value; or

(v) pledge of the contract as collateral or subjection of the contract to borrowing, whether in a single loan or under a schedule of borrowing, for amounts that in the aggregate exceed 25 percent of the loan value prescribed by the contract; or

(2) directly or indirectly receive a commission or other compensation that results or may result from a solicitation, sale, or other agency transaction described by Subdivision (1).

(b) A person who holds a permanent license may not circumvent or attempt to circumvent the intent of this section by acting for or with a person holding a temporary license. (V.T.I.C. Art. 21.07, Sec. 3A(f).)

Sec. 4001.159. SUSPENSION OR REVOCATION OF TEMPORARY APPOINTMENT POWERS OF AGENT, INSURER, OR HEALTH MAINTENANCE ORGANIZATION. (a) The department may suspend or revoke the temporary appointment powers of an agent, insurer, or health maintenance organization if, after notice and opportunity for

hearing, the department determines that the agent, insurer, or health maintenance organization has abused the temporary appointment powers.

(b) In determining whether abuse has occurred, the department may consider:

(1) the number of temporary appointments made;

(2) the percentage of appointees taking the examination required for licensing as an agent, as provided by Section 4001.161; and

(3) the number of appointees who pass the examination. (V.T.I.C. Art. 21.07, Sec. 3A(g) (part).)

Sec. 4001.160. TRAINING OF APPLICANT FOR TEMPORARY LICENSE. (a) An agent, insurer, or health maintenance organization that is considering appointment of a temporary license applicant as its agent shall provide at least 40 hours of training to the applicant not later than the 14th day after the date the application, nonrefundable fee, and certificate are delivered or mailed to the department.

(b) At least 10 hours of the training must be taught in a classroom setting, including:

(1) an accredited college, university, junior college, or community college;

(2) a business school; or

(3) a private institute or classes sponsored by the agent, insurer, or health maintenance organization and specifically established for that purpose.

(c) The training program must be designed to provide an

applicant with basic knowledge of:

(1) the broad principles of insurance, including the licensing and regulatory laws of this state;

(2) the broad principles of health maintenance organizations, including membership requirements and related licensing and regulatory laws of this state; and

(3) the ethical obligations and duties of an agent.

(d) If the department determines under Section 4001.159 that an abuse of temporary appointment powers has occurred, the department may require the affected agent, insurer, or health maintenance organization to:

(1) file with the department a description of the agent's, insurer's, or health maintenance organization's training program; and

(2) obtain the approval of the department before continuing to use the training program. (V.T.I.C. Art. 21.07, Secs. 3A(a) (part), (h), (i).)

Sec. 4001.161. DUTY TO ENSURE THAT APPLICANTS TAKE LICENSING EXAMINATION. An agent, insurer, or health maintenance organization shall ensure that, during any two consecutive calendar quarters, at least 70 percent of the agent's, insurer's, or health maintenance organization's applicants for temporary licenses take the required licensing examination. At least 50 percent of the applicants taking the examination must pass the examination during that period. (V.T.I.C. Art. 21.07, Sec. 3A(j).)

Sec. 4001.162. RESTRICTION ON APPOINTMENT OF TEMPORARY LICENSE HOLDERS. An agent, insurer, or health maintenance

organization may not appoint more than 250 temporary license holders during a calendar year. (V.T.I.C. Art. 21.07, Sec. 3A(k).)

[Sections 4001.163-4001.200 reserved for expansion]

SUBCHAPTER E. APPOINTMENT OF AGENT

Sec. 4001.201. APPOINTMENT REQUIRED. A person who obtains a license under this title may not engage in business as an agent unless the person has been appointed to act as an agent by an insurer designated by the provisions of this code and authorized to engage in business in this state. (V.T.I.C. Art. 21.07, Sec. 1(a) (part).)

Sec. 4001.202. APPOINTMENT BY MULTIPLE INSURERS. (a) Except as specifically prohibited by this code, an agent may represent and act as an agent for more than one insurer.

(b) Not later than the 30th day after the effective date of the appointment, the agent and the insurer involved shall notify the department, on a form prescribed by the department, of any additional appointment authorizing the agent to act as agent for one or more additional insurers. The notice must be accompanied by a nonrefundable fee in an amount set by the department for each additional appointment for which the insurer applies. (V.T.I.C. Art. 21.07, Sec. 6(a).)

Sec. 4001.203. TERM OF APPOINTMENT. (a) An appointment authorizing an agent to act for an insurer continues in effect without the necessity of renewal until the appointment is terminated or withdrawn by the insurer or the agent.

(b) A renewal license issued to an agent authorizes the agent to represent and act for each insurer for which the agent

holds an appointment until the appointment is terminated or withdrawn, and the agent is considered to be the agent of each appointing insurer for the purposes of this code. (V.T.I.C. Art. 21.07, Sec. 6(b) (part).)

Sec. 4001.204. AUTHORITY TO ACT AS AGENT BEFORE NOTICE OF APPOINTMENT. An agent appointed under this subchapter may act on behalf of the appointing insurer before the department receives the notice filed under Section 4001.202(b). (V.T.I.C. Art. 21.07, Sec. 6(c).)

Sec. 4001.205. APPOINTMENT OF SUBAGENT; TERMINATION. (a) A general life, accident, and health agent or a general property and casualty agent appointed by an insurer authorized to engage in the business of insurance in this state shall notify the department on a form prescribed by the department if the agent appoints a subagent. The notice must be accompanied by a nonrefundable fee in an amount set by the department.

(b) An insurer is not required to separately appoint a subagent who has been designated by an agent in a notice filed with the department under Subsection (a).

(c) An agent who terminates the appointment of a subagent for a reason other than for cause shall promptly report the termination to the department. The termination ends the subagent's authority to act for the agent or the insurer for whom the agent is acting.

(d) Section 4001.206 applies to the termination of the appointment of a subagent for cause. (V.T.I.C. Art. 21.07, Secs. 6(d), (e), (f).)

Sec. 4001.206. TERMINATION OF APPOINTMENT OF AGENT FOR CAUSE; LIABILITY. (a) On termination of the appointment of an agent for cause, the insurer or agent shall immediately file with the department a statement of the facts relating to the termination of the appointment and the date and cause of the termination. On receipt of the statement, the department shall record the termination of the appointment of that agent to represent the insurer in this state.

(b) A document, record, statement, or other information required to be made or disclosed to the department under this section is a privileged and confidential communication and is not admissible in evidence in a court action or proceeding except under a subpoena issued by a court of record.

(c) A person, including an insurer or an employee or agent of an insurer, who provides without malice information required to be disclosed under this section is not liable for providing the information. (V.T.I.C. Art. 21.07, Secs. 6(b) (part), 6B.)

[Sections 4001.207-4001.250 reserved for expansion]

SUBCHAPTER F. REGULATION OF AGENTS

Sec. 4001.251. INCORPORATION OF SOLE PROPRIETORSHIP. An individual engaged in business as a sole proprietorship under a license issued under this title may incorporate. The corporation does not have greater license authority than that granted to the license holder in the holder's individual capacity. (V.T.I.C. Art. 21.07, Sec. 2(g).)

Sec. 4001.252. NOTIFICATION TO DEPARTMENT OF CERTAIN INFORMATION. (a) An individual licensed as an agent shall notify

the department on a monthly basis of:

(1) a change of the license holder's mailing address;

(2) a felony conviction of the license holder; or

(3) an administrative action taken against the license holder by a financial or insurance regulator of this state, another state, or the United States.

(b) A corporation or partnership licensed as an agent under this title shall file under oath, on a form developed by the department, biographical information for:

(1) each executive officer, director, or unlicensed partner who administers the entity's operations in this state;

(2) each shareholder who is in control of the corporation or partner who has the right or ability to control the partnership; and

(3) if the corporation or partnership is owned, in whole or in part, by another entity, each individual who is in control of the parent entity.

(c) A corporation or partnership shall notify the department not later than the 30th day after the date of:

(1) a felony conviction of a licensed agent of the entity or an individual associated with the entity who is required to file biographical information with the department;

(2) an event for which notification would be required under Section 81.003; or

(3) the addition or removal of an officer, director, partner, member, or manager. (V.T.I.C. Art. 21.07, Secs. 2(h), (k), (l).)

Sec. 4001.253. RESTRICTION ON ACQUISITION OF OWNERSHIP INTEREST IN ENTITY LICENSED AS AGENT. (a) A person may not acquire in any manner an ownership interest in an entity licensed as an agent under this title if the person is, or after the acquisition would be, directly or indirectly in control of the license holder, or otherwise acquire control of or exercise any control over the license holder, unless the person has filed with the department under oath:

(1) a biographical form for each person by whom or on whose behalf the acquisition of control is to be effected;

(2) a statement certifying that no person who is acquiring an ownership interest in or control of the license holder has been the subject of a disciplinary action taken by a financial or insurance regulator of this state, another state, or the United States;

(3) a statement certifying that, immediately on the change of control, the license holder will be able to satisfy the requirements for the issuance of the license to solicit each line of insurance for which it is licensed; and

(4) any additional information that the commissioner by rule may prescribe as necessary or appropriate to the protection of the insurance consumers of this state or as in the public interest.

(b) The department may require a partnership, syndicate, or other group that is required to file a statement under Subsection (a) to provide the information under that subsection for each partner of the partnership, each member of the syndicate or group,

and each person who controls the partner or member. If the partner, member, or person is a corporation or the person required to file the statement under Subsection (a) is a corporation, the department may require that the information required under that subsection be provided regarding:

(1) the corporation;

(2) each individual who is an executive officer or director of the corporation; and

(3) each person who is directly or indirectly the beneficial owner of more than 10 percent of the outstanding voting securities of the corporation.

(c) The department may disapprove an acquisition of control if, after notice and opportunity for hearing, the commissioner determines that:

(1) immediately on the change of control the license holder would not be able to satisfy the requirements for the issuance of the license to solicit each line of insurance for which it is presently licensed;

(2) the competence, trustworthiness, experience, and integrity of the persons who would control the operation of the license holder are such that it would not be in the interest of the insurance consumers of this state to permit the acquisition of control; or

(3) the acquisition of control would violate this code or another law of this state, another state, or the United States.

(d) Notwithstanding Subsection (c), a change in control is considered approved if the department has not proposed to deny the

requested change before the 61st day after the date the department receives all information required by this section. (V.T.I.C. Art. 21.07, Secs. 2(n), (o), (p), (q).)

Sec. 4001.254. MAINTENANCE OF QUALIFICATIONS. The department shall, in the manner provided by Subchapter C, Chapter 4005, revoke, suspend, or refuse to renew the license of a license holder who does not maintain the qualifications necessary to obtain the license. (V.T.I.C. Art. 21.07, Sec. 2(s).)

Sec. 4001.255. MAINTENANCE OF RECORDS. An agent shall maintain all insurance records, including all records relating to customer complaints, separate from the records of any other business in which the agent may be engaged. (V.T.I.C. Art. 21.07, Sec. 2(t).)

[Sections 4001.256-4001.300 reserved for expansion]

SUBCHAPTER G. OTHER PERSONS WHO MAY SHARE IN PROFITS OF AGENCY

Sec. 4001.301. PROFITS AFTER DEATH OF AGENT WHO IS MEMBER OF AGENCY PARTNERSHIP. On the death of an agent who is a member of an agency partnership, the surviving spouse and children, if any, of the deceased partner, or a trust for the surviving spouse and children, may share in the profits of the agency partnership during the lifetime of the surviving spouse or children, as the case may be, as provided by:

(1) a written partnership agreement; or

(2) in the absence of a written agreement, an agreement by the surviving partner or partners and the surviving spouse, the trustee, and the legal representative of the surviving

children. (V.T.I.C. Art. 21.07, Sec. 2A(a).)

Sec. 4001.302. PROFITS AFTER DEATH OF AGENT WHO IS SOLE PROPRIETOR. (a) On the death of an agent who is a sole proprietor, unless otherwise provided by the probated will of the deceased agent, the surviving spouse and children, if any, of the deceased agent, or a trust for the surviving spouse or children, may share in the profits of the agency business of the deceased agent during the lifetime of the surviving spouse and children if the agency business is continued by an agent.

(b) The surviving spouse and children or trust is not required to qualify as an agent to share in the profits of the agency but may not perform an act of an agent in connection with the agency business without first being licensed as an agent. (V.T.I.C. Art. 21.07, Sec. 2A(b) (part).)

Sec. 4001.303. PROFITS AFTER DEATH OF SHAREHOLDER OF CORPORATE AGENCY. (a) On the death of a shareholder of a corporate licensed agency, the surviving spouse and children, if any, of the deceased shareholder, or a trust for the surviving spouse and children, may share in the profits of the corporate agency during the lifetime of the surviving spouse or children as provided by a contract entered into by each shareholder and the corporation.

(b) The surviving spouse and children or trust is not required to qualify as an agent to share in the profits of the corporation but may not perform an act of an agent on behalf of the corporation without qualifying as an agent. (V.T.I.C. Art. 21.07, Sec. 2A(c) (part).)

Sec. 4001.304. TRANSFER OF INTEREST IN AGENCY BY AGENT WHO

IS SOLE PROPRIETOR. (a) An agent who is a sole proprietor may transfer an interest in the agency to the agent's children, or a trust for the agent's children, and may operate that interest for their use and benefit. The children may share in the profits of the agency during their lifetime.

(b) The children are not required to qualify as agents to share in the profits of the agency but may not perform an act of an agent in connection with the agency business without first being licensed as agents. (V.T.I.C. Art. 21.07, Sec. 2A(b) (part).)

Sec. 4001.305. TRANSFER OF INTEREST IN AGENCY BY SHAREHOLDER OF CORPORATE AGENCY. (a) A shareholder of a corporate licensed agency may, if provided by a contract entered into by each shareholder and the corporation, transfer an interest in the agency to the shareholder's children or a trust for the shareholder's children. The children or trust may share in the profits of the agency to the extent of that interest during the children's lifetime.

(b) The children or trust is not required to qualify as an agent to share in the profits of the corporation but may not perform an act of an agent on behalf of the corporation without qualifying as an agent. (V.T.I.C. Art. 21.07, Sec. 2A(c) (part).)

CHAPTER 4002. EXAMINATION OF LICENSE APPLICANTS

SUBCHAPTER A. GENERAL PROVISIONS

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SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4002.001. EXAMINATION REQUIRED. (a) Except as otherwise provided by this code, an applicant for a license to act as an agent in this state must:

(1) take a personal written examination prescribed by the commissioner; and

(2) pass the examination to the satisfaction of the department.

(b) The examination must determine the applicant's competence with respect to:

(1) the type of insurance contracts for which the

applicant seeks a license;

(2) the laws of this state regulating the business of insurance; and

(3) the ethical obligations and duties of an agent. (V.T.I.C. Art. 21.01-1, Sec. 2(a).)

Sec. 4002.002. EXAMINATION FOR LIMITED LICENSE. (a) The commissioner shall prescribe a limited written examination for an applicant for a limited agent's license under Chapter 4051 or 4054.

(b) The examination must determine the applicant's competence and understanding of:

(1) the basic principles of insurance contracts;

(2) the basic laws of this state regulating the business of insurance; and

(3) the ethical obligations and duties of an agent. (V.T.I.C. Art. 21.01-1, Sec. 2(c).)

Sec. 4002.003. EXEMPTIONS FROM EXAMINATION REQUIREMENT. (a) The department may not require a person to take an examination under this chapter if the person is:

(1) an applicant for the renewal of an unexpired license issued by the department;

(2) an applicant whose license issued by the department expired less than one year before the date of the application, if the previous license was not denied, revoked, or suspended by the commissioner;

(3) a partnership, corporation, or depository institution;

(4) an applicant for a life, accident, and health

license who is designated as a chartered life underwriter (CLU);

(5) an applicant for a life and health insurance counselor license who is designated as a chartered life underwriter (CLU), chartered financial consultant (ChFC), or certified financial planner (CFP);

(6) an applicant for a property and casualty license who is designated as a chartered property casualty underwriter (CPCU);

(7) an applicant for a specialty license issued under Chapter 4055;

(8) a nonresident individual who is exempt from the examination requirement under Chapter 4056; or

(9) an applicant for a general life, accident, and health license who was authorized to solicit or procure insurance on behalf of a fraternal benefit society on September 1, 1999, if the applicant:

(A) solicited or procured insurance on behalf of the fraternal benefit society for at least 24 months preceding September 1, 1999; and

(B) does not, on or after September 1, 1999, solicit or procure:

(i) insurance for any other insurer or a different fraternal benefit society;

(ii) an insurance contract from anyone other than a person who is eligible for membership in the fraternal benefit society; or

(iii) an interest-sensitive life insurance

contract that exceeds $35,000 of coverage on an individual life, unless the applicant is designated as a "Fraternal Insurance Counselor" at the time the contract is solicited or procured.

(b) A license to which the exemption authorized by Subsection (a)(9) applies must be held by the applicant in an individual capacity and is not transferable. (V.T.I.C. Art. 21.01-1, Secs. 2(d), (e).)

Sec. 4002.004. ADVISORY BOARD. (a) The commissioner may appoint one or more advisory boards to make recommendations to the commissioner or the testing service regarding:

(1) the scope, type, and conduct of examinations required by this chapter; and

(2) the times and locations in this state where the examinations shall be held.

(b) The commissioner may appoint to an advisory board any combination of the following:

(1) a person who holds a license for which an examination is intended;

(2) an employee of an insurer that appoints license holders for which an examination is intended;

(3) a person who acts as a general agent or manager;

(4) a person who teaches insurance at an accredited college or university in this state; or

(5) a resident of this state who is not described by Subdivisions (1)-(4).

(c) A member of an advisory board serves without compensation but is entitled to reimbursement for reasonable

expenses incurred in attending meetings of the advisory board. (V.T.I.C. Art. 21.01-1, Sec. 1(b).)

Sec. 4002.005. EXAMINATION FEE. (a) The department shall charge each applicant an examination fee in an amount determined by the department as necessary to administer the examination.

(b) The examination fee must accompany each application to take the examination.

(c) An applicant may receive a refund of the examination fee only if:

(1) the applicant fails to take the examination because of an emergency;

(2) the applicant notifies the department of the emergency at least 24 hours before the time of the examination; and

(3) the department agrees to refund the fee. (V.T.I.C. Art. 21.01-1, Sec. 2(b).)

Sec. 4002.006. BILINGUAL EXAMINATION. An examination administered under this chapter shall be offered in English and Spanish. (V.T.I.C. Art. 21.01-1, Sec. 2(f).)

Sec. 4002.007. EXAMINATION RESULTS. (a) The department shall notify each examinee of the results of a licensing examination administered under this code not later than the 30th day after the date the examination is administered. If an examination is graded or reviewed by a testing service, the department shall notify each examinee of the results of the examination not later than the 14th day after the date the department receives the results from the testing service.

(b) The department may require a testing service to notify

examinees of the results of an examination.

(c) If the notice of the results of an examination graded or reviewed by a testing service will be delayed for longer than 90 days after the examination date, the department shall notify the examinee of the reason for the delay before the 90th day.

(d) If requested in writing by a person who fails a licensing examination administered under this code, the department shall provide to the person an analysis of the person's performance on the examination. (V.T.I.C. Art. 21.01-1, Secs. 1(d), (e).)

[Sections 4002.008-4002.050 reserved for expansion]

SUBCHAPTER B. ADMINISTRATION OF EXAMINATION BY TESTING SERVICE

Sec. 4002.051. ADMINISTRATION BY TESTING SERVICE AUTHORIZED. The commissioner may accept an examination administered by a testing service to satisfy the examination requirements of a person seeking a license as an agent, counselor, or adjuster under this code. (V.T.I.C. Art. 21.01-1, Sec. 1(a) (part).)

Sec. 4002.052. AGREEMENT WITH TESTING SERVICE. (a) The commissioner may negotiate an agreement with a testing service to perform examination services, including:

(1) developing an examination;

(2) scheduling an examination;

(3) arranging the site for an examination; and

(4) administering, grading, reporting, and analyzing an examination.

(b) The commissioner may require a testing service to:

(1) correspond directly with applicants with regard to the administration of examinations;

(2) collect fees for administering examinations directly from applicants; and

(3) provide for the administration of examinations in specific locations and at specified frequencies.

(c) The commissioner shall retain the authority to establish the scope and type of each examination. (V.T.I.C. Art. 21.01-1, Sec. 1(a) (part).)

Sec. 4002.053. HEARING REQUIRED BEFORE AGREEMENT. Before the department may negotiate and enter into an agreement with a testing service:

(1) a hearing must be held in accordance with Chapter 2001, Government Code; and

(2) the commissioner must adopt any rules or standards that the commissioner considers appropriate to implement the authority granted by this chapter. (V.T.I.C. Art. 21.01-1, Sec. 1(a) (part).)

[Sections 4002.054-4002.100 reserved for expansion]

SUBCHAPTER C. DUTIES OF DEPARTMENT

Sec. 4002.101. ADMINISTRATION BY DEPARTMENT. In the absence of an agreement with a testing service, the department shall administer any required examination in accordance with this chapter. (V.T.I.C. Art. 21.01-1, Sec. 1(c) (part).)

Sec. 4002.102. RULES. (a) The commissioner may adopt rules relating to:

(1) the scope, type, and conduct of an examination;

(2) the time and location in this state at which an examination is conducted; or

(3) the designation of textbooks, manuals, and other materials to be studied by an applicant for an examination.

(b) The textbooks, manuals, or other materials designated by the commissioner under Subsection (a)(3) may consist of:

(1) material available to an applicant by purchase from the publisher; or

(2) material prepared at the direction of the commissioner and distributed to an applicant on request and on payment of the reasonable cost of the material. (V.T.I.C. Art. 21.01-1, Sec. 1(c) (part).)

Sec. 4002.103. CONTENT OF EXAMINATION QUESTIONS. All examination questions must be prepared from the contents of the textbooks, manuals, and other materials designated or prepared by the commissioner under Section 4002.102. (V.T.I.C. Art. 21.01-1, Sec. 1(c) (part).)

CHAPTER 4003. LICENSE EXPIRATION AND RENEWAL

Sec. 4003.009. INTERSTATE MOVE BY AGENT

Sec. 4003.010. CHAPTER NOT APPLICABLE TO THIRD-PARTY ADMINISTRATORS

CHAPTER 4003. LICENSE EXPIRATION AND RENEWAL

Sec. 4003.001. LICENSE EXPIRATION. (a) Unless a staggered renewal system is adopted under Section 4003.002, each agent license issued by the department and not suspended or revoked by the commissioner expires on the second anniversary of the date the license is issued.

(b) The commissioner by rule may change the two-year expiration period if the commissioner determines that the change is necessary to promote uniformity of license periods of this state with those of other states. (V.T.I.C. Art. 21.01-2, Sec. 1A(a) (part).)

Sec. 4003.002. STAGGERED RENEWAL SYSTEM. (a) The commissioner by rule may adopt a system under which licenses expire on various dates during a licensing period.

(b) For the licensing period in which the license expiration is changed, license fees shall be prorated so that each license holder pays only that portion of the license fee allocable to the period during which the license is valid. On renewal of the license on the new expiration date, the total renewal fee is payable.

(c) The commissioner shall adopt a system under which a person who holds more than one license may renew all the licenses held in a single process. (V.T.I.C. Art. 21.01-2, Sec. 1A(j).)

Sec. 4003.003. NOTICE OF LICENSE EXPIRATION. Not later than the 30th day before the date a person's license expires, the

department shall send written notice of the impending license expiration to the person at the person's last known mailing address according to the department's records. (V.T.I.C. Art. 21.01-2, Sec. 1A(i).)

Sec. 4003.004. PROCEDURE FOR RENEWAL OF LICENSE. (a) A person may renew an unexpired license by:

(1) filing a properly completed renewal application with the department in the form prescribed by the department; and

(2) paying to the department the required renewal fee in an amount set by the department.

(b) A person may not renew a license that has been suspended or revoked. (V.T.I.C. Art. 21.01-2, Secs. 1A(a) (part), (b) (part).)

Sec. 4003.005. RENEWAL FEE NONREFUNDABLE. A renewal fee paid under this chapter is nonrefundable. (V.T.I.C. Art. 21.01-2, Sec. 1A(a) (part).)

Sec. 4003.006. CONTINUATION OF ORIGINAL LICENSE. The original license of a person who has applied for license renewal in compliance with Section 4003.004 remains in effect from the date the renewal application is filed until the date:

(1) the department issues the renewal license; or

(2) the commissioner issues an order revoking the license. (V.T.I.C. Art. 21.01-2, Sec. 1A(b) (part).)

Sec. 4003.007. RENEWAL OF EXPIRED LICENSE. (a) A person whose license has been expired for 90 days or less may renew the license by:

(1) filing a renewal application with the department

in the form prescribed by the department; and

(2) paying to the department:

(A) the required renewal fee; and

(B) an additional fee equal to one-half of the required renewal fee.

(b) A person whose license has been expired for more than 90 days but less than one year may not renew the license. The person may obtain a new license without taking the applicable examination by:

(1) filing a new application with the department; and

(2) paying to the department:

(A) the license fee; and

(B) an additional fee equal to one-half of the license fee.

(c) A person whose license has been expired for one year or more may not renew the license. The person may obtain a new license by:

(1) submitting to reexamination, if examination is required for original issuance of the license; and

(2) complying with the other requirements and procedures for obtaining an original license. (V.T.I.C. Art. 21.01-2, Secs. 1A(c), (d), (e).)

Sec. 4003.008. RENEWAL OF EXPIRED LICENSE BY OUT-OF-STATE AGENT. (a) The department may renew without reexamination an expired license of a person who was licensed in this state, moved to another state, and is currently licensed and has been in continual practice in the other state preceding the date of the application.

(b) The person must pay to the department a fee equal to the license fee. (V.T.I.C. Art. 21.01-2, Sec. 1A(f).)

Sec. 4003.009. INTERSTATE MOVE BY AGENT. (a) Not later than the 30th day after moving from one state to another state, an agent licensed in this state shall file with the department:

(1) the agent's new address; and

(2) proof of authorization to engage in the business of insurance in the new state of residence.

(b) The department may not charge a fee or require a license application under this section. (V.T.I.C. Art. 21.01-2, Secs. 1A(g), (h).)

Sec. 4003.010. CHAPTER NOT APPLICABLE TO THIRD-PARTY ADMINISTRATORS. This chapter does not apply to a certificate of authority issued under Chapter 4151. (V.T.I.C. Art. 21.01-2, Sec. 1A(k).)

CHAPTER 4004. CONTINUING EDUCATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4004.001. DEPARTMENT JURISDICTION EXCLUSIVE

Sec. 4004.002. ADVISORY COUNCIL

[Sections 4004.003-4004.050 reserved for expansion]

SUBCHAPTER B. AGENT CONTINUING EDUCATION REQUIREMENTS

Sec. 4004.051. GENERAL REQUIREMENTS

Sec. 4004.052. EXTENSIONS AND EXEMPTIONS

Sec. 4004.053. REQUIREMENTS BASED ON TYPE OF LICENSE HELD

Sec. 4004.054. ETHICS REQUIREMENT

[Sections 4004.055-4004.100 reserved for expansion]

SUBCHAPTER C. CONTINUING EDUCATION PROGRAMS

Sec. 4004.101. PROGRAM CERTIFICATION

Sec. 4004.102. CERTIFICATION FEE

Sec. 4004.103. PROVIDER REGISTRATION; OTHER REQUIREMENTS

Sec. 4004.104. INDEPENDENT CONTRACTORS

CHAPTER 4004. CONTINUING EDUCATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4004.001. DEPARTMENT JURISDICTION EXCLUSIVE. The department has exclusive jurisdiction of all matters relating to the continuing education of agents licensed under this code. (V.T.I.C. Art. 21.01-1, Sec. 3(a).)

Sec. 4004.002. ADVISORY COUNCIL. (a) The commissioner may appoint an advisory council to provide the commissioner with information and assistance in the conduct of the continuing education program for agents licensed under this title.

(b) If an advisory council is appointed, the council must be composed of nine members, four of whom must be public members.

(c) A public member is entitled to reimbursement for the member's travel expenses as provided by Chapter 660, Government Code, and the General Appropriations Act.

(d) A public member may not:

(1) be an officer, director, or employee of an insurer, insurance agency, agent, broker, adjuster, or other business entity regulated by the department;

(2) be a person required to register with the Texas Ethics Commission under Chapter 305, Government Code; or

(3) be related to a person described by Subdivision (1) or (2) within the second degree by affinity or consanguinity, as

determined under Chapter 573, Government Code. (V.T.I.C. Art. 21.01-1, Sec. 3(g).)

[Sections 4004.003-4004.050 reserved for expansion]

SUBCHAPTER B. AGENT CONTINUING EDUCATION REQUIREMENTS

Sec. 4004.051. GENERAL REQUIREMENTS. (a) Except as provided by Section 4004.052 or other law, each individual who holds a license issued by the department shall complete continuing education as provided by this chapter.

(b) All required continuing education hours must be completed before the expiration date of the individual's license.

(c) At least 50 percent of all required continuing education hours must be completed in a classroom setting or a classroom equivalent setting approved by the department.

(d) The department may accept continuing education hours completed in other professions or in association with professional designations in an insurance-related field. (V.T.I.C. Art. 21.01-1, Sec. 3(b) (part).)

Sec. 4004.052. EXTENSIONS AND EXEMPTIONS. (a) On the timely written request of an agent, the department may extend the time for the agent to comply with the continuing education requirements of this chapter or may exempt the agent from some or all of the requirements for a licensing period if the department determines that the agent is unable to comply with the requirements because of illness, medical disability, or another extenuating circumstance beyond the control of the agent. The commissioner by rule shall prescribe the criteria for an exemption or extension under this subsection.

(b) An individual who has continuously held for at least 20 years an agent license issued under this code is exempt from the continuing education requirements of this chapter.

(c) The commissioner by rule may provide for other reasonable exemptions from the continuing education requirements of this chapter. (V.T.I.C. Art. 21.01-1, Secs. 3(c), (d).)

Sec. 4004.053. REQUIREMENTS BASED ON TYPE OF LICENSE HELD. (a) An individual who holds a general life, accident, and health license, a life and health insurance counselor license, or a general property and casualty license must complete 15 hours of continuing education annually. If the individual holds more than one license for which continuing education is otherwise required, the individual is not required to complete more than 15 continuing education hours annually.

(b) An individual who holds a limited life, accident, and health license or a limited property and casualty license must complete five hours of continuing education annually. (V.T.I.C. Art. 21.01-1, Sec. 3(b) (part).)

Sec. 4004.054. ETHICS REQUIREMENT. Each individual who holds a license issued by the department shall complete two hours of continuing education in ethics during each license renewal period. (V.T.I.C. Art. 21.01-1, Sec. 3(b) (part).)

[Sections 4004.055-4004.100 reserved for expansion]

SUBCHAPTER C. CONTINUING EDUCATION PROGRAMS

Sec. 4004.101. PROGRAM CERTIFICATION. (a) The department shall certify continuing education programs for agents. The certification criteria must be designed to ensure that continuing

education programs enhance the knowledge, understanding, and professional competence of the license holder.

(b) Only a program that satisfies the criteria established by rule by the commissioner may receive certification. (V.T.I.C. Art. 21.01-1, Sec. 3(e) (part).)

Sec. 4004.102. CERTIFICATION FEE. (a) A nonrefundable certification fee, in an amount set by the commissioner as necessary to administer this chapter, must accompany each application for certification of a continuing education program.

(b) The commissioner by rule shall establish the certification fee based on a graduated scale according to the number of hours required to complete the program. (V.T.I.C. Art. 21.01-1, Sec. 3(e) (part).)

Sec. 4004.103. PROVIDER REGISTRATION; OTHER REQUIREMENTS. (a) Each continuing education program provider shall register with the department as a course provider.

(b) The department shall assess a registration fee for each application for registration as a course provider, set by the commissioner in an amount necessary for the proper administration of this chapter.

(c) The commissioner may adopt rules establishing other requirements for continuing education program providers. (V.T.I.C. Art. 21.01-1, Sec. 3(f) (part).)

Sec. 4004.104. INDEPENDENT CONTRACTORS. (a) The department may enter into agreements with independent contractors under which the independent contractor certifies and registers continuing education programs and providers.

(b) The department may require the independent contractors to correspond directly with providers with regard to the administration of continuing education programs. The contractors may collect fees from the providers for administration of the courses.

(c) Notwithstanding Subsections (a) and (b), the department retains the authority to establish the scope and type of continuing education requirements for each type of license. (V.T.I.C. Art. 21.01-1, Sec. 3(f) (part).)

CHAPTER 4005. CONDUCT, DISCIPLINARY ACTIONS, AND SANCTIONS

SUBCHAPTER A. AUTHORIZED CONDUCT

Sec. 4005.001. DEFINITION

Sec. 4005.002. AUTHORIZATION TO OBTAIN CERTAIN RECORDS OR PHOTOGRAPHS

Sec. 4005.003. FEES

[Sections 4005.004-4005.050 reserved for expansion]

SUBCHAPTER B. PROHIBITED CONDUCT

Sec. 4005.051. APPLICABILITY OF SUBCHAPTER

Sec. 4005.052. CERTAIN CONDUCT PROHIBITED AFTER REVOCATION OF LICENSE

Sec. 4005.053. CERTAIN PAYMENTS PROHIBITED TO OR FROM PERSON NOT HOLDING LICENSE

Sec. 4005.054. RECEIVING ADDITIONAL FEE PROHIBITED

Sec. 4005.055. CERTAIN COVERAGE FOR LOSS BY FIRE PROHIBITED

[Sections 4005.056-4005.100 reserved for expansion]

CHAPTER 4005. CONDUCT, DISCIPLINARY ACTIONS, AND SANCTIONS

SUBCHAPTER A. AUTHORIZED CONDUCT

Sec. 4005.001. DEFINITION. In this subchapter, "client" means:

(1) an applicant for insurance coverage; or

(2) an insured. (V.T.I.C. Art. 21.35A, Sec. (a).)

Sec. 4005.002. AUTHORIZATION TO OBTAIN CERTAIN RECORDS OR PHOTOGRAPHS. (a) In connection with a client's application for insurance coverage, the issuance of an insurance policy to a client, or on a client's request, a general property and casualty agent may obtain:

(1) the motor vehicle record of a person insured under or to be insured under an insurance policy; or

(2) a photograph of property insured under or to be insured under an insurance policy.

(b) The agent must provide a copy of the motor vehicle record to the client. (V.T.I.C. Art. 21.35A, Sec. (b) (part).)

Sec. 4005.003. FEES. (a) A general property and casualty agent may charge a client a fee to reimburse the agent for costs the agent incurred in obtaining a motor vehicle record or photograph of property described under Section 4005.002. The fee may not exceed the actual costs to the agent.

(b) For services provided to a client, a general property and casualty agent may charge a reasonable fee, including a fee for:

(1) special delivery or postal charges;

(2) printing or reproduction costs;

(3) electronic mail costs;

(4) telephone transmission costs; and

(5) similar costs that the agent incurs on behalf of the client.

(c) A general property and casualty agent may charge a client a fee under this section only if, before the agent incurs an expense for the client, the agent:

(1) notifies the client of the agent's fee; and

(2) obtains the client's written consent for each fee to be charged. (V.T.I.C. Art. 21.35A, Secs. (b) (part), (c), (d).)

[Sections 4005.004-4005.050 reserved for expansion]

SUBCHAPTER B. PROHIBITED CONDUCT

Sec. 4005.051. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a person who holds a license or certificate of authority issued under Title 11. (V.T.I.C. Art. 21.01-2, Sec. 2A(i).)

Sec. 4005.052. CERTAIN CONDUCT PROHIBITED AFTER REVOCATION OF LICENSE. A person whose insurance license has been revoked in this state or any other state may not:

(1) solicit or otherwise engage in business under Chapter 885 unless the department determines it to be in the public interest, for good cause shown, to permit the person to act in that capacity; or

(2) act as an officer, director, member, manager, or partner, or as a shareholder with a controlling interest, of an entity holding a license issued under this title unless the department determines it to be in the public interest, for good

cause shown, to permit the person to act in that capacity. (V.T.I.C. Art. 21.01-2, Secs. 2A(e), (f).)

Sec. 4005.053. CERTAIN PAYMENTS PROHIBITED TO OR FROM PERSON NOT HOLDING LICENSE. (a) An insurer or agent engaged in the business of insurance in this state may not pay to any person, directly or indirectly, and may not accept from any person a commission or other valuable consideration for a service performed by that person as an agent in this state unless the person holds a license to act as an agent in this state.

(b) Subsection (a) does not prevent the payment of a renewal or other deferred commission to a person or the acceptance of a renewal or other deferred compensation by a person solely because the person no longer holds a license to act as an agent.

(c) An agent may not pay, permit, or give or offer to pay, permit, or give, directly or indirectly, to any person who does not hold a license as an agent:

(1) a rebate of premiums payable, a commission, employment, a contract for service, or any other valuable consideration or inducement that is not specified in the insurance policy or contract for or on account of the solicitation or negotiation of an insurance contract; or

(2) a fee or other valuable consideration for referring a customer who seeks to purchase an insurance product or seeks an opinion on or advice regarding an insurance product, based on that customer's purchase of insurance. (V.T.I.C. Art. 21.01-2, Secs. 2A(b), (c), (h).)

Sec. 4005.054. RECEIVING ADDITIONAL FEE PROHIBITED. A

person who holds a license under this code and receives a commission or other consideration for services as an agent may not receive an additional fee for those services provided to the same client except for a fee described by Section 550.001 or 4005.003. (V.T.I.C. Art. 21.01-2, Sec. 2A(a).)

Sec. 4005.055. CERTAIN COVERAGE FOR LOSS BY FIRE PROHIBITED. A property and casualty agent may not knowingly grant, write, or permit a greater amount of insurance against loss by fire than the reasonable value of the insured subject. (V.T.I.C. Art. 21.01-2, Sec. 2A(g).)

[Sections 4005.056-4005.100 reserved for expansion]

SUBCHAPTER C. DISCIPLINARY ACTIONS AND PROCEDURES; ENFORCEMENT

Sec. 4005.101. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION. (a) This section does not apply to a person who holds a license or certificate of authority issued under Title 11.

(b) The department may deny a license application or discipline a license holder under this subchapter if the department determines that the applicant or license holder, individually or through an officer, director, or shareholder:

(1) has wilfully violated an insurance law of this state;

(2) has intentionally made a material misstatement in the license application;

(3) has obtained or attempted to obtain a license by fraud or misrepresentation;

(4) has misappropriated, converted to the applicant's

or license holder's own use, or illegally withheld money belonging to:

(A) an insurer;

(B) a health maintenance organization; or

(C) an insured, enrollee, or beneficiary;

(5) has engaged in fraudulent or dishonest acts or practices;

(6) has materially misrepresented the terms and conditions of an insurance policy or contract, including a contract relating to membership in a health maintenance organization;

(7) has made or issued, or caused to be made or issued, a statement misrepresenting or making incomplete comparisons regarding the terms or conditions of an insurance or annuity contract legally issued by an insurer or a membership issued by a health maintenance organization to induce the owner of the contract or membership to forfeit or surrender the contract or membership or allow it to lapse for the purpose of replacing the contract or membership with another;

(8) has been convicted of a felony;

(9) has offered or given a rebate of an insurance premium or commission to an insured or enrollee;

(10) is not actively engaged in soliciting or writing insurance for the public generally as required by Section 4001.104(a); or

(11) has obtained or attempted to obtain a license, not for the purpose of holding the applicant or license holder out to the general public as an agent, but primarily for the purpose of

soliciting, negotiating, or procuring an insurance or annuity contract or membership covering:

(A) the applicant or license holder;

(B) a member of the applicant's or license holder's family; or

(C) a business associate of the applicant or license holder. (V.T.I.C. Art. 21.01-2, Secs. 3A(c), (h).)

Sec. 4005.102. REMEDIES FOR VIOLATION OF INSURANCE LAWS OR COMMISSIONER RULES. In addition to any other remedy available under Chapter 82, for a violation of this code, another insurance law of this state, or a rule of the commissioner, the department may:

(1) deny an application for an original license;

(2) suspend, revoke, or deny renewal of a license;

(3) place on probation a person whose license has been suspended;

(4) assess an administrative penalty; or

(5) reprimand a license holder. (V.T.I.C. Art. 21.01-2, Sec. 3A(a) (part).)

Sec. 4005.103. PROBATED LICENSE SUSPENSION. If a license suspension is probated, the commissioner may require the license holder to:

(1) report regularly to the department on any matter that is the basis of the probation;

(2) limit the license holder's practice to the areas prescribed by the department; or

(3) continue or review professional education until

the license holder attains a degree of skill satisfactory to the commissioner in each area that is the basis of the probation. (V.T.I.C. Art. 21.01-2, Sec. 3A(a) (part).)

Sec. 4005.104. HEARING. (a) If the department proposes to deny an application for an original license or to suspend, revoke, or deny renewal of a license, the applicant or license holder is entitled to a hearing conducted by the State Office of Administrative Hearings as provided by Chapter 40.

(b) Notice of the hearing shall be provided to:

(1) the applicant or license holder; and

(2) any insurer indicated on the application as desiring that the license be issued. (V.T.I.C. Art. 21.01-2, Sec. 3A(b).)

Sec. 4005.105. APPLICATION FOR LICENSE AFTER DENIAL OF APPLICATION OR REVOCATION OF LICENSE. (a) This section does not apply to a person who holds a license or certificate of authority issued under Title 11.

(b) An individual whose license application has been denied or whose license has been revoked under this subchapter may not apply for an agent license before the fifth anniversary of:

(1) the effective date of the denial or revocation; or

(2) the date of a final court order affirming the denial or revocation if judicial review was sought.

(c) A license application filed after the time required by Subsection (b) may be denied by the commissioner if the applicant fails to show good cause why the denial or revocation should not be a bar to the issuance of a new license.

(d) Subsection (c) does not apply to an applicant whose license application was denied for failure by the applicant to:

(1) pass a required written examination; or

(2) submit a properly completed license application. (V.T.I.C. Art. 21.01-2, Secs. 3A(d), (e), (h).)

Sec. 4005.106. APPLICATION FOR LICENSE AFTER CERTAIN DETERMINATIONS. (a) In addition to any other penalty imposed under this code, a person who the department determines has engaged in conduct described by this section may not obtain a license as an agent before the fifth anniversary of the date of the determination.

(b) This section applies to a person who:

(1) acts as an agent without holding a license under this code;

(2) solicits an insurance contract or acts as an agent without having been appointed or designated by an authorized insurer, association, or organization to do so as provided by this code;

(3) solicits an insurance contract or acts as an agent for a person, including an insurer, association, or organization, who is not authorized to engage in the business of insurance in this state without holding a surplus lines agent license issued under Chapter 981; or

(4) as an officer or representative of an insurer, knowingly contracts with or appoints as an agent a person who does not hold a valid license. (V.T.I.C. Art. 21.01-2, Sec. 2A(d).)

Sec. 4005.107. DISCIPLINARY PROCEEDING FOR CONDUCT

COMMITTED BEFORE SURRENDER OR FORFEITURE OF LICENSE. (a) The department may institute a disciplinary proceeding against a former license holder for conduct committed before the effective date of a voluntary surrender or automatic forfeiture of the license.

(b) In a proceeding under this section, the fact that the license holder has surrendered or forfeited the license does not affect the former license holder's culpability for the conduct that is the subject of the proceeding. (V.T.I.C. Art. 21.01-2, Sec. 3A(g).)

Sec. 4005.108. DISABILITY PROBATION. (a) This section does not apply to a person who holds a license or certificate of authority issued under Title 11.

(b) Instead of or in addition to taking disciplinary action under Section 4005.102, 4005.103, 4005.105(c), or 4005.107, the department may order that a license holder who is disabled be placed on disability probation under the terms specified under Chapter 4006 and department rules. (V.T.I.C. Art. 21.01-2, Secs. 3A(f), (h).)

Sec. 4005.109. FINES. (a) To expedite the department's processing of certain violations of this code, the commissioner by rule may establish fines for certain violations.

(b) A violation for which a fine may be assessed under this section includes a failure to:

(1) obtain the total number of continuing education hours before the renewal date of a license;

(2) timely report a change of address to the department; or

(3) notify the department of an administrative action against the agent by a financial or insurance regulator of another state or of the federal government.

(c) This section does not limit the department's authority to take any other disciplinary action against a license holder as otherwise provided by this code.

(d) The dispute of an assessment of a fine under this section is a contested case subject to Chapter 2001, Government Code. (V.T.I.C. Art. 21.01-2, Sec. 5A.)

Sec. 4005.110. ENFORCEMENT OF TITLE. The attorney general, a district or county attorney, or the department acting through the commissioner may bring a proceeding for an injunction or bring any other proceeding to enforce this title and to enjoin any person, firm, corporation, or depository institution from engaging in or attempting to engage in the business of insurance in violation of this code or any other insurance law of this state. (V.T.I.C. Art. 21.01-2, Sec. 6A (part).)

[Sections 4005.111-4005.150 reserved for expansion]

SUBCHAPTER D. CRIMINAL PENALTIES

Sec. 4005.151. ACTING AS AGENT AFTER LICENSE SUSPENSION OR REVOCATION; CRIMINAL PENALTY. (a) A person commits an offense if the person acts as an agent after the person's agent license has been suspended or revoked.

(b) An offense under this section is a felony punishable by:

(1) a fine not to exceed $5,000;

(2) imprisonment for a term of not more than two years; or

(3) both fine and imprisonment under this subsection. (V.T.I.C. Art. 21.15-1, Sec. 1.)

Sec. 4005.152. AGENT ASSISTING OR CONSPIRING WITH PERSON WHOSE LICENSE HAS BEEN SUSPENDED OR REVOKED; CRIMINAL PENALTY. (a) A person commits an offense if the person is an agent who holds a license under this code and the person assists or conspires with a person whose license as an agent has been suspended or revoked to act as an agent.

(b) An offense under this section is a misdemeanor punishable by:

(1) a fine not to exceed $1,000;

(2) confinement in jail for a term of not more than six months; or

(3) both fine and confinement in jail under this subsection. (V.T.I.C. Art. 21.15-1, Sec. 2.)

Sec. 4005.153. EMBEZZLEMENT OR CONVERSION BY AGENT; CRIMINAL PENALTY. (a) A person commits an offense if the person, as an agent for an insurer lawfully engaged in the business of insurance in this state, collects premiums or otherwise receives money or a substitute for money, and the person:

(1) embezzles, fraudulently converts, or appropriates to the person's own use the money or substitute for money; or

(2) with intent to embezzle and contrary to the instructions of or without the consent of the insurer, takes, secretes, or otherwise disposes of or fraudulently withholds, appropriates, lends, invests, or otherwise uses or applies, any money or substitute for money received by the person in the person's

capacity as agent or broker.

(b) A person who commits an offense under this section shall be punished as if the person had stolen the money or substitute for money. (V.T.I.C. Art. 21.15-5.)

CHAPTER 4006. DISABILITY PROBATION OF AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4006.001. DEFINITION

Sec. 4006.002. RULES

[Sections 4006.003-4006.050 reserved for expansion]

SUBCHAPTER B. POWERS AND DUTIES OF DEPARTMENT

Sec. 4006.051. DISABILITY PROBATION ORDER

Sec. 4006.052. RESTITUTION

Sec. 4006.053. DURATION OF PROBATION

Sec. 4006.054. PROBATION CONDITIONS

Sec. 4006.055. SUPERVISION DURING PROBATION

Sec. 4006.056. EFFECT OF NONCOMPLIANCE

CHAPTER 4006. DISABILITY PROBATION OF AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4006.001. DEFINITION. In this chapter, "disability" means any physical, mental, or emotional condition that results in an agent's inability to carry out the agent's professional responsibilities to insureds, the profession, or the public. (V.T.I.C. Art. 21.15-6, Sec. (a) (part).)

Sec. 4006.002. RULES. The commissioner may adopt rules as necessary to implement this chapter. (V.T.I.C. Art. 21.15-6, Sec. (g).)

[Sections 4006.003-4006.050 reserved for expansion]

SUBCHAPTER B. POWERS AND DUTIES OF DEPARTMENT

Sec. 4006.051. DISABILITY PROBATION ORDER. (a) The department may order that an agent be placed on disability probation if, after notice and an opportunity for a hearing, the department determines that the agent is suffering from a disability.

(b) The department may order disability probation for an agent only if the agent demonstrates that:

(1) the disability can be successfully arrested and treated while the agent is engaged in the agent's professional business;

(2) the disability is unlikely to cause harm to the public during the period of rehabilitation;

(3) adequate supervision of any necessary conditions of the probation will occur; and

(4) the agent is capable of competently performing the agent's professional duties. (V.T.I.C. Art. 21.15-6, Secs. (a) (part), (b).)

Sec. 4006.052. RESTITUTION. (a) The department may order disability probation for an agent only if the agent makes full restitution during the probation period to all insureds and other persons harmed by the agent's:

(1) violation of this code or other laws regulating the business of insurance in this state; or

(2) failure to comply with other professional responsibilities.

(b) The department shall require the restitution described

by Subsection (a) as a condition of the probation. (V.T.I.C. Art. 21.15-6, Sec. (e).)

Sec. 4006.053. DURATION OF PROBATION. (a) If the department orders disability probation, the department shall set the probation for a specified period or until further order of the department.

(b) The department may order a probation period that exceeds the one-year maximum suspension authorized under Section 82.052(1). (V.T.I.C. Art. 21.15-6, Sec. (c).)

Sec. 4006.054. PROBATION CONDITIONS. (a) An order placing an agent on disability probation must state the probation conditions.

(b) In establishing the probation conditions, the department shall consider:

(1) the nature and circumstances of the agent's conduct;

(2) the agent's history, character, and condition; and

(3) the nature of the agent's disability.

(c) The department may impose on the agent any of the following probation conditions:

(1) periodic reports to the department;

(2) satisfactory completion of a course of study required by the department;

(3) payment of costs, including reasonable attorney's fees and other expenses, related to the proceedings before the department;

(4) psychological evaluation, counseling, and

treatment;

(5) drug and alcohol abuse evaluation, counseling, and treatment;

(6) abstinence from alcohol or drugs;

(7) mandatory attendance at meetings of Alcoholics Anonymous, Narcotics Anonymous, or similar support groups;

(8) periodic random urine testing to screen for drug and alcohol abuse; and

(9) any other probation condition that the department considers appropriate. (V.T.I.C. Art. 21.15-6, Sec. (d).)

Sec. 4006.055. SUPERVISION DURING PROBATION. The department shall supervise an agent placed on disability probation. (V.T.I.C. Art. 21.15-6, Sec. (f) (part).)

Sec. 4006.056. EFFECT OF NONCOMPLIANCE. On a showing of an agent's failure to comply with the disability probation conditions, the department may:

(1) revoke the probation; or

(2) impose other conditions that the department considers necessary for the public's protection and the agent's rehabilitation. (V.T.I.C. Art. 21.15-6, Sec. (f) (part).)

[Chapters 4007-4050 reserved for expansion]

SUBTITLE B. AGENTS

CHAPTER 4051. PROPERTY AND CASUALTY AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4051.001. APPLICABILITY OF CHAPTER

Sec. 4051.002. REQUIREMENTS APPLICABLE TO CERTAIN AGENT CONTRACTS

CHAPTER 4051. PROPERTY AND CASUALTY AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4051.001. APPLICABILITY OF CHAPTER. (a) This subchapter and Subchapters B-E and G apply to each agent of an insurer authorized to engage in the business of property and casualty insurance in this state.

(b) This subchapter and Subchapters B-E and G apply to each person who performs the acts of an agent, as described by Section 4001.051, whether through an oral, written, electronic, or other form of communication, by soliciting, negotiating, procuring, or collecting a premium on an insurance contract offered by any kind of insurer authorized to engage in the business of property and casualty insurance in this state, including:

(1) a fidelity or surety company;

(2) a mutual insurance company, including a farm mutual or a county mutual;

(3) a reciprocal or interinsurance exchange; and

(4) a Lloyd's plan. (V.T.I.C. Art. 21.14, Sec. 1(b).)

Sec. 4051.002. REQUIREMENTS APPLICABLE TO CERTAIN AGENT CONTRACTS. An agent's contract entered into on or after August 27,

1973, by an insurer engaged in the business of property and casualty insurance in this state is subject to Article 21.11-2. (New.)

[Sections 4051.003-4051.050 reserved for expansion]

SUBCHAPTER B. GENERAL PROPERTY AND CASUALTY LICENSE

Sec. 4051.051. LICENSE REQUIRED. A person is required to hold a general property and casualty license if the person acts as:

(1) an agent who writes property and casualty insurance for an insurer authorized to engage in the business of property and casualty insurance in this state;

(2) a subagent of a person who holds a license as an agent under this chapter who solicits and binds insurance risks for that agent; or

(3) an agent who writes any other kind of insurance as required by the commissioner for the protection of the insurance consumers of this state. (V.T.I.C. Art. 21.14, Sec. 2.)

Sec. 4051.052. AUTHORITY TO WRITE ADDITIONAL LINES. A person who holds a general property and casualty license may, in addition, write the kinds of insurance contracts described by:

(1) Section 4051.101 and Subchapter E; or

(2) Chapter 4055. (V.T.I.C. Art. 21.14, Sec. 3.)

Sec. 4051.053. AUTHORITY TO WRITE CERTAIN ACCIDENT AND HEALTH INSURANCE. A person who holds a general property and casualty license may, without holding a license under Chapter 4054, write health and accident insurance for a property and casualty insurer authorized to sell those insurance products in this state. (V.T.I.C. Art. 21.14, Sec. 4.)

Sec. 4051.054. DECEASED, DISABLED, OR INSOLVENT AGENTS;

EMERGENCY LICENSE. (a) If a property and casualty agent dies, becomes disabled, or is found to be insolvent and unable to pay for premiums as they become due to an insurer, the department may issue, without examination, to an applicant for a property and casualty agent license an emergency license on receipt of proof satisfactory to the department that the emergency license is necessary to preserve the agency assets of the deceased, disabled, or insolvent agent.

(b) An emergency license is valid for 90 days in any 12 consecutive months and may be renewed by the department for an additional 90 days during the 12-month period if the other requirements of Subtitle A are satisfied. (V.T.I.C. Art. 21.14, Sec. 5.)

[Sections 4051.055-4051.100 reserved for expansion]

SUBCHAPTER C. LIMITED PROPERTY AND CASUALTY LICENSE

Sec. 4051.101. LICENSE REQUIRED. (a) Except as provided by Section 4051.052, a person is required to hold a limited property and casualty license if the person acts as an agent who writes:

(1) job protection insurance as defined by Article 25.01;

(2) exclusively, insurance on growing crops under Subchapter F;

(3) any form of insurance authorized under Chapter 911 for a farm mutual insurance company;

(4) exclusively, any form of insurance authorized to be solicited and written in this state that relates to:

(A) the ownership, operation, maintenance, or

use of a motor vehicle designed for use on the public highways, including a trailer or semitrailer, and the motor vehicle's accessories or equipment; or

(B) the ownership, occupancy, maintenance, or use of a manufactured home classified as personal property under Section 2.001, Property Code;

(5) a prepaid legal services contract under Article 5.13-1 or Chapter 961;

(6) exclusively, an industrial fire insurance policy:

(A) covering dwellings, household goods, and wearing apparel;

(B) written on a weekly, monthly, or quarterly basis on a continuous premium payment plan; and

(C) written for an insurer exclusively engaged in the business as described by Section 912.310;

(7) credit insurance, except as otherwise provided by Chapter 4055; or

(8) any other kind of insurance, if holding a limited property and casualty license to write that kind of insurance is determined necessary by the commissioner for the protection of the insurance consumers of this state.

(b) Subsection (a)(2) applies to an entity chartered by the federal Farm Credit Administration, as provided by the farm credit system under 12 U.S.C. Section 2001 et seq., as amended.

(c) This section does not apply to a person who wrote for the previous calendar year:

(1) policies authorized by Chapter 911 for a farm

mutual insurance company that generated, in the aggregate, less than $50,000 in direct premium; or

(2) industrial fire insurance policies that generated, in the aggregate, less than $20,000 in direct premium. (V.T.I.C. Art. 21.14, Secs. 6(a), (b), (d).)

Sec. 4051.102. DESIGNATION OF KINDS OF INSURANCE. A person who holds a limited property and casualty license may write only the kind of insurance designated on the license. (V.T.I.C. Art. 21.14, Sec. 6(c).)

[Sections 4051.103-4051.150 reserved for expansion]

SUBCHAPTER D. INSURANCE SERVICE REPRESENTATIVE LICENSE

Sec. 4051.151. LICENSE REQUIRED. A person is required to hold an insurance service representative license if the person is a salaried employee who performs assigned duties only in an office of a property and casualty agent, including explaining insurance coverage, describing an insurance product, quoting insurance premium rates, and issuing insurance binders only with the express approval of the property and casualty agent who supervises the license holder. (V.T.I.C. Art. 21.14, Sec. 8(a).)

Sec. 4051.152. APPLICABILITY OF CERTAIN REQUIREMENTS. The provisions of this title that apply to the holder of a general property and casualty license apply to the holder of a license issued under this subchapter, except that proof of financial responsibility is not required for a person licensed only under this subchapter. (V.T.I.C. Art. 21.14, Sec. 8(b).)

[Sections 4051.153-4051.200 reserved for expansion]

SUBCHAPTER E. COUNTY MUTUAL AGENT LICENSE

Sec. 4051.201. LICENSE ISSUANCE. The department shall issue a license to an individual applicant to act as an agent for a county mutual insurance company under Chapter 912 on receipt of certification from the company that the applicant has:

(1) completed a course of study and instruction in compliance with this subchapter; and

(2) passed without aid a written examination administered by the company. (V.T.I.C. Art. 21.14, Sec. 9(a) (part).)

Sec. 4051.202. COURSE. (a) To be eligible to receive a license under this subchapter, an applicant must complete a course of study and instruction offered by the applicable company on motor vehicle insurance and insurance covering dwellings.

(b) The course of study and instruction must:

(1) be at least five hours in duration; and

(2) include instruction on:

(A) the policies to be sold; and

(B) the laws relating to the regulation of insurance in this state. (V.T.I.C. Art. 21.14, Secs. 9(a) (part), (b).)

Sec. 4051.203. EXAMINATION. (a) The commissioner shall prescribe a uniform examination for applicants that fairly tests knowledge of the information contained in the course provided under Section 4051.202.

(b) The department shall authorize a county mutual insurance company to administer the examination after approval by the department of a complete outline and explanation of the course

and the manner of conducting the examination. (V.T.I.C. Art. 21.14, Sec. 9(c).)

Sec. 4051.204. INVESTIGATION BY DEPARTMENT. The department may investigate as necessary the manner of instruction and the examination administered by a company under this subchapter. (V.T.I.C. Art. 21.14, Sec. 9(d) (part).)

Sec. 4051.205. WITHDRAWAL OF COMPANY'S AUTHORITY. The department may withdraw from a county mutual insurance company the authority under this subchapter to offer instruction and administer an examination. (V.T.I.C. Art. 21.14, Sec. 9(d) (part).)

Sec. 4051.206. APPLICABILITY OF LIMITED LICENSE LAWS. Except as specifically provided by this subchapter, the provisions of this title that apply to the holder of a limited license apply to the holder of a license issued under this subchapter. (V.T.I.C. Art. 21.14, Sec. 9(e).)

[Sections 4051.207-4051.250 reserved for expansion]

SUBCHAPTER F. AGRICULTURAL INSURANCE AGENT

Sec. 4051.251. APPOINTMENT OF AGENT. (a) An insurer that holds a valid certificate of authority to engage in the business of insurance in this state and whose authority in this state and each other jurisdiction in which the insurer is authorized to engage in the business of insurance is limited to the business of insuring risks on growing crops may, subject to this subchapter, appoint and act through an agent licensed under Subchapter B, C, or E.

(b) An agent appointed under Subsection (a) may act as an agent for more than one insurer but may act as an agent under this subchapter only with respect to the business of insuring risks on

growing crops.

(c) This title applies to the licensing and regulation of an agent appointed under this subchapter. (V.T.I.C. Art. 21.14-2, Secs. 1, 3, 4.)

Sec. 4051.252. REQUIREMENTS FOR APPOINTMENT; PROCEDURE. (a) To appoint an agent under this subchapter, an insurer must submit a completed appointment form to the department and pay a nonrefundable fee in an amount set by the department.

(b) The appointment form must be signed by a representative of the insurer.

(c) The department shall approve an appointment unless the department determines that the applicant does not meet the requirements of this title.

(d) The department may waive any examination requirement imposed by this title for a license applicant seeking an appointment under this subchapter who has passed an examination as required by Federal Crop Insurance Corporation guidelines for administering the federal crop insurance program. (V.T.I.C. Art. 21.14-2, Secs. 2(a), (b), (c).)

Sec. 4051.253. ACCEPTANCE OF CERTAIN CONTINUING EDUCATION. The department may accept continuing education hours completed under the guidelines of the Federal Crop Insurance Corporation as satisfying the continuing education requirements imposed under this title. (V.T.I.C. Art. 21.14-2, Sec. 2(d).)

Sec. 4051.254. RULES. The commissioner may adopt rules necessary to implement this subchapter and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art.

21.14-2, Sec. 5.)

[Sections 4051.255-4051.300 reserved for expansion]

SUBCHAPTER G. REGISTRATION OF HOME OFFICE EMPLOYEES

Sec. 4051.301. REGISTRATION AND DISCLOSURE REQUIRED; FEE. (a) A person is required to be registered with the department if the person acts as a full-time home office salaried employee who solicits or receives an application for the sale of insurance through an oral, written, or electronic communication for an insurer authorized to engage in the business of insurance in this state.

(b) A person who registers under this section must submit a nonrefundable registration fee in an amount set by the department.

(c) A person registered under this section shall disclose that the person is registered on making an oral, written, or electronic communication to solicit or receive an application for the sale of insurance. (V.T.I.C. Art. 21.14, Secs. 7(a), (d), (e).)

Sec. 4051.302. CONTINUING EDUCATION REQUIREMENTS. (a) An insurer authorized to engage in the business of insurance in this state whose general plan of operation includes the use of employees described by Section 4051.301 shall certify to the department that each of those employees receives at least 15 hours of continuing education annually.

(b) Each continuing education course provided by the insurer must be submitted to the department for certification as provided by Chapter 4004.

(c) A person registered under this subchapter shall comply with the continuing education requirements imposed by Chapter 4004

as if the person were a licensed agent.

(d) The continuing education required by this section must be designed to give the employees:

(1) reasonable familiarity with:

(A) the broad principles of insurance;

(B) insurance licensing and regulatory laws; and

(C) the terms and conditions of the insurance that the employees transact;

(2) a fair and general understanding of the duties of an insurer to an insured; and

(3) training in ethical considerations. (V.T.I.C. Art. 21.14, Sec. 7(b).)

Sec. 4051.303. SUSPENSION OF REGISTERED EMPLOYEE; DISCIPLINARY ACTION AGAINST INSURER. The registration of an employee under this subchapter shall be suspended and the insurer who employs the registered employee may be disciplined for any act for which an agent may be disciplined under Subchapter C, Chapter 4005. (V.T.I.C. Art. 21.14, Sec. 7(c).)

[Sections 4051.304-4051.350 reserved for expansion]

SUBCHAPTER H. TERMINATION OR SUSPENSION OF AGENT CONTRACTS BY PROPERTY AND CASUALTY INSURERS

Sec. 4051.351. APPLICABILITY OF SUBCHAPTER. (a) Except as provided by Subsection (b), this subchapter applies to each contract between an agent and an insurer engaged in the business of property and casualty insurance in this state.

(b) This subchapter does not apply to:

(1) the termination or suspension by an insurer of an

agent's contract because of:

(A) insolvency;

(B) abandonment;

(C) gross and wilful misconduct;

(D) failure to pay the insurer money due to the insurer after receipt of a written demand; or

(E) revocation of the agent's license by the department; or

(2) the termination or suspension by an insurer of an agent's contract if the insurance policies and insurance business are owned by the insurer rather than the agent. (V.T.I.C. Art. 21.11-1, Secs. 3, 4.)

Sec. 4051.352. SUSPENSION OF AGENT'S CONTRACT; OTHER DEFINITIONS. (a) For purposes of this subchapter, "suspension," with regard to an agent's contract, means the temporary cessation of business relations between an insurer and an agent and refusal by the insurer to accept insurance contracts submitted by the agent. The term does not include a situation in which business is suspended immediately after a natural disaster.

(b) The commissioner shall adopt reasonable rules to provide definitions necessary to accomplish the purposes of this subchapter. (V.T.I.C. Art. 21.11-1, Secs. 1(a) (part), (f).)

Sec. 4051.353. NOTICE REQUIRED BEFORE TERMINATION OR SUSPENSION OF CONTRACT. (a) An insurer may not terminate or suspend a contract with an appointed agent that has been in effect for at least two years unless the insurer provides written notice of the termination or suspension to the agent at least six months

before the date the termination or suspension takes effect.

(b) A contract that replaces or revises a contract that has been in effect for at least two years is subject to this subchapter if there has not been a material change in the ownership of the agency. (V.T.I.C. Art. 21.11-1, Secs. 1(a) (part), (e).)

Sec. 4051.354. AUTOMATIC TERMINATION OF CONTRACT ON WITHDRAWAL FROM STATE OR REDUCTION OF BUSINESS. (a) An insurer that withdraws from this state or reduces the insurer's total annual premium volume by at least 75 percent in any year is considered to have terminated the contracts of the insurer's agents. Except as provided by Subsection (b), the insurer shall comply with the requirements of this subchapter.

(b) An insurer described by Subsection (a) shall renew each contract for property and casualty insurance for the affected agent for 24 months from the date of the notice of termination or suspension of the contract.

(c) This section does not apply to the transfer of business from an insurer to another insurer with which the agent has a contract and that:

(1) is under common ownership; and

(2) is admitted to engage in the business of insurance in this state. (V.T.I.C. Art. 21.11-1, Sec. 5.)

Sec. 4051.355. RENEWAL OF INSURANCE CONTRACTS AFTER NOTICE OF TERMINATION OR SUSPENSION. (a) Except as provided by Subsection (b), an insurer that terminates or suspends an agent's contract with an appointed agent shall renew all contracts for property and casualty insurance for the agent during the six months after the

effective date of the termination or suspension of the contract.

(b) The insurer may decline to renew an insurance contract if any risk does not meet the insurer's current underwriting standards. The insurer must provide at least 60 days' notice to the agent of the insurer's intent not to renew the contract.

(c) An insurer that renews an insurance contract under this section shall pay to the agent commissions for the renewal according to the commission schedule that was in effect for the agent before the insurer's decision to terminate or suspend the agent's contract.

(d) An insurer that renews an insurance contract under this section may not require the agent to convert from agency billing to company billing during the termination period unless the agent agrees in writing to the conversion. (V.T.I.C. Art. 21.11-1, Sec. 1(b) (part).)

Sec. 4051.356. INSURER REFUSAL TO RENEW AGENT'S BUSINESS PROHIBITED. During the term of the agent's contract, the insurer may not refuse to renew business from the agent that complies with the underwriting standards in effect for agents of the insurer whose contracts have not been terminated or suspended. (V.T.I.C. Art. 21.11-1, Sec. 2.)

Sec. 4051.357. INSURER APPROVAL FOR NEW BUSINESS OR INCREASE IN LIABILITY. An agent who receives notice of termination or suspension of the agent's contract from an insurer may not write, without the written approval of the insurer:

(1) any new business; or

(2) any increase in liability on a renewal policy or an

existing policy. (V.T.I.C. Art. 21.11-1, Sec. 1(c).)

Sec. 4051.358. PROVISION OF UNDERWRITING STANDARDS TO AGENT WHOSE CONTRACT IS TERMINATED OR SUSPENDED. (a) On providing notice to an agent of termination or suspension of the agent's contract under this subchapter, the insurer shall provide to the agent the insurer's written underwriting standards. The standards must conform to the underwriting standards that were in effect for that agent before the insurer's decision to terminate or suspend the agent's contract.

(b) An insurer may provide different underwriting standards to different agents of the insurer if the standards are not used in a way that prevents or discourages the renewal of the insurance policies of an agent whose contract is terminated or suspended. (V.T.I.C. Art. 21.11-1, Sec. 1(b) (part).)

Sec. 4051.359. PAYMENT OF MONEY DUE INSURER. An insurer shall allow an agent whose contract has been terminated or suspended under this subchapter to pay to the insurer all money due under the same accounts current payment terms in effect for agents of the insurer whose contracts have not been terminated or suspended. (V.T.I.C. Art. 21.11-1, Sec. 1(b) (part).)

Sec. 4051.360. REVISION OF TERMINATION PROVISIONS OF AGENT'S CONTRACT. (a) This subchapter does not prohibit an amendment of or addendum to an agent's contract providing that the contract may be terminated before the time required by this subchapter if the agent agrees in writing to the earlier termination.

(b) An insurer that proposes to revise the termination

provisions of an agent's contract must first present the agent with a separate written impact statement that summarizes any effect that the proposed amendment or addendum would have on the agent's rights under this subchapter. (V.T.I.C. Art. 21.11-1, Sec. 1(d).)

Sec. 4051.361. ADMINISTRATIVE PENALTY. If the department determines that an insurer has violated this subchapter, the insurer is subject to an administrative penalty as provided by Chapter 84 of not less than $1,000 or more than $10,000. (V.T.I.C. Art. 21.11-1, Sec. 6.)

Sec. 4051.362. ACTION FOR DAMAGES. An agent who has sustained actual damages as a result of an insurer's violation of this subchapter may bring an action against the insurer regardless of whether the department has determined that there has been a violation of this subchapter. (V.T.I.C. Art. 21.11-1, Sec. 7.)

CHAPTER 4052. LIFE AND HEALTH INSURANCE COUNSELORS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4052.001. DEFINITION

Sec. 4052.002. USE OF CERTAIN TITLES NOT PROHIBITED

Sec. 4052.003. APPLICABILITY OF OTHER LAW

Sec. 4052.004. EXEMPTIONS

Sec. 4052.005. RULES

[Sections 4052.006-4052.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4052.051. LICENSE REQUIRED

Sec. 4052.052. EXAMINATION

Sec. 4052.053. APPOINTMENT TO ACT FOR INSURER NOT REQUIRED

Sec. 4052.054. LIMITS ON ADVERTISING

Sec. 4052.055. DUAL COMPENSATION PROHIBITED

Sec. 4052.056. ELIGIBILITY FOR NEW LICENSE AFTER REVOCATION

[Sections 4052.057-4052.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT OF COUNSELOR'S AGREEMENT

Sec. 4052.101. ENFORCEMENT OF AGREEMENT

CHAPTER 4052. LIFE AND HEALTH INSURANCE COUNSELORS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4052.001. DEFINITION. In this chapter, "life and health insurance counselor" means a person who:

(1) for compensation, offers to examine or examines a life, accident, or health insurance policy, a health benefit plan, or an annuity or pure endowment contract to give advice or other information regarding:

(A) the policy, plan, or contract terms, conditions, benefits, coverage, or premiums; or

(B) the advisability of:

(i) changing, exchanging, converting, replacing, surrendering, continuing, or rejecting a policy, plan, or contract; or

(ii) accepting or procuring a policy, plan, or contract from an insurer or health benefit plan issuer; or

(2) in any public manner:

(A) uses as a title:

(i) "insurance adviser";

(ii) "insurance analyst";

(iii) "insurance counselor";

(iv) "insurance specialist";

(v) "policyholders' adviser";

(vi) "policyholders' counselor"; or

(vii) any other similar title; or

(B) uses any other title indicating that the person gives or is engaged in the business of giving advice or other information to an insured, a beneficiary, or any other person having an interest in a life, accident, or health insurance policy, a health benefit plan, or an annuity or pure endowment contract. (V.T.I.C. Art. 21.07-2, Sec. 1 (part).)

Sec. 4052.002. USE OF CERTAIN TITLES NOT PROHIBITED. This chapter does not prohibit a person who, through the completion of a course of instruction recognized in the business of insurance, is designated as a chartered life underwriter (CLU), chartered financial consultant (ChFC), or certified financial planner (CFP) from using that designation to indicate professional achievement. (V.T.I.C. Art. 21.07-2, Sec. 1 (part).)

Sec. 4052.003. APPLICABILITY OF OTHER LAW. Except as provided by this chapter, the provisions of this title that apply to the licensing and regulation of agents apply to the licensing and regulation of a life and health insurance counselor. (V.T.I.C. Art. 21.07-2, Secs. 5(a) (part), 6.)

Sec. 4052.004. EXEMPTIONS. This chapter does not apply to:

(1) a licensed agent for a life insurance company while acting as an agent for the company;

(2) a licensed attorney at law of this state while acting in the course or scope of the attorney's profession;

(3) a licensed public accountant of this state while acting in the course or scope of the accountant's profession;

(4) a regular salaried officer or employee of an authorized insurer issuing policies of life or health insurance while acting for the insurer in discharging the duties of the position or employment;

(5) an officer or employee of a bank or trust company who does not receive compensation from a source other than the bank or trust company for activities connected with the position or employment; or

(6) an employer, an employer's officer or employee, or a trustee of an employee benefit plan to the extent that the employer, officer, employee, or trustee is engaged in the administration or operation of an employee benefit program that involves the use of insurance or annuities issued by a legal reserve life insurer. (V.T.I.C. Art. 21.07-2, Sec. 3.)

Sec. 4052.005. RULES. The commissioner may adopt rules necessary to implement this chapter and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.07-2, Sec. 10.)

[Sections 4052.006-4052.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4052.051. LICENSE REQUIRED. A person may not act as a life and health insurance counselor unless the person holds a license issued by the department under this chapter. (V.T.I.C. Art. 21.07-2, Sec. 2.)

Sec. 4052.052. EXAMINATION. (a) An applicant for a life

and health insurance counselor license must take an examination administered under Chapter 4002 that includes the following:

(1) fundamentals of life and health insurance;

(2) group life insurance, pensions, and health insurance;

(3) law, trust, and taxation;

(4) finance and economics; and

(5) business insurance and estate planning.

(b) The department may not issue a life and health insurance counselor license to a person unless the person has passed each part of the examination.

(c) The department may schedule and give the examination. (V.T.I.C. Art. 21.07-2, Secs. 5(b), (c) (part).)

Sec. 4052.053. APPOINTMENT TO ACT FOR INSURER NOT REQUIRED. An appointment to act for an insurer is not a condition to the issuance of a life and health insurance counselor license. (V.T.I.C. Art. 21.07-2, Sec. 5(a) (part).)

Sec. 4052.054. LIMITS ON ADVERTISING. A life and health insurance counselor may not advertise in any manner and may not circulate materials indicating professional superiority or the performance of professional service in a superior manner. (V.T.I.C. Art. 21.07-2, Sec. 5(a) (part).)

Sec. 4052.055. DUAL COMPENSATION PROHIBITED. A life and health insurance counselor is not entitled to receive compensation for the same service provided to the same client if the counselor:

(1) holds a license under Chapter 4054; and

(2) receives compensation for the service as an agent

licensed under that chapter. (V.T.I.C. Art. 21.07-2, Sec. 4a.)

Sec. 4052.056. ELIGIBILITY FOR NEW LICENSE AFTER REVOCATION. If the department revokes a life and health insurance counselor's license, the license holder is not eligible for a new license until the second anniversary of the revocation date. (V.T.I.C. Art. 21.07-2, Sec. 7 (part).)

[Sections 4052.057-4052.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT OF COUNSELOR'S AGREEMENT

Sec. 4052.101. ENFORCEMENT OF AGREEMENT. A life and health insurance counselor, or a person acting on the counselor's behalf, may enforce an agreement between the counselor and a person, firm, or corporation relating to the services of the counselor only if:

(1) the agreement is in writing;

(2) the agreement is executed in duplicate by the person, firm, or corporation to be charged;

(3) a duplicate is delivered to and retained by the person, firm, or corporation when executed; and

(4) the agreement specifies:

(A) the amount of the compensation paid or to be paid to the counselor; and

(B) the services to be provided by the counselor. (V.T.I.C. Art. 21.07-2, Sec. 4 (part).)

CHAPTER 4053. MANAGING GENERAL AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4053.001. DEFINITIONS

Sec. 4053.002. EXCEPTION

Sec. 4053.003. INAPPLICABILITY OF CHAPTER

CHAPTER 4053. MANAGING GENERAL AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4053.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who is classified as an affiliate under Section 823.003(a).

(2) "Insurer" means an insurance company, carrier, corporation, reciprocal or interinsurance exchange, mutual, association, county mutual insurance company, Lloyd's plan, or other insurance carrier authorized to engage in the business of insurance in this state.

(3) "Managing general agent" means a person, firm, or corporation that has supervisory responsibility for the local agency and field operations of an insurer in this state or that is authorized by an insurer to accept or process on the insurer's behalf insurance policies produced and sold by other agents. (V.T.I.C. Art. 21.07-3, Secs. 2(a) (part), (b) (part), (e).)

Sec. 4053.002. EXCEPTION. An agent licensed under Subchapter E of Chapter 981, Subchapters B-E of Chapter 4051, or Chapter 4056 is not a managing general agent unless the agent accepts 50 percent or more of the agent's total annual business or does $500,000 or more of total annual business as measured by premium volume, whichever amount is less, from insurance policies produced and sold by other agents. (V.T.I.C. Art. 21.07-3, Sec. 2(a) (part).)

Sec. 4053.003. INAPPLICABILITY OF CHAPTER. This chapter does not apply to:

(1) the transaction of the business of life, health,

and accident insurance, including variable life insurance and variable annuity contracts;

(2) a full-time salaried employee of an insurer acting for and in connection with the insurance business of the insurer; or

(3) an adjuster or inspector of risks for an insurer. (V.T.I.C. Art. 21.07-3, Secs. 2(b) (part), 16.)

Sec. 4053.004. REGULATION OF MANAGING GENERAL AGENTS. This title applies to the licensing and regulation of a person acting as a managing general agent. (V.T.I.C. Art. 21.07-3, Sec. 19(a).)

Sec. 4053.005. RULES. The commissioner may adopt reasonable rules for the administration of this chapter. (V.T.I.C. Art. 21.07-3, Sec. 21.)

[Sections 4053.006-4053.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4053.051. LICENSE REQUIRED; EXEMPTIONS. (a) Except as provided by Subsection (b), a person, firm, or corporation may not act as a managing general agent unless the person, firm, or corporation holds a license issued under this chapter.

(b) A business corporation is not required to hold a license issued under this chapter to act as a managing general agent if:

(1) the corporation is authorized to engage in business in this state;

(2) all of the corporation's outstanding stock is solely owned by an insurer authorized to engage in business in this state and the corporation's business affairs are completely controlled by that insurer;

(3) the principal purpose for which the corporation

exists is to facilitate the accumulation of commissions from the insurer and its subsidiaries and affiliates for the account of and payment to an agent who could otherwise lawfully receive the commissions directly from the insurer and its subsidiaries and affiliates; and

(4) the corporation does not engage in any other act of a managing general agent as provided by this chapter.

(c) Notwithstanding Subsection (b), the managing general agent shall execute on the insurer's behalf a contract entered into with an agent. (V.T.I.C. Art. 21.07-3, Sec. 3.)

Sec. 4053.052. ISSUANCE OF TEMPORARY OR EMERGENCY LICENSE. The commissioner may, without requiring an examination, issue a temporary or emergency license under this chapter to an applicant for a period not to exceed six months:

(1) on the death or disability of a managing general agent or for another good cause satisfactory to the commissioner; and

(2) if the applicant meets the other requirements of this chapter. (V.T.I.C. Art. 21.07-3, Sec. 7.)

Sec. 4053.053. SINGLE LICENSE REQUIRED. A license issued under this chapter entitles the license holder to represent or act for one or more insurers as a managing general agent. The license holder is not required to hold a separate license for each insurer the license holder represents. (V.T.I.C. Art. 21.07-3, Sec. 11(a).)

Sec. 4053.054. NOTICE AND APPROVAL OF APPOINTMENT. (a) Each appointment to act as a managing general agent shall be

reported to the commissioner on a form prescribed by the commissioner.

(b) The form must include:

(1) the details required by rules adopted under this chapter;

(2) the insurer's name and identifying number;

(3) the managing general agent's name and address;

(4) a statement by an officer of the insurer that the officer or the officer's agent has personal knowledge that the managing general agent has had experience or instruction that qualifies the agent to act as a managing general agent;

(5) a statement of whether the managing general agent may exercise claim settlement authority for the insurer and, if so:

(A) whether that authority exceeds $25,000 on any one claim; and

(B) whether that authority includes third-party liability other than property damage; and

(6) a statement of whether funds exceeding $100,000 are customarily held by the managing general agent to pay losses and loss adjustment expenses for the insurer.

(c) For each additional appointment for which a managing general agent applies, the agent shall pay a nonrefundable fee in an amount not to exceed $16 as determined by the department.

(d) If approval of an additional appointment is not received from the commissioner before the eighth day after the date the commissioner receives the completed application and fee, the managing general agent and insurer may assume, in the absence of

notice of disapproval from the commissioner, that the commissioner approves the application and the managing general agent may act for the insurer. (V.T.I.C. Art. 21.07-3, Secs. 11(c), (d), (e).)

Sec. 4053.055. LAPSE OF LICENSE. If a license holder is not appointed or under appointment to represent an insurer at the time the license is subject to renewal, the license lapses and the commissioner shall deny the renewal application. (V.T.I.C. Art. 21.07-3, Sec. 11(b).)

[Sections 4053.056-4053.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF MANAGING GENERAL AGENTS

Sec. 4053.101. GENERAL POWERS AND DUTIES. A managing general agent acting for an insurer may:

(1) receive and pass on daily reports and monthly accounts;

(2) receive and be responsible for agency balances;

(3) handle the adjustment of losses; or

(4) appoint or direct general property and casualty agents in this state. (V.T.I.C. Art. 21.07-3, Sec. 2(a) (part).)

Sec. 4053.102. CONTRACTS. (a) An insurer may not accept business from a managing general agent and the agent may not place business with the insurer without a written contract that addresses:

(1) the responsibilities of each party;

(2) cancellation or termination;

(3) reports, records, and auditing; and

(4) if applicable:

(A) premium volume limits;

(B) appointment or cancellation of agents;

(C) claims settlement;

(D) underwriting; and

(E) reinsurance.

(b) The commissioner may adopt rules establishing requirements for a contract with a managing general agent.

(c) A contract with a managing general agent and a report or record submitted under that contract are subject to review by the department under Section 38.001. (V.T.I.C. Art. 21.07-3, Sec. 3A.)

Sec. 4053.103. ACCOUNT REPORT. (a) At least once each calendar quarter, a managing general agent shall submit an account report to each insurer with whom the agent has a contract.

(b) The account report must include, as applicable, a statement of:

(1) written, earned, and unearned premiums;

(2) losses and loss expenses paid and outstanding;

(3) losses incurred but not reported; and

(4) management fees. (V.T.I.C. Art. 21.07-3, Sec. 3C(a).)

Sec. 4053.104. SEPARATE RECORDS. (a) For each insurer with which a managing general agent has a contract, the agent shall maintain separate records of the business handled by the agent for the insurer.

(b) The managing general agent shall make a record required under Subsection (a) available for inspection by:

(1) each insurer; and

(2) the department's examiners. (V.T.I.C. Art.

21.07-3, Sec. 3C(b).)

Sec. 4053.105. ESCROW ACCOUNT. (a) A managing general agent shall maintain an escrow account in a bank that:

(1) is a member of the Federal Reserve System; and

(2) has its accounts insured by the Federal Deposit Insurance Corporation.

(b) On receipt, the managing general agent shall deposit in the escrow account all money collected for each insurer with which the agent has a contract.

(c) Except as provided by the contract required by Section 4053.102, a managing general agent may not use, take as an offset, or convert money that is or should have been deposited in the escrow account. (V.T.I.C. Art. 21.07-3, Secs. 3C(c), (d).)

Sec. 4053.106. FIDUCIARY CAPACITY. A managing general agent holds money on behalf of an insured or insurer in a fiduciary capacity and shall properly account for that money as required by law, department rules, and a contract with an insurer. The department's examiners may audit money held in a fiduciary capacity. (V.T.I.C. Art. 21.07-3, Sec. 3C(e).)

Sec. 4053.107. FINANCIAL EXAMINATION. (a) As the commissioner considers necessary, a managing general agent shall submit to an examination of the agent's financial condition and the agent's compliance with the laws of this state affecting the conduct of the agent's business.

(b) The examination may be conducted by:

(1) the commissioner;

(2) one or more commissioned examiners; or

(3) a certified public accountant or other person or firm qualified to perform those examinations.

(c) The managing general agent shall pay the examination expenses in an amount the commissioner certifies as just and reasonable. (V.T.I.C. Art. 21.07-3, Sec. 3C(f).)

Sec. 4053.108. REQUIRED NOTICES TO DEPARTMENT. (a) On forms prescribed by the department, a managing general agent shall notify the department not later than the 30th day after the date any of the following occurs:

(1) balances due to an insurer for more than 90 days exceed:

(A) $1 million; or

(B) 10 percent of the insurer's policyholder surplus, as reported in the annual statement filed with the department;

(2) balances due for more than 60 days from a property and casualty agent or managing general agent appointed by or reporting to the managing general agent exceed $500,000;

(3) authority to settle claims for an insurer is withdrawn;

(4) money held for an insurer for losses is greater than an amount that is $100,000 more than the amount necessary to pay the losses and loss adjustment expenses expected to be paid on the insurer's behalf within the next 60-day period; or

(5) the contract required under Section 4053.102 is canceled or terminated.

(b) Notwithstanding the time limitation imposed by

Subsection (a), the requirement to file under Subsections (a)(1), (2), and (4) may be met with a single annual report if:

(1) the managing general agent routinely operates above the limits established by those subsections; and

(2) the department verifies that fact in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.07-3, Sec. 11A.)

Sec. 4053.109. REINSURANCE. (a) A managing general agent may not knowingly cede, arrange, facilitate, or bind an insurer to reinsurance.

(b) Notwithstanding Subsection (a), a managing general agent may bind a facultative reinsurance contract in accordance with an obligatory facultative agreement if the contract with the insurer contains reinsurance underwriting guidelines including, for both assumed and ceded reinsurance:

(1) a list of reinsurers with whom the automatic agreements are in effect;

(2) the coverages and amounts or percentages that may be reinsured; and

(3) commission schedules.

(c) A managing general agent may not commit an insurer to participate in insurance or reinsurance syndicates. (V.T.I.C. Art. 21.07-3, Sec. 3B.)

Sec. 4053.110. REDEMPTION OF CORPORATE SHARES. A corporation acting as a managing general agent may redeem the shares of a shareholder or a deceased shareholder:

(1) on terms agreed on by the board of directors and

the shareholder or the shareholder's personal representative; or

(2) at a price and on terms provided in the articles of incorporation, the bylaws, or an existing contract entered into between the shareholders. (V.T.I.C. Art. 21.07-3, Sec. 4.)

[Sections 4053.111-4053.150 reserved for expansion]

SUBCHAPTER D. ENFORCEMENT

Sec. 4053.151. DISCIPLINARY ACTION. A person, firm, or corporation that violates this chapter or a rule or order adopted under this title, including this chapter, is subject to:

(1) Subchapters B and C, Chapter 4005; and

(2) Chapter 82. (V.T.I.C. Art. 21.07-3, Sec. 19(b).)

Sec. 4053.152. GUARANTY FUND REIMBURSEMENT. (a) If a court finds by a final nonappealable judgment that a violation of this chapter by a managing general agent contributes materially to the insolvency of an insurer under which the agent held an appointment, the agent shall reimburse the appropriate guaranty fund for money paid to cover losses of the insolvent insurer in an amount equal to all payments made from that guaranty fund in excess of:

(1) gross earned premiums and investment income earned on those premiums; and

(2) loss reserves for that business.

(b) The reimbursement made under this section shall be used for losses, loss adjustments, and administrative expenses on business placed by the managing general agent. (V.T.I.C. Art. 21.07-3, Sec. 19A.)

CHAPTER 4054. LIFE, ACCIDENT, AND HEALTH AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

CHAPTER 4054. LIFE, ACCIDENT, AND HEALTH AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4054.001. APPLICABILITY OF CHAPTER. (a) This chapter applies to each agent of an insurer authorized to provide life, accident, and health insurance coverage in this state.

(b) This chapter applies to each person who:

(1) performs the acts of an agent, as described by Section 4001.051, whether through an oral, written, electronic, or other form of communication by soliciting, negotiating, procuring, or collecting a premium on an insurance or annuity contract offered by any type of insurer authorized to engage in the business of life, accident, and health insurance in this state; or

(2) represents or purports to represent a health maintenance organization in soliciting, negotiating, procuring, or effecting membership in the health maintenance organization. (V.T.I.C. Art. 21.07-1, Sec. 1(b).)

[Sections 4054.002-4054.050 reserved for expansion]

SUBCHAPTER B. GENERAL LIFE, ACCIDENT, AND HEALTH LICENSE

Sec. 4054.051. LICENSE REQUIRED. A person is required to hold a general life, accident, and health license if the person acts as:

(1) an agent who represents a health maintenance organization;

(2) an industrial life insurance agent for an insurer that writes only weekly premium life insurance on a debit basis under Chapter 1151;

(3) an agent who writes life, accident, and health insurance for a life insurance company;

(4) an agent who writes only accident and health insurance;

(5) an agent who writes fixed or variable annuity contracts or variable life contracts;

(6) an agent who writes for a stipulated premium company:

(A) only life insurance in excess of $15,000 on any one life;

(B) only accident and health insurance; or

(C) both kinds of insurance described by Paragraphs (A) and (B);

(7) an agent who writes life, accident, and health insurance for any type of authorized life insurance company that is domiciled in this state, including a legal reserve life insurance company, and who represents the company:

(A) in a foreign country or territory; and

(B) on a United States military installation or with United States military personnel;

(8) an agent who writes life, accident, and health insurance for a fraternal benefit society except as provided by Section 885.352; or

(9) an agent who writes any other kind of insurance as required by the commissioner for the protection of the insurance consumers of this state. (V.T.I.C. Art. 21.07-1, Sec. 2(a).)

Sec. 4054.052. COMBINATION LIFE INSURANCE AGENT. (a) In this section, a "combination company" means an insurer that writes weekly premium life insurance or monthly ordinary life insurance on a debit basis.

(b) A person may not act as a combination life insurance agent for a combination company unless the person holds a general life, accident, and health license.

(c) A combination company and a combination life insurance agent may also write ordinary life insurance contracts. (V.T.I.C. Art. 21.07-1, Sec. 2(b).)

Sec. 4054.053. AUTHORITY TO WRITE ADDITIONAL LINES. A person who holds a general life, accident, and health license may, without obtaining an additional license, write the kinds of insurance contracts described by:

(1) Subchapter C, D, or E; or

(2) Chapter 4055. (V.T.I.C. Art. 21.07-1, Sec. 3.)

[Sections 4054.054-4054.100 reserved for expansion]

SUBCHAPTER C. LIMITED LIFE, ACCIDENT, AND HEALTH LICENSE

Sec. 4054.101. LICENSE REQUIRED. Except as provided by Section 4054.053, an agent is required to hold a limited life, accident, and health license if the agent writes:

(1) a policy or rider to a policy that provides only:

(A) lump-sum cash benefits in the event of accidental death or dismemberment; or

(B) ambulance expense benefits in the event of accident or sickness;

(2) a prepaid legal services contract under Article 5.13-1 or Chapter 961;

(3) credit insurance, except as otherwise provided by Chapter 4055; or

(4) any other kind of insurance, if holding a limited life, accident, and health license to write that kind of insurance is determined necessary by the commissioner for the protection of the insurance consumers of this state. (V.T.I.C. Art. 21.07-1, Sec. 4(a).)

Sec. 4054.102. DESIGNATION OF KINDS OF INSURANCE. A person who holds a limited life, accident, and health license may write only the kind of insurance designated on the license. (V.T.I.C. Art. 21.07-1, Sec. 4(b).)

Sec. 4054.103. TEMPORARY LICENSE. An applicant for a limited life, accident, and health license is eligible for a

temporary license under Subchapter D, Chapter 4001. (V.T.I.C. Art. 21.07-1, Sec. 4(c).)

[Sections 4054.104-4054.150 reserved for expansion]

SUBCHAPTER D. FUNERAL PREARRANGEMENT LIFE INSURANCE LICENSE

Sec. 4054.151. FUNERAL PREARRANGEMENT LIFE INSURANCE AGENT. A funeral prearrangement life insurance agent is a life insurance agent who, subject to the limitations of this subchapter, writes only life insurance policies and fixed annuity contracts to secure the delivery of funeral services and merchandise under prepaid funeral contracts regulated by the Texas Department of Banking under Chapter 154, Finance Code. (V.T.I.C. Art. 21.07-1, Sec. 5(a).)

Sec. 4054.152. LICENSE ISSUANCE. The department shall issue a license to an individual applicant to act as a funeral prearrangement life insurance agent on receipt of certification from an insurer authorized to write life insurance policies and fixed annuity contracts in this state that the applicant has:

(1) completed a course of study and instruction in compliance with this subchapter; and

(2) passed without aid a written examination administered by the insurer. (V.T.I.C. Art. 21.07-1, Sec. 5(b) (part).)

Sec. 4054.153. COURSE. (a) To be eligible to receive a license under this subchapter, an applicant must complete a course of study and instruction offered by an insurer under this section on life insurance policies and fixed annuity contracts.

(b) The course of study and instruction must:

(1) be at least five hours in duration; and

(2) include instruction on:

(A) the life insurance policies and fixed annuity contracts to be sold; and

(B) the laws relating to funeral prearrangement. (V.T.I.C. Art. 21.07-1, Sec. 5(b) (part).)

Sec. 4054.154. EXAMINATION. (a) The commissioner shall prescribe a uniform examination for applicants that fairly tests knowledge of the information contained in the course under Section 4054.153.

(b) The department shall authorize an insurer to administer the examination as provided by this section after approval by the department of a complete outline and explanation of the course and the manner of conducting the examination. (V.T.I.C. Art. 21.07-1, Sec. 5(c).)

Sec. 4054.155. INVESTIGATION BY DEPARTMENT. The department may investigate as necessary the manner of instruction and the examination administered by an insurer under this subchapter. (V.T.I.C. Art. 21.07-1, Sec. 5(d) (part).)

Sec. 4054.156. WITHDRAWAL OF INSURER'S AUTHORITY. The department may withdraw from an insurer the authority under this subchapter to offer instruction and administer an examination. (V.T.I.C. Art. 21.07-1, Sec. 5(d) (part).)

Sec. 4054.157. LIMIT ON AGENT'S AUTHORITY. A funeral prearrangement life insurance agent licensed under this subchapter may not write any coverage or combination of coverages with an initial guaranteed death benefit that exceeds $15,000 on any life.

(V.T.I.C. Art. 21.07-1, Sec. 5(e) (part).)

Sec. 4054.158. REVOCATION; NOTIFICATION. (a) A license issued under this subchapter to act as an agent for an insurer is revoked if the license holder ceases to act as an agent for the insurer.

(b) Not later than the 15th day after the date on which the license holder ceases to act as an agent for an insurer, the insurer or agent shall send written notification to the department. (V.T.I.C. Art. 21.07-1, Sec. 5(f).)

Sec. 4054.159. CONTINUING EDUCATION EXEMPTION. (a) Notwithstanding any other provision of this code, a funeral home employee or other person who holds a funeral prearrangement life insurance agent license and who writes only life insurance policies and fixed annuity contracts to secure the delivery of funeral services and merchandise under prepaid funeral contracts regulated by the Texas Department of Banking under Chapter 154, Finance Code, is not required to comply with any continuing education requirements to maintain the license, except that the appointing insurer must educate its appointed agents about any new products sold by the agent to fund prepaid funeral contracts.

(b) A license holder to whom this section applies may be appointed by more than one insurer. (V.T.I.C. Art. 21.07-1, Sec. 5B (part).)

Sec. 4054.160. APPLICABILITY OF LIMITED LICENSE LAWS. Except as specifically provided by this subchapter, the provisions of this title that apply to the holder of a limited license apply to the holder of a license issued under this subchapter. (V.T.I.C.

Art. 21.07-1, Sec. 5(g).)

[Sections 4054.161-4054.200 reserved for expansion]

SUBCHAPTER E. LIFE INSURANCE NOT EXCEEDING $15,000

Sec. 4054.201. LICENSE ISSUANCE; EXCEPTION. (a) The department shall issue a license to an individual applicant to act as an agent who writes only life insurance policies in an amount that does not exceed $15,000 on any one life on receipt of certification from a stipulated premium company, a statewide mutual assessment company, a local mutual aid association, or a local mutual burial association, that the applicant has:

(1) completed a course of study and instruction in compliance with this subchapter; and

(2) passed without aid a written examination administered by the insurer.

(b) A license is not required under this subchapter for an agent who, in the preceding calendar year, wrote policies that generated, in the aggregate, less than $20,000 in direct premium. (V.T.I.C. Art. 21.07-1, Secs. 6(a) (part), (e).)

Sec. 4054.202. COURSE. (a) To be eligible to receive a license under this subchapter, an applicant must complete a course of study and instruction offered by an insurer under this section on life insurance and fixed annuities.

(b) The course of study and instruction must:

(1) be at least five hours in duration; and

(2) include instruction on:

(A) the policies to be sold; and

(B) the laws relating to the regulation of

insurance in this state. (V.T.I.C. Art. 21.07-1, Sec. 6(a) (part).)

Sec. 4054.203. EXAMINATION. (a) The commissioner shall prescribe a uniform examination for applicants that fairly tests knowledge of the information contained in the course provided under Section 4054.202.

(b) The department shall authorize an insurer described by Section 4054.201 to administer the examination as provided by this section after approval by the department of a complete outline and explanation of the course and the manner of conducting the examination. (V.T.I.C. Art. 21.07-1, Sec. 6(b).)

Sec. 4054.204. INVESTIGATION BY DEPARTMENT. The department may investigate as necessary the manner of instruction and the examination administered by an insurer under this subchapter. (V.T.I.C. Art. 21.07-1, Sec. 6(c) (part).)

Sec. 4054.205. WITHDRAWAL OF INSURER'S AUTHORITY. The department may withdraw from an insurer the authority under this subchapter to offer instruction and administer an examination. (V.T.I.C. Art. 21.07-1, Sec. 6(c) (part).)

Sec. 4054.206. LIMIT ON AGENT'S AUTHORITY. An insurance agent licensed under this subchapter may not write any coverage or combination of coverages with an initial guaranteed death benefit that exceeds $15,000 on any life. (V.T.I.C. Art. 21.07-1, Sec. 6(d).)

Sec. 4054.207. CONTINUING EDUCATION EXEMPTION. (a) Notwithstanding any other provision of this code, a person who holds a license under this subchapter and who writes only life

insurance policies and fixed annuity contracts to secure the delivery of funeral services and merchandise under prepaid funeral contracts regulated by the Texas Department of Banking under Chapter 154, Finance Code, is not required to comply with any continuing education requirements to maintain the license, except that the appointing insurer must educate its appointed agents about any new products sold by the agent to fund prepaid funeral contracts.

(b) A license holder to whom this section applies may be appointed by more than one insurer. (V.T.I.C. Art. 21.07-1, Sec. 5B (part).)

Sec. 4054.208. APPLICABILITY OF LIMITED LICENSE LAWS. Except as specifically provided by this subchapter, the provisions of this title that apply to the holder of a limited license apply to the holder of a license issued under this subchapter. (V.T.I.C. Art. 21.07-1, Sec. 6(f).)

[Sections 4054.209-4054.250 reserved for expansion]

SUBCHAPTER F. RENEWAL OR SERVICE COMMISSIONS TO AGENTS OF LIFE INSURANCE COMPANIES DISCONTINUING BUSINESS IN STATE

Sec. 4054.251. INSURANCE COMPANY LIABILITY FOR PAYMENT OF COMMISSIONS. A life insurance company that discontinues the business of issuing life insurance policies on the lives of residents of this state remains liable for the payment of renewal or service commissions on life insurance policies previously written by the company under the terms of the company's contracts previously made with agents residing in this state. (V.T.I.C. Art. 21.08 (part).)

Sec. 4054.252. MONTHLY AND QUARTERLY STATEMENTS. (a) A life insurance company shall provide to each agent who may be entitled to receive renewal or service commissions from the company under Section 4054.251:

(1) a monthly statement that shows the policies written by the agent for the company that terminated during the month for which the statement is made; and

(2) at least quarterly, a detailed statement of all policies written by the agent for the company on the lives of residents of this state that shows:

(A) the policies in force; and

(B) the policies that have terminated, with the reason for the termination.

(b) A life insurance company is not required to provide an agent with a statement under this section after the expiration of the period during which renewal or service commissions are payable as to all of the policies written by the agent for the company. (V.T.I.C. Art. 21.08 (part).)

Sec. 4054.253. PRESUMPTION IN LAWSUIT. In a suit against a life insurance company for the recovery of a renewal or service commission under this subchapter, a presumption exists that each policy written by the company on the life of a resident of this state by the agent bringing the suit continues in effect unless the defendant proves the contrary by competent evidence. (V.T.I.C. Art. 21.08 (part).)

CHAPTER 4055. SPECIALTY AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

CHAPTER 4055. SPECIALTY AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4055.001. DEFINITION. In this chapter, "specialty license holder" means a person who holds a license issued under this chapter. (V.T.I.C. Art. 21.09, Sec. 1(a) (part).)

Sec. 4055.002. APPLICABILITY OF CHAPTER TO CERTAIN AGENTS. (a) A person who holds a general property and casualty license issued under Chapter 4051 or a general life, accident, and health license issued under Chapter 4054 or who holds a substantially equivalent license under this code, as determined by the commissioner, is not required to obtain a specialty license.

(b) A person described by Subsection (a) is subject to the other requirements of this chapter in the solicitation, sale, or delivery of an insurance product that is subject to this chapter. (V.T.I.C. Art. 21.09, Sec. 1(j).)

Sec. 4055.003. RULES. The commissioner may adopt rules necessary to implement this chapter and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.09, Sec. 1(a) (part).)

Sec. 4055.004. APPLICATION. To obtain a specialty license an applicant must:

(1) submit to the commissioner:

(A) a written application:

(i) signed by the applicant;

(ii) on a form and supplements to the form prescribed by the commissioner; and

(iii) containing the information prescribed by the commissioner;

(B) a certification by an insurer authorized to engage in business in this state:

(i) signed and sworn to by an officer of the insurer;

(ii) stating that the insurer is satisfied that the applicant is trustworthy and competent to act as the insurer's agent for a limited purpose authorized by this chapter; and

(iii) stating that if the specialty license applied for is issued by the department the insurer will appoint the applicant to act as an agent for a kind of insurance that is subject to this chapter; and

(C) a nonrefundable license fee set by the department in an amount necessary to administer this chapter; and

(2) comply with the other requirements of this chapter. (V.T.I.C. Art. 21.09, Sec. 1(b).)

Sec. 4055.005. LICENSE ISSUANCE. The commissioner may issue a specialty license to an applicant who complies with Section 4055.004 and the other requirements of this chapter. (V.T.I.C. Art. 21.09, Sec. 1(a) (part).)

Sec. 4055.006. EXAMINATION AND CONTINUING EDUCATION NOT REQUIRED. (a) An examination is not required for issuance of a specialty license.

(b) A person is not required to comply with continuing education requirements to hold a specialty license. (V.T.I.C. Art. 21.09, Sec. 1(l).)

Sec. 4055.007. APPOINTMENT AS AGENT BY INSURER. An insurer

that appoints an agent under this chapter shall:

(1) submit a certification of the appointment signed by an officer of the insurer; and

(2) affirm that the insurer is satisfied that the specialty license holder is trustworthy and competent to act as an agent on behalf of the insurer. (V.T.I.C. Art. 21.09, Sec. 1(k).)

Sec. 4055.008. GENERAL POWERS AND DUTIES. (a) A specialty license holder may act as an agent for the kinds of insurance that are subject to this chapter for any insurer authorized to engage in the business of those kinds of insurance in this state.

(b) Except as otherwise provided by this chapter, a specialty license holder acting under this chapter shall comply with this title. (V.T.I.C. Art. 21.09, Sec. 1(a) (part), (e).)

Sec. 4055.009. CERTAIN REPRESENTATIONS PROHIBITED. A specialty license holder may not advertise, represent, or otherwise hold out the license holder or an employee of the license holder as an agent licensed under another chapter unless the entity or individual holds the applicable license. (V.T.I.C. Art. 21.09, Sec. 1(i).)

Sec. 4055.010. TREATMENT OF CERTAIN PREMIUMS. Notwithstanding any other provision of this title or any rule adopted by the commissioner, a specialty license holder is not required to treat as money received in a fiduciary capacity premiums collected from a consumer who purchases insurance coverage when completing a consumer transaction associated with the coverage if:

(1) the insurer represented by the license holder has

consented in writing, signed by an officer of the insurer, that premiums are not required to be segregated from money received by the license holder because of the consumer transaction associated with the insurance coverage; and

(2) the charges for insurance coverage are itemized but not billed to the consumer separately from the charges for the associated consumer transaction. (V.T.I.C. Art. 21.09, Sec. 1(f).)

Sec. 4055.011. AUTHORITY OF EMPLOYEE OF SPECIALTY LICENSE HOLDER. An employee of a specialty license holder may act as an agent with respect to the kinds of insurance the license holder is authorized to offer under this chapter only if the employee:

(1) is trained under Section 4055.012 to act individually on behalf of the license holder;

(2) acts on behalf of and under the supervision of the license holder; and

(3) is not compensated based primarily on the amount of insurance sold by the employee under this chapter. (V.T.I.C. Art. 21.09, Sec. 1(c).)

Sec. 4055.012. TRAINING REQUIRED TO ACT ON BEHALF OF SPECIALTY LICENSE HOLDER. (a) A specialty license holder may not allow an individual to act on the license holder's behalf with respect to a kind of insurance that the license holder is authorized to offer unless the individual has completed an approved training program.

(b) The materials for the training program must be provided to the specialty license holder by an insurer that writes the kind of insurance authorized under the specialty license.

(c) An insurer that provides training program materials under Subsection (b) must submit the training program to the commissioner for approval before the training program is used.

(d) The training program must meet the following minimum standards:

(1) each trainee must receive basic instruction about the kinds of insurance the specialty license holder is authorized to offer for purchase by prospective consumers;

(2) each trainee must be instructed to inform a prospective consumer that, except as may be specifically provided by another law of this state or the United States, the purchase of the kind of insurance offered is not required to complete the associated consumer transaction; and

(3) each trainee must be instructed with respect to the disclosures required to be made to consumers. (V.T.I.C. Art. 21.09, Sec. 1(d).)

Sec. 4055.013. ASSIGNMENT AND TRANSFER OF COMPENSATION BY CERTAIN AGENTS. A person who is licensed as a general life, accident, and health agent or as a general property and casualty agent or who holds a substantially equivalent license under this code, as determined by the commissioner, and who enters into a contract with an insurer to act as the insurer's agent in soliciting or writing policies or certificates of insurance that are subject to this chapter may assign and transfer to the agent's employer any commission, fee, or other compensation to be paid to the agent under the agent's contract with the insurer only if the sale of the insurance product occurs within the scope of the agent's

employment. (V.T.I.C. Art. 21.09, Sec. 1(m).)

Sec. 4055.014. DISCLOSURES REQUIRED BEFORE ISSUANCE OF INSURANCE. Except as provided by Section 4055.105, insurance coverage may not be issued under this chapter unless:

(1) at each location at which sales of the coverage occur, brochures or other written materials are prominently displayed and readily available to a prospective consumer that:

(A) summarize, clearly and correctly, the material terms of the coverage offered to consumers, including the identity of the insurer;

(B) disclose that the coverage offered by the specialty license holder may duplicate coverage already provided by a consumer's personal auto insurance policy, homeowner's insurance policy, personal liability insurance policy, or another source of coverage;

(C) state that, except as specifically provided by another law of this state or the United States, the purchase by the consumer of the kind of insurance offered is not required to complete the associated consumer transaction;

(D) describe the process for filing a claim for benefits; and

(E) contain any additional information required by the commissioner by rule regarding the price, benefits, exclusions, conditions, or other limitations of the coverage; and

(2) evidence of coverage is provided to each consumer who purchases the coverage. (V.T.I.C. Art. 21.09, Secs. 1(g), 2(d) (part), 4(d), 5(d), 7(d).)

Sec. 4055.015. VIOLATION BY SPECIALTY LICENSE HOLDER; PENALTIES. If a specialty license holder violates this title, the commissioner may:

(1) impose any disciplinary action authorized by Subchapter C, Chapter 4005; or

(2) after notice and opportunity for hearing, impose other penalties, including suspending the transaction of insurance at specific locations where a violation of this title has occurred, as the commissioner considers necessary or appropriate to implement the purposes of this title. (V.T.I.C. Art. 21.09, Sec. 1(h).)

[Sections 4055.016-4055.050 reserved for expansion]

SUBCHAPTER B. RENTAL CAR COMPANY LICENSE

Sec. 4055.051. DEFINITIONS. In this subchapter:

(1) "Rental agreement" means a written agreement that states the terms and conditions governing the use of a vehicle or vehicle equipment provided by a rental car company.

(2) "Rental car company" means a person engaged in the business of providing leased or rented vehicles or vehicle equipment to the public.

(3) "Renter" means a person who obtains the use of a vehicle or vehicle equipment from a rental car company under the terms of a rental agreement.

(4) "Vehicle" means:

(A) a private passenger motor vehicle, including passenger vans and minivans that are primarily intended for the transport of persons;

(B) a motor home;

(C) a motorcycle;

(D) a trailer with a gross vehicle weight rating of 10,000 pounds or less; or

(E) a truck with a gross vehicle weight rating of 26,000 pounds or less and the operation of which does not require a commercial driver's license.

(5) "Vehicle equipment" means a cartop carrier, tow bar, or tow dolly specifically designed for use with a vehicle. (V.T.I.C. Art. 21.09, Sec. 2(a).)

Sec. 4055.052. ISSUANCE OF LICENSE. Notwithstanding any other provision of this chapter or this code, the commissioner shall issue a specialty license to a rental car company, or to the franchisee of a rental car company, that complies with this subchapter. The specialty license may be issued only for the limited purposes specified by this subchapter. (V.T.I.C. Art. 21.09, Sec. 2(b).)

Sec. 4055.053. AUTHORITY OF RENTAL CAR COMPANY OR FRANCHISEE. (a) A rental car company or franchisee licensed under this chapter may act as an agent for an authorized insurer only:

(1) in connection with the rental of vehicles or vehicle equipment; and

(2) with respect to:

(A) excess liability insurance that provides coverage in excess of the standard liability limits provided by the rental car company in the rental agreement to the rental car company or franchisee and to renters and other authorized drivers of rental vehicles for liability arising from the negligent operation or use

of the rental vehicle or vehicle equipment;

(B) accident and health insurance that provides coverage to renters and other rental vehicle occupants for accidental death or dismemberment and for medical expenses resulting from an accident involving the vehicle or vehicle equipment that occurs during the rental period;

(C) personal effects insurance that provides coverage to renters and other rental vehicle occupants for the loss of or damage to personal effects or household belongings that occurs during the rental period; or

(D) any other coverage the commissioner approves as meaningful and appropriate in connection with the rental of vehicles or vehicle equipment.

(b) A rental car company or franchisee licensed under this chapter may not issue insurance under this subchapter in connection with a rental agreement if the rental period under the agreement exceeds 30 consecutive days. (V.T.I.C. Art. 21.09, Secs. 2(c), (d) (part).)

[Sections 4055.054-4055.100 reserved for expansion]

SUBCHAPTER C. CREDIT INSURANCE LICENSE

Sec. 4055.101. GENERAL DEFINITIONS. In this subchapter:

(1) "Credit insurance" includes:

(A) credit life insurance;

(B) credit accident and health insurance;

(C) credit property insurance;

(D) credit involuntary unemployment insurance; and

(E) insurance that covers the difference between the actual cash value of a motor vehicle used as security for a loan or lease and the outstanding balance of that loan or lease if loss or damage renders the vehicle an actual or constructive total loss while the debt for which the vehicle serves as security exceeds the actual cash value of the vehicle.

(2) "Credit insurance agent" means a person licensed under this chapter to sell credit insurance as specifically provided by this subchapter. (V.T.I.C. Art. 21.09, Secs. 3(a)(1), (2).)

Sec. 4055.102. DEFINITION OF CREDIT PROPERTY INSURANCE. (a) In this subchapter, "credit property insurance" means insurance that covers personal property:

(1) used as security for a personal or consumer loan; or

(2) under an installment sales agreement or through a consumer credit transaction that is purchased in connection with or in relation to the personal or consumer loan, installment sale, or consumer credit transaction.

(b) "Credit property insurance" does not include insurance that:

(1) provides theft, collision, liability, property damage, or comprehensive insurance coverage on an automobile, motorized aircraft, motorcycle, truck, truck-tractor, traction engine, or any other self-propelled vehicle or craft that is designed primarily for operation in the air, or on highways, roadways, waterways, or the sea, and the operating equipment of the

self-propelled vehicle or craft; or

(2) is necessary because of liability imposed by law for damages arising out of the ownership, operation, maintenance, or use of a vehicle or craft described by Subdivision (1), other than single interest coverage on any vehicle or craft described by Subdivision (1) that insures the interest of the creditor in the same manner as security for a loan. (V.T.I.C. Art. 21.09, Sec. 3(a)(3).)

Sec. 4055.103. ISSUANCE OF LICENSE. Notwithstanding any other provision of this chapter or this code, the commissioner may issue a specialty license to a retail distributor of goods, an automobile dealer, a bank, a state or federal savings and loan, a state or federal credit union, a finance company, a production credit association, a manufactured home retailer, or a mobile home retailer that complies with this subchapter. The specialty license may be issued only for the limited purposes specified by this subchapter. (V.T.I.C. Art. 21.09, Sec. 3(b).)

Sec. 4055.104. AUTHORITY OF CREDIT INSURANCE AGENT. A credit insurance agent appointed by an insurer authorized to engage in the business of insurance under this code may act as the agent for the insurer in the sale of any kind of credit insurance in the business of which the insurer is authorized to engage, including individual or group credit insurance. (V.T.I.C. Art. 21.09, Sec. 3(c).)

Sec. 4055.105. EXEMPTION FROM CERTAIN DISCLOSURE REQUIREMENTS. A specialty license holder and the license holder's representative are not required to make the disclosures required by

Section 4055.014 as that section relates to the sale or delivery of a credit insurance product that is subject to this subchapter if the license holder or representative complies with all disclosure requirements prescribed by another provision of this code or another law of this state or the United States with regard to the sale or delivery of that product. (V.T.I.C. Art. 21.09, Sec. 3(d).)

[Sections 4055.106-4055.150 reserved for expansion]

SUBCHAPTER D. TRAVEL INSURANCE LICENSE

Sec. 4055.151. DEFINITIONS. In this subchapter:

(1) "Planned trip" means any journey or travel arranged through the services of a travel agency.

(2) "Travel agency" means an entity engaged in the business of selling or arranging transportation or accommodations for the public.

(3) "Traveler" means an individual who seeks the assistance of a travel agency in connection with the planning and purchase of a trip. (V.T.I.C. Art. 21.09, Sec. 4(a).)

Sec. 4055.152. ISSUANCE OF LICENSE. Notwithstanding any other provision of this chapter or this code, the commissioner may issue a specialty license to a travel agency, the franchisee of a travel agency, or a public carrier that complies with this subchapter. The specialty license may be issued only for the limited purposes specified by this subchapter. (V.T.I.C. Art. 21.09, Sec. 4(b).)

Sec. 4055.153. AUTHORITY OF TRAVEL AGENCY OR FRANCHISEE. A travel agency or franchisee licensed under this chapter may act as an agent for an authorized insurer only:

(1) in connection with the sale or arrangement of transportation or accommodations for travelers; and

(2) with respect to:

(A) accident and health insurance that provides coverage to a traveler for accidental death or dismemberment and for medical expenses resulting from an accident involving the traveler that occurs during the planned trip;

(B) insurance that provides coverage to a traveler for expenses incurred as a result of trip cancellation or interruption of a planned trip;

(C) personal effects insurance that provides coverage to a traveler for loss of or damage to personal effects during the planned trip;

(D) life insurance not exceeding $150,000 on any one life covering risks of travel during a planned trip; or

(E) any other coverage the commissioner approves as meaningful and appropriate in connection with the transportation or accommodations arranged through a travel agency. (V.T.I.C. Art. 21.09, Sec. 4(c).)

[Sections 4055.154-4055.200 reserved for expansion]

SUBCHAPTER E. SELF-SERVICE STORAGE FACILITY LICENSE

Sec. 4055.201. DEFINITIONS. In this subchapter:

(1) "Rental agreement" means a written agreement that states the terms governing the use of storage space provided by a self-service storage facility.

(2) "Renter" means a person who obtains the use of storage space from a self-service storage facility under a rental

agreement.

(3) "Self-service storage facility" means a person engaged in the business of providing leased or rented storage space to the public.

(4) "Storage space" means a room, unit, locker, or open space offered for rental to the public for temporary storage of personal belongings or light commercial goods. (V.T.I.C. Art. 21.09, Sec. 5(a).)

Sec. 4055.202. ISSUANCE OF LICENSE. Notwithstanding any other provision of this chapter or this code, the commissioner may issue a specialty license to a self-service storage facility or to the franchisee of a self-service storage facility that complies with this subchapter. The specialty license may be issued only for the limited purposes specified by this subchapter. (V.T.I.C. Art. 21.09, Sec. 5(b).)

Sec. 4055.203. AUTHORITY OF SELF-SERVICE STORAGE FACILITY OR FRANCHISEE. A self-service storage facility or franchisee licensed under this chapter may act as an agent for any authorized insurer only:

(1) in connection with the rental of storage space; and

(2) with respect to:

(A) hazard insurance coverage provided to a renter for loss of or damage to tangible personal property in storage or in transit during the rental period; or

(B) any other coverage the commissioner approves as meaningful and appropriate in connection with the rental of

storage space. (V.T.I.C. Art. 21.09, Sec. 5(c).)

[Sections 4055.204-4055.250 reserved for expansion]

SUBCHAPTER F. TELECOMMUNICATIONS EQUIPMENT VENDOR LICENSE

Sec. 4055.251. DEFINITIONS. In this subchapter:

(1) "Customer" means a person who purchases telecommunications equipment in a retail sales transaction.

(2) "Telecommunications equipment" includes handsets, pagers, automatic answering devices, batteries, and other devices used to originate or receive wireless communications exclusive of cordless, wireline communications. (V.T.I.C. Art. 21.09, Sec. 7(a).)

Sec. 4055.252. ISSUANCE OF LICENSE. Notwithstanding any other provision of this chapter or this code, the commissioner may issue a specialty license to a retail vendor of telecommunications equipment who complies with this subchapter. The specialty license may be issued only for the limited purposes specified by this subchapter. (V.T.I.C. Art. 21.09, Sec. 7(b).)

Sec. 4055.253. AUTHORITY OF RETAIL VENDOR OF TELECOMMUNICATIONS EQUIPMENT. A retail vendor of telecommunications equipment licensed under this chapter may act as an agent for an authorized insurer only:

(1) in connection with the sale and use of telecommunications equipment; and

(2) with respect to:

(A) insurance coverage provided to customers for the loss or malfunction of or damage to telecommunications equipment; or

(B) any other coverage the commissioner approves as meaningful and appropriate in connection with the use of telecommunications equipment. (V.T.I.C. Art. 21.09, Sec. 7(c).)

CHAPTER 4056. NONRESIDENT AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 4056.006-4056.050 reserved for expansion]

SUBCHAPTER B. NONRESIDENT AGENT LICENSE

Sec. 4056.058. SERVICE OF PROCESS

CHAPTER 4056. NONRESIDENT AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4056.001. APPLICABILITY OF TITLE. This title applies to licensing of a nonresident agent under this chapter. (V.T.I.C. Art. 21.11, Sec. 3(c).)

Sec. 4056.002. RIGHTS OF LICENSE HOLDERS. Except as otherwise specifically provided by this code, an individual who is not a resident of this state and to whom a license is issued under this chapter has the same rights and privileges as a resident license holder. (V.T.I.C. Art. 21.11, Sec. 2(a).)

Sec. 4056.003. RECIPROCAL LICENSING AGREEMENTS. The commissioner may enter into an agreement with the appropriate official of another state as necessary to implement reciprocal licensing of nonresident agents. (V.T.I.C. Art. 21.11, Sec. 1(b).)

Sec. 4056.004. HOME OFFICE EMPLOYEES. This chapter does not affect the authority established under Subchapter G, Chapter 4051, of a full-time home office salaried employee of an insurer authorized to engage in the business of insurance in this state. (V.T.I.C. Art. 21.11, Sec. 4.)

Sec. 4056.005. RULES. The commissioner may adopt rules as necessary to implement this subchapter and Subchapter B and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.11, Sec. 5.)

[Sections 4056.006-4056.050 reserved for expansion]

SUBCHAPTER B. NONRESIDENT AGENT LICENSE

Sec. 4056.051. APPLICATION FOR NONRESIDENT AGENT LICENSE;

CRIMINAL HISTORY. (a) To apply for a license to act as a nonresident agent, a person who is not a resident of this state must submit to the department:

(1) an application on a form prescribed by the department; and

(2) the nonrefundable license application fee.

(b) An applicant who does not hold an insurance agent's license in the applicant's state of residence must, through the law enforcement agency of the state of residence, submit to the department a copy of the applicant's criminal history records. The department shall use the criminal history records to determine the applicant's eligibility for issuance of a license in accordance with this title and other laws of this state. (V.T.I.C. Art. 21.11, Secs. 1(a) (part), (e).)

Sec. 4056.052. ISSUANCE OF LICENSE TO NONRESIDENT AGENT LICENSED IN OTHER STATE. (a) The department shall issue a license to an applicant under this chapter if:

(1) the applicant holds a license in good standing as an agent in the applicant's state of residence; and

(2) the applicant's state of residence will grant a nonresident agent license on a reciprocal basis to a resident agent of this state.

(b) The department may issue a reciprocal nonresident agent license to an applicant if the authority granted by the license issued by the applicant's state of residence is generally comparable to the authority granted by a license issued by this state. (V.T.I.C. Art. 21.11, Secs. 1(a) (part), 3(a).)

Sec. 4056.053. ISSUANCE OF LICENSE TO NONRESIDENT AGENT NOT LICENSED IN OTHER STATE. The department shall issue a license to an applicant under this chapter if the applicant has:

(1) passed the examination for an agent's license required under this title;

(2) met the eligibility requirements for issuance of a license after an examination of the applicant's criminal history records under Section 4056.051(b); and

(3) satisfied the requirements for a license for an individual under this code, including Subchapter C, Chapter 4001. (V.T.I.C. Art. 21.11, Sec. 1(a) (part).)

Sec. 4056.054. ISSUANCE OF LICENSE TO CORPORATION OR PARTNERSHIP. The department shall issue a license to an applicant under this chapter if the applicant has satisfied the requirements for a license for a corporation or partnership under Subchapter C, Chapter 4001. (V.T.I.C. Art. 21.11, Sec. 1(a) (part).)

Sec. 4056.055. WAIVER OF REQUIREMENTS FOR NONRESIDENT AGENT LICENSED IN OTHER STATE OR JURISDICTION. The department may waive any license requirement for an applicant who holds a valid license from another state or jurisdiction if:

(1) that state or jurisdiction has license requirements substantially equivalent to those of this state; or

(2) the waiver is necessary to promote reciprocal licensing of nonresident agents among a majority of the states. (V.T.I.C. Art. 21.11, Sec. 1(c).)

Sec. 4056.056. RESTRICTIONS ON LINE OF INSURANCE BUSINESS FOR RECIPROCAL NONRESIDENT AGENT LICENSE. A nonresident agent

licensed under Section 4056.052 may not act as a nonresident agent for a line of insurance business in this state unless the agent is authorized in the agent's state of residence to act in that state as an agent for that line of insurance business. (V.T.I.C. Art. 21.11, Sec. 3(b).)

Sec. 4056.057. CONTINUING EDUCATION. (a) The continuing education requirements imposed under Chapter 4004 do not apply to a person who:

(1) holds a license issued under this chapter; and

(2) is in compliance with the continuing education requirements of the person's state of residence.

(b) A person who holds a license issued under this chapter and who does not hold an insurance agent's license in the person's state of residence shall comply with the continuing education requirements imposed under Chapter 4004. (V.T.I.C. Art. 21.11, Secs. 2(b), (c).)

Sec. 4056.058. SERVICE OF PROCESS. The commissioner is the agent for service of process in the manner provided by Subchapter C, Chapter 804, in a legal proceeding against a nonresident agent who holds a license issued under this chapter if:

(1) the nonresident agent does not appoint or maintain an agent for service in this state;

(2) an agent for service is appointed but cannot with reasonable diligence be found; or

(3) the license of the nonresident agent is revoked. (V.T.I.C. Art. 21.11, Sec. 1(d).)

[Chapters 4057-4100 reserved for expansion]

SUBTITLE C. ADJUSTERS

CHAPTER 4101. INSURANCE ADJUSTERS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 4101.007-4101.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

[Sections 4101.062-4101.100 reserved for expansion]

SUBCHAPTER C. SPECIAL LICENSES

[Sections 4101.103-4101.150 reserved for expansion]

SUBCHAPTER D. POWERS AND DUTIES OF ADJUSTER

Sec. 4101.151. PLACE OF BUSINESS

Sec. 4101.152. REFERRAL BY INSURER

[Sections 4101.153-4101.200 reserved for expansion]

SUBCHAPTER E. ENFORCEMENT

Sec. 4101.201. GROUNDS FOR DISCIPLINARY ACTION

Sec. 4101.202. REINSTATEMENT OR REISSUANCE OF LICENSE

Sec. 4101.203. CRIMINAL PENALTY

CHAPTER 4101. INSURANCE ADJUSTERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4101.001. DEFINITIONS. (a) In this chapter, "adjuster" means an individual who:

(1) investigates or adjusts losses on behalf of an insurer as an independent contractor or as an employee of:

(A) an adjustment bureau;

(B) an association;

(C) a general property and casualty agent;

(D) an independent contractor;

(E) an insurer; or

(F) a managing general agent; or

(2) supervises the handling of claims.

(b) For purposes of this chapter, "insurer" includes a self-insured. (V.T.I.C. Art. 21.07-4, Secs. 1(a), (c).)

Sec. 4101.002. GENERAL EXEMPTIONS. (a) This chapter does not apply to:

(1) an attorney who:

(A) adjusts insurance losses periodically and incidentally to the practice of law; and

(B) does not represent that the attorney is an adjuster;

(2) a salaried employee of an insurer who is not regularly engaged in the adjustment, investigation, or supervision of insurance claims;

(3) a person employed only to furnish technical assistance to a licensed adjuster, including:

(A) an attorney;

(B) an engineer;

(C) an estimator;

(D) a handwriting expert;

(E) a photographer; and

(F) a private detective;

(4) an agent or general agent of an authorized insurer who processes an undisputed or uncontested loss for the insurer under a policy issued by the agent or general agent;

(5) a person who performs clerical duties and does not negotiate with parties to disputed or contested claims;

(6) a person who handles claims arising under life, accident, and health insurance policies;

(7) a person:

(A) who is employed principally as:

(i) a right-of-way agent; or

(ii) a right-of-way and claims agent;

(B) whose primary responsibility is the

acquisition of easements, leases, permits, or other real property rights; and

(C) who handles only claims arising out of operations under those easements, leases, permits, or other contracts or contractual obligations; or

(8) an individual who is employed to investigate suspected fraudulent insurance claims but who does not adjust losses or determine claims payments.

(b) A nonresident adjuster is not required to hold a license under this chapter to:

(1) adjust a single loss in this state;

(2) adjust losses arising out of a catastrophe common to all those losses; or

(3) act as a temporary substitute for a licensed adjuster. (V.T.I.C. Art. 21.07-4, Secs. 1(b), 2(a) (part).)

Sec. 4101.003. TEMPORARY EXEMPTION. An individual who is undergoing training as an adjuster under the supervision of a licensed adjuster may act as an adjuster for a period not to exceed 12 months without having a license issued under this chapter if, at the beginning of the period, the individual has been registered with the commissioner as a trainee. (V.T.I.C. Art. 21.07-4, Sec. 2(a) (part).)

Sec. 4101.004. RECIPROCITY. The department may waive any license requirement imposed under this chapter for an applicant who holds a valid license from another state if the state has license requirements substantially equivalent to the requirements for a license issued under this chapter. (V.T.I.C. Art. 21.07-4, Sec.

4.)

Sec. 4101.005. RULES. The commissioner may adopt rules necessary to implement this chapter and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.07-4, Sec. 24.)

Sec. 4101.006. ADVISORY BOARD. (a) An advisory board shall make recommendations to the commissioner regarding:

(1) the scope, time, and conduct of written examinations under Subchapter B;

(2) the times and locations in this state where the examinations are held; and

(3) any other matter the commissioner submits to the advisory board for a recommendation.

(b) The advisory board is composed of nine members appointed by the commissioner as follows:

(1) the presiding officer of the unauthorized practice of law committee of the State Bar of Texas;

(2) three members who represent the public;

(3) two members with knowledge and experience in the profession of insurance adjusting;

(4) one member from a domestic insurer authorized to engage in business in this state;

(5) one member from a foreign insurer authorized to engage in business in this state; and

(6) one member who is an independent adjuster.

(c) A member who represents the public may not be:

(1) an officer, director, or employee of:

(A) an adjuster;

(B) an agent;

(C) a broker;

(D) an insurance agency;

(E) an insurer; or

(F) any other business entity regulated by the department;

(2) a person required to register as a lobbyist under Chapter 305, Government Code; or

(3) a person related to a person described by Subdivision (1) or (2) within the second degree of affinity or consanguinity.

(d) A member of the advisory board serves without compensation. If authorized by the commissioner, an advisory board member is entitled to reimbursement for reasonable expenses incurred in attending meetings of the advisory board. (V.T.I.C. Art. 21.07-4, Sec. 9.)

[Sections 4101.007-4101.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4101.051. LICENSE REQUIRED. Except as otherwise provided by this chapter, a person may not act as or represent that the person is an adjuster in this state unless the person holds a license under this chapter. (V.T.I.C. Art. 21.07-4, Sec. 2(a) (part).)

Sec. 4101.052. APPLICATION. (a) An applicant for a license under this chapter must submit to the department an application on a form prescribed and provided by the department, and include as part

of or in connection with the application any information that the department reasonably requires, including information about the applicant's:

(1) identity;

(2) personal history;

(3) experience; and

(4) business record.

(b) The application must be accompanied by the fee required by Section 4101.057. (V.T.I.C. Art. 21.07-4, Secs. 3, 14(b).)

Sec. 4101.053. QUALIFICATIONS; ISSUANCE. (a) To qualify for a license under this chapter, an applicant must:

(1) comply with this chapter;

(2) present evidence satisfactory to the department that the applicant:

(A) is at least 18 years of age;

(B) resides in this state or a state or country that permits a resident of this state to act as an adjuster in that state or country;

(C) has complied with all federal laws relating to employment or the transaction of business in the United States, if the applicant does not reside in the United States;

(D) is trustworthy; and

(E) has had experience, special education, or training of sufficient duration and extent regarding the handling of loss claims under insurance contracts to make the applicant competent to fulfill the responsibilities of an adjuster; and

(3) pass an examination conducted under this

subchapter or present evidence that the applicant has been exempted under Section 4101.056.

(b) The commissioner shall issue a license to an applicant who meets the qualifications prescribed by this section. (V.T.I.C. Art. 21.07-4, Sec. 7.)

Sec. 4101.054. EXAMINATION REQUIRED. (a) To be eligible for a license under this chapter, an applicant must personally take and pass, to the satisfaction of the commissioner, a written examination of the applicant's qualifications and competency.

(b) The department may supplement a written examination under Subsection (a) with an oral examination.

(c) The commissioner shall prescribe each examination under this section. An examination must be of sufficient scope to reasonably test the applicant's knowledge relative to the kinds of insurance that may be dealt with under the license and of:

(1) the duties of a licensed adjuster; and

(2) the laws of this state that apply to a licensed adjuster.

(d) The commissioner may require a reasonable waiting period before an applicant who fails to pass an examination is eligible to be retested on a similar examination. (V.T.I.C. Art. 21.07-4, Secs. 10 (part), 11(a), 12(a), (c).)

Sec. 4101.055. EXAMINATION PROCEDURES. (a) The department shall prepare and make available to applicants instructions specifying in general terms the subjects that may be covered in an examination required under Section 4101.054.

(b) An examination under this subchapter shall be given at

times and locations in this state necessary to reasonably serve the convenience of the department and applicants. (V.T.I.C. Art. 21.07-4, Secs. 11(b), 12(b).)

Sec. 4101.056. EXEMPTION FROM EXAMINATION REQUIREMENT. (a) An applicant for a license under this chapter is not required to pass an examination under Section 4101.054 to receive the license if the applicant:

(1) had been principally engaged in the investigation, adjustment, or supervision of losses on August 27, 1973, and during the 90-day period preceding that date;

(2) is applying for a renewal license under this chapter;

(3) is licensed as an adjuster in another state with which a reciprocal agreement has been entered into by the commissioner; or

(4) has completed a course in adjusting losses as prescribed and approved by the commissioner and it is certified to the commissioner on completion of the course that the applicant has:

(A) completed the course; and

(B) passed an examination testing the applicant's knowledge and qualification, as prescribed by the commissioner.

(b) An applicant wishing to claim an exemption under Subsection (a)(4) is responsible for the scheduling and administration of the examination required under that subsection. (V.T.I.C. Art. 21.07-4, Secs. 10 (part), 12(d).)

Sec. 4101.057. FEES. (a) Before issuing or renewing a license under this chapter, the department shall set and collect a nonrefundable license fee in an amount not to exceed $50.

(b) An applicant must remit the fee required by Subsection (a) biennially after the issuance of the original license. If the applicant's license has been expired for not more than 90 days, an applicant for a renewal license must remit, in addition to the fee assessed under Subsection (a), a fee equal to one-half of the original license fee.

(c) Before administering an examination under this subchapter, the department shall set and collect a nonrefundable examination fee in an amount not to exceed $50.

(d) Before issuing a duplicate license requested by an adjuster, the department shall set and collect a duplicate license fee.

(e) The department shall deposit a fee collected under this chapter to the credit of the Texas Department of Insurance operating account. (V.T.I.C. Art. 21.07-4, Secs. 14(a), (c), 23.)

Sec. 4101.058. LICENSE FORM. (a) The commissioner shall prescribe the form of a license issued under this chapter.

(b) A license must contain:

(1) the adjuster's name;

(2) the address of the adjuster's place of business;

(3) the date of issuance and the date of expiration of the license; and

(4) the name of the firm or insurer with whom the adjuster is employed at the time the license is issued. (V.T.I.C.

Art. 21.07-4, Sec. 13.)

Sec. 4101.059. CONTINUING EDUCATION: GENERAL REQUIREMENTS. (a) To renew a license under this chapter a licensed adjuster must participate in a continuing education program relating to consumer protection. The program must include education relating to consumer protection laws, including:

(1) Chapter 541;

(2) Chapter 547;

(3) Subchapter A, Chapter 542;

(4) Subchapter E, Chapter 17, Business & Commerce Code; and

(5) any other similar laws specified by the department.

(b) The department may certify continuing education programs. (V.T.I.C. Art. 21.07-4, Secs. 7A(a), (b).)

Sec. 4101.060. CONTINUING EDUCATION: EXEMPTIONS AND WAIVERS. (a) On written request of a licensed adjuster and if the department determines that the adjuster is unable to comply with continuing education requirements under this subchapter because of illness, medical disability, or another extenuating circumstance beyond the control of the adjuster, the department may:

(1) extend the time for the adjuster to comply with the continuing education requirements; or

(2) exempt the adjuster from any of the requirements for a licensing period.

(b) The commissioner by rule shall establish the criteria for an extension or exemption under Subsection (a).

(c) The department may waive any continuing education requirement imposed under this chapter for a nonresident adjuster who holds a valid license from another state if the state has continuing education requirements substantially equivalent to the requirements for a license issued under this chapter. (V.T.I.C. Art. 21.07-4, Secs. 7A(c), (d).)

Sec. 4101.061. EXPIRATION; RENEWAL. Expiration and renewal of a license issued under this chapter are governed by rules adopted by the commissioner or any applicable provision of this code or another insurance law of this state. (V.T.I.C. Art. 21.07-4, Sec. 16.)

[Sections 4101.062-4101.100 reserved for expansion]

SUBCHAPTER C. SPECIAL LICENSES

Sec. 4101.101. EMERGENCY LICENSE. (a) If a catastrophe or an emergency arises out of a disaster, act of God, riot, civil commotion, conflagration, or other similar occurrence, the commissioner shall, on application, issue an emergency license to a person if the application is certified to the commissioner not later than the fifth day after the date on which the person begins work as an adjuster by:

(1) a person who holds a license under this chapter; or

(2) an insurer that maintains an office in this state and holds a certificate of authority to engage in the business of insurance in this state.

(b) The person or insurer that certifies an application under Subsection (a) is responsible for the loss or claims practices of the emergency license holder whom the person or

insurer certifies.

(c) The commissioner may, after notice and hearing, revoke an emergency license on grounds specified by Section 4101.201.

(d) An emergency license is effective for a period not to exceed 90 days. The commissioner may extend the term of the emergency license for an additional period of 90 days.

(e) The commissioner shall establish a fee for an emergency license in an amount not to exceed $20. A person issued an emergency license shall remit the fee to the department not later than the 30th day after the date on which the department issues the license.

(f) The commissioner may issue an emergency license to an applicant who meets the requirements of Subsection (a) regardless of whether the applicant is:

(1) a resident of this state; or

(2) an otherwise licensed adjuster. (V.T.I.C. Art. 21.07-4, Sec. 5.)

Sec. 4101.102. LIMITED LICENSE. (a) If considered necessary by the commissioner, the department may issue a limited license to an applicant in the manner otherwise provided for the issuance of a license under this chapter.

(b) The license shall specifically limit the kinds of insurance that may be handled by the person.

(c) The person may not adjust claims in a kind of insurance other than that for which the adjuster is specifically licensed. (V.T.I.C. Art. 21.07-4, Secs. 8(a), (b), (c).)

[Sections 4101.103-4101.150 reserved for expansion]

SUBCHAPTER D. POWERS AND DUTIES OF ADJUSTER

Sec. 4101.151. PLACE OF BUSINESS. (a) A licensed adjuster shall maintain a place of business that is:

(1) located at the place at which the adjuster principally conducts transactions under the license; and

(2) accessible to the public.

(b) A licensed adjuster shall promptly notify the commissioner if the adjuster changes the location of the adjuster's place of business. (V.T.I.C. Art. 21.07-4, Sec. 15.)

Sec. 4101.152. REFERRAL BY INSURER. (a) An insurer may not knowingly refer a claim or loss for adjustment in this state to a person purporting to be or acting as an adjuster unless the person holds a license under this chapter.

(b) Before referring a claim or loss for adjustment, an insurer must ascertain from the commissioner whether the person performing the adjustment holds a license under this chapter. Once the insurer has ascertained that the person holds a license, the insurer may refer the claim or loss to the person and may continue to refer claims or losses to the person until the insurer has knowledge or receives information from the commissioner that the person no longer holds a license. (V.T.I.C. Art. 21.07-4, Sec. 6.)

[Sections 4101.153-4101.200 reserved for expansion]

SUBCHAPTER E. ENFORCEMENT

Sec. 4101.201. GROUNDS FOR DISCIPLINARY ACTION. (a) The commissioner may discipline an adjuster or deny an application for a license under this chapter under a department rule or any applicable insurance law of this state.

(b) Department rules may specify grounds for discipline that are comparable to grounds for discipline of other license holders under this title. (V.T.I.C. Art. 21.07-4, Sec. 17.)

Sec. 4101.202. REINSTATEMENT OR REISSUANCE OF LICENSE. The commissioner may not reinstate or reissue the license of a license holder or former license holder whose license has been suspended, revoked, or refused renewal until the commissioner determines that the cause for a suspension, revocation, or refusal of a license issued under this chapter no longer exists. (V.T.I.C. Art. 21.07-4, Sec. 20.)

Sec. 4101.203. CRIMINAL PENALTY. A person commits an offense if the person violates Section 4101.051 or 4101.102(c). An offense under this section is a misdemeanor punishable by:

(1) a fine of not more than $500;

(2) confinement in the county jail for not more than six months; or

(3) both the fine and the confinement. (V.T.I.C. Art. 21.07-4, Secs. 2(b), 8(d).)

[Chapters 4102-4150 reserved for expansion]

SUBTITLE D. OTHER PROFESSIONALS

CHAPTER 4151. THIRD-PARTY ADMINISTRATORS

SUBCHAPTER A. GENERAL PROVISIONS

CHAPTER 4151. THIRD-PARTY ADMINISTRATORS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4151.001. DEFINITIONS. In this chapter:

(1) "Administrator" means a person who, in connection with annuities or life, health, and accident benefits, including pharmacy benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. The term does not include a person described by Section 4151.002.

(2) "Insurer" means a person who engages in the business of life, health, or accident insurance under the law of this state.

(3) "Person" means an individual, partnership, corporation, organization, government or governmental subdivision or agency, business trust, estate trust, association, or any other legal entity.

(4) "Plan" means a plan, fund, or program established, adopted, or maintained by a plan sponsor or insurer to the extent that the plan, fund, or program is established, adopted, or maintained to provide indemnification or expense reimbursement for any type of life, health, or accident benefit.

(5) "Plan sponsor" means a person, other than an insurer, who establishes, adopts, or maintains a plan that covers residents of this state, including a plan established, adopted, or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan.

(V.T.I.C. Art. 21.07-6, Secs. 1(1) (part), (5), (6), (7), (8).)

Sec. 4151.002. EXEMPTIONS. A person is not an administrator if the person is:

(1) an employer acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer;

(2) a union acting on behalf of its members;

(3) an insurer or a group hospital service corporation subject to Chapter 842 acting with respect to a policy lawfully issued and delivered by the insurer or corporation in and under the law of a state in which the insurer or corporation was authorized to engage in the business of insurance;

(4) a health maintenance organization that is authorized to operate in this state under Chapter 843 with respect to any activity that is specifically regulated under that chapter, Chapter 1271, 1272, or 1367, or Subchapter A, Chapter 1452;

(5) an agent licensed under Subchapter B, Chapter 4054, who receives commissions as an agent and is acting:

(A) under appointment on behalf of an insurer authorized to engage in the business of insurance in this state; and

(B) in the customary scope and duties of the person's authority as an agent;

(6) a creditor acting on behalf of its debtor with respect to insurance that covers a debt between the creditor and its debtor, if the creditor performs only the functions of a group policyholder or a creditor;

(7) a trust established in conformity with 29 U.S.C.

Section 186 or a trustee or employee who is acting under the trust;

(8) a trust that is exempt from taxation under Section 501(a), Internal Revenue Code of 1986, or a trustee or employee acting under the trust;

(9) a custodian or a custodian's agent or employee who is acting under a custodian account that complies with Section 401(f), Internal Revenue Code of 1986;

(10) a bank, credit union, savings and loan association, or other financial institution that is subject to supervision or examination under federal or state law by a federal or state regulatory authority, if the institution is performing only those functions for which the institution holds a license under federal or state law;

(11) a company that advances and collects a premium or charge from its credit card holders on their authorization, if the company does not adjust or settle claims and acts only in the company's debtor-creditor relationship with its credit card holders;

(12) a person who adjusts or settles claims in the normal course of the person's practice or employment as a licensed attorney and who does not collect any premium or charge in connection with annuities or with life, health, or accident benefits, including pharmacy benefits;

(13) an adjuster licensed by the department who is engaged in the performance of the person's powers and duties as an adjuster in the scope of the person's license;

(14) a person who provides technical, advisory,

utilization review, precertification, or consulting services to an insurer, plan, or plan sponsor but does not make any management or discretionary decisions on behalf of the insurer, plan, or plan sponsor;

(15) an attorney in fact for a Lloyd's plan operating under Chapter 941 or for a reciprocal or interinsurance exchange operating under Chapter 942 who is acting in the capacity of attorney in fact under the applicable chapter;

(16) a joint fund, risk management pool, or self-insurance pool composed of political subdivisions of this state that participate in a fund or pool through interlocal agreements, any nonprofit administrative agency or governing body or other nonprofit entity that acts solely on behalf of a fund, pool, agency, or body, or any other fund, pool, agency, or body established under or for the purpose of implementing an interlocal governmental agreement;

(17) a self-insured political subdivision;

(18) a plan under which insurance benefits are provided exclusively by an insurer authorized to engage in the business of insurance in this state and the administrator of which is:

(A) a full-time employee of the plan's organizing or sponsoring association, trust, or other entity; or

(B) a trustee of the organizing or sponsoring trust; or

(19) a parent of a wholly owned direct or indirect subsidiary insurer authorized to engage in the business of

insurance in this state or a wholly owned direct or indirect subsidiary insurer that is a part of the parent's holding company system that, under an agreement regulated and approved under Chapter 823 or a similar statute of the domiciliary state if the parent or subsidiary insurer is a foreign insurer engaged in business in this state, on behalf of only itself or an affiliated insurer:

(A) collects premiums or contributions, if the parent or subsidiary insurer:

(i) prepares only billing statements and places those statements in the United States mail; and

(ii) causes all collected premiums to be deposited directly in a depository account of the particular affiliated insurer; or

(B) furnishes proof-of-loss forms, reviews claims, determines the amount of the liability for those claims, and negotiates settlements, if the parent or subsidiary insurer pays claims only from the funds of the particular subsidiary by checks or drafts of that subsidiary. (V.T.I.C. Art. 21.07-6, Sec. 1(1) (part).)

Sec. 4151.003. APPLICABILITY OF OTHER PROVISIONS OF CODE. An administrator is subject to Section 823.457, Subchapter H of Chapter 101, Chapter 541, Subchapter A of Chapter 542, and Chapter 804. (V.T.I.C. Art. 21.07-6, Sec. 23.)

Sec. 4151.004. APPLICABILITY TO CERTAIN INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS. An insurer or health maintenance organization that is not exempt under Section 4151.002(3) or (4) is

subject to all provisions of this chapter other than Sections 4151.005, 4151.051-4151.054, 4151.056, and 4151.206(a)(1). (V.T.I.C. Art. 21.07-6, Sec. 24.)

Sec. 4151.005. ADMINISTRATOR NOT INSURANCE AGENT. (a) An administrator licensed in any state who accepts an agent's commission for coverage for a risk located in this state and disburses that commission to an agent in this state is not considered an agent for purposes of this state's laws relating to the licensing of agents.

(b) The exemption provided by this section does not authorize an administrator to perform any other act for which a license as an agent is required by law. (V.T.I.C. Art. 21.07-6, Sec. 10.)

Sec. 4151.006. RULES. The commissioner may adopt fair and reasonable rules, minimum standards, or limitations as appropriate to augment and implement this chapter. (V.T.I.C. Art. 21.07-6, Sec. 2.)

[Sections 4151.007-4151.050 reserved for expansion]

SUBCHAPTER B. CERTIFICATE OF AUTHORITY

Sec. 4151.051. CERTIFICATE OF AUTHORITY REQUIRED. (a) An individual, corporation, organization, trust, partnership, or other legal entity may not act as or hold itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under this chapter.

(b) An administrator is required to hold only one certificate of authority issued under this chapter. (V.T.I.C. Art.

21.07-6, Secs. 3(a), (b).)

Sec. 4151.052. APPLICATION. An application for a certificate of authority to engage in business as an administrator must be in a form prescribed by the commissioner and must include the following:

(1) a copy of each basic organizational document of the applicant, including the articles of incorporation, bylaws, articles of association, trade name certificate, and any other similar document and a copy of any amendment to any of those documents;

(2) a description of the applicant and the applicant's services, facilities, and personnel;

(3) if the applicant is not domiciled in this state, a power of attorney executed by the applicant appointing the commissioner, the commissioner's successors in office, or the commissioner's appointed designee as the applicant's attorney in this state on whom process may be served in any legal action or proceeding based on a cause of action arising in this state against the applicant;

(4) an audited financial statement of the applicant covering the preceding three calendar years or any lesser period that the applicant and any predecessors of the applicant have been in existence, or if an audited financial statement is not available, an unaudited financial statement as of a date not earlier than the 120th day before the date the application is filed, accompanied by an affidavit or certification of the applicant that:

(A) the unaudited financial statement is true and

correct, as of its date; and

(B) a material change in financial condition has not occurred from the date of the financial statement to the execution date of the affidavit or certification; and

(5) any other information the commissioner reasonably requires. (V.T.I.C. Art. 21.07-6, Sec. 4.)

Sec. 4151.053. APPROVAL OF APPLICATION. The commissioner shall approve an application for a certificate of authority to engage in business in this state as an administrator if the commissioner is satisfied that:

(1) granting the application would not violate a federal or state law;

(2) the financial condition of the applicant or of each person who would operate or control the applicant is such that granting a certificate of authority would not be adverse to the public interest;

(3) the applicant has not attempted to obtain the certificate of authority through fraud or bad faith;

(4) the applicant has complied with this chapter and rules adopted by the commissioner under this chapter; and

(5) the name under which the applicant will engage in business in this state is not so similar to that of another administrator or insurer that it is likely to mislead the public. (V.T.I.C. Art. 21.07-6, Sec. 5(a).)

Sec. 4151.054. DENIAL OF APPLICATION. (a) If the commissioner is unable to approve an application for a certificate of authority, the commissioner shall:

(1) provide the applicant with written notice specifying each deficiency in the application; and

(2) offer the applicant the opportunity for a hearing to address each reason and circumstance for possible denial of the application.

(b) The commissioner must provide an opportunity for a hearing before the commissioner finally denies an application.

(c) At the hearing, the applicant has the burden to produce sufficient competent evidence on which the commissioner can make the determinations required by Section 4151.053. (V.T.I.C. Art. 21.07-6, Sec. 5(b).)

Sec. 4151.055. FIDELITY BOND REQUIRED. (a) If the commissioner approves an application for a certificate of authority, before the commissioner issues the certificate of authority, the applicant must:

(1) obtain and maintain a fidelity bond that complies with this section; and

(2) submit to the commissioner proof that the applicant has obtained the fidelity bond.

(b) The fidelity bond must protect against an act of fraud or dishonesty by the applicant in exercising the applicant's powers and duties as administrator.

(c) The fidelity bond may not be less than $10,000 and may not be more than the lesser of:

(1) 10 percent of the amount of funds handled during the preceding year or, if no funds were handled during the preceding year, 10 percent of the amount of funds reasonably estimated to be

handled by the administrator during the current calendar year; or

(2) $500,000.

(d) On written request by an administrator for reduction of the amount of the fidelity bond for a particular year, the commissioner may authorize the reduction of the amount of the bond if the administrator presents evidence that the amount of funds to be handled during that year will be less than the amount handled during the preceding year.

(e) For purposes of this section, the amount of funds handled by a person in the person's capacity as administrator is either the total amount of premiums and contributions received by the administrator or the total amount of benefits paid by the administrator, whichever is greater, during the preceding calendar year in all jurisdictions in which the person acts as an administrator.

(f) Unless the administrator and the insurer or plan agree otherwise in writing, an administrator is required to obtain and maintain only one fidelity bond for all insurers and plans for which the administrator acts as administrator in this state. (V.T.I.C. Art. 21.07-6, Sec. 6.)

Sec. 4151.056. DURATION OF CERTIFICATE OF AUTHORITY. A certificate of authority issued to an administrator under this chapter is effective until it is suspended, canceled, or revoked. The issuance, denial, suspension, cancellation, or revocation of a certificate of authority to act as an administrator is subject to:

(1) Subchapters B and C, Chapter 4005; and

(2) Chapter 82. (V.T.I.C. Art. 21.07-6, Sec. 3(c).)

[Sections 4151.057-4151.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF THIRD-PARTY ADMINISTRATORS

Sec. 4151.101. WRITTEN AGREEMENT WITH INSURER OR PLAN SPONSOR REQUIRED. An administrator may provide services only under a written agreement with an insurer or plan sponsor. (V.T.I.C. Art. 21.07-6, Sec. 11(a).)

Sec. 4151.102. CONTENTS OF WRITTEN AGREEMENT. (a) The written agreement must include each requirement prescribed by this subchapter except for a requirement that does not apply to any function the administrator performs.

(b) If a policy or plan document is issued to a trustee, a copy of the trust agreement and any amendment to that trust agreement becomes part of the written agreement.

(c) The written agreement may not contain a provision that unreasonably restricts the availability to a plan participant of an individual life, health, or accident policy or annuity through an agent selected by the plan participant. (V.T.I.C. Art. 21.07-6, Secs. 11(d), (e), (f).)

Sec. 4151.103. RETENTION OF WRITTEN AGREEMENT; INSPECTION BY COMMISSIONER. (a) During the term of the written agreement, the administrator and the insurer, plan, or plan sponsor shall retain a copy of the agreement as part of their official records.

(b) On written request by the commissioner, the administrator shall make the written agreement available for inspection by the commissioner or the commissioner's designee.

(c) Information the commissioner or the commissioner's

designee obtains from the written agreement is confidential and may not be made available to the public. An employee of the department may examine the information in exercising powers and performing duties under this chapter. (V.T.I.C. Art. 21.07-6, Secs. 11(b), (c).)

Sec. 4151.104. NOTICE OF USE OF ADMINISTRATOR'S SERVICES. If an insurer, plan, or plan sponsor uses the services of an administrator, the administrator shall give written notice to each insured or plan participant of the administrator's identity and the relationship among the administrator and the insurer, plan, or plan sponsor and the insured or plan participant. The insurer, plan, or plan sponsor must approve the notice before the notice is distributed. (V.T.I.C. Art. 21.07-6, Sec. 13(a).)

Sec. 4151.105. PAYMENTS TO ADMINISTRATOR. (a) If an insurer, plan, or plan sponsor uses the services of an administrator:

(1) a payment of a premium or contribution to the administrator by or on behalf of an insured or plan participant is considered to have been received by the insurer, plan, or plan sponsor; and

(2) a payment of a return premium, contribution, or claim to the administrator by the insurer, plan, or plan sponsor is not considered payment to the insured, plan participant, or claimant until the insured, plan participant, or claimant receives the payment.

(b) This section does not limit a right of an insurer, plan, or plan sponsor against the administrator resulting from the

administrator's failure to make a payment to an insured, plan participant, or claimant. (V.T.I.C. Art. 21.07-6, Sec. 12.)

Sec. 4151.106. CERTAIN FUNDS COLLECTED OR RECEIVED BY ADMINISTRATOR. (a) An administrator who collects funds must identify and state separately in writing the amount of any premium or contribution specified by the insurer, plan, or plan sponsor for the coverage and provide the information to any person who pays to the administrator a premium or contribution.

(b) An administrator holds in a fiduciary capacity:

(1) a premium or contribution the administrator collects on behalf of an insurer, plan, or plan sponsor; and

(2) a return premium the administrator receives from an insurer, plan, or plan sponsor. (V.T.I.C. Art. 21.07-6, Secs. 13(b), 17(a).)

Sec. 4151.107. DELIVERY OR DEPOSIT OF CERTAIN FUNDS RECEIVED BY ADMINISTRATOR. (a) On receiving a premium, contribution, or return premium, an administrator shall:

(1) timely deliver the funds to the person entitled to the funds according to terms of the written agreement; or

(2) promptly deposit the funds in a fiduciary bank account established and maintained by the administrator.

(b) If premiums or contributions deposited in a fiduciary bank account were collected on behalf of more than one insurer, plan, or plan sponsor, the administrator shall:

(1) maintain records that clearly record separately the deposits to and withdrawals from the account on behalf of each insurer, plan, or plan sponsor; and

(2) on request of an insurer, plan, or plan sponsor, provide to the insurer, plan, or plan sponsor a copy of the records relating to deposits and withdrawals on behalf of that insurer or plan.

(c) The requirements of Subsection (b):

(1) are in addition to requirements of any other federal or state law; and

(2) do not authorize the commingling of funds if otherwise prohibited by law. (V.T.I.C. Art. 21.07-6, Secs. 17(b), (c).)

Sec. 4151.108. WITHDRAWALS FROM FIDUCIARY ACCOUNT. A withdrawal from a fiduciary bank account established under Section 4151.107 may be made only as provided in the written agreement for any of the following purposes:

(1) delivery to an insurer, plan, or plan sponsor entitled to payment;

(2) deposit in an account controlled and maintained in the name of the insurer, plan, or plan sponsor;

(3) transfer to and deposit in a claims payment account for payment of a claim as provided by Section 4151.111;

(4) payment to a group policyholder for delivery to the insurer entitled to payment;

(5) payment to the administrator of the administrator's commission, fees, or charges;

(6) delivery of a return premium to any person entitled to payment; or

(7) payment of a premium for stop-loss or excess loss

insurance. (V.T.I.C. Art. 21.07-6, Sec. 17(e).)

Sec. 4151.109. PAYMENT OF CLAIMS FROM FIDUCIARY ACCOUNT PROHIBITED. An administrator may not pay a claim from a fiduciary bank account established under Section 4151.107. (V.T.I.C. Art. 21.07-6, Sec. 17(d).)

Sec. 4151.110. UNDERWRITING STANDARDS. If an administrator has the authority to accept or reject a risk, the written agreement must address underwriting or other standards of the insurer or plan. (V.T.I.C. Art. 21.07-6, Sec. 16.)

Sec. 4151.111. ADJUDICATION OF CLAIMS. (a) An administrator shall adjudicate a claim not later than the 60th day after the date on which the administrator receives valid proof of loss in connection with the claim.

(b) The administrator shall pay each claim on a draft authorized by the insurer, plan, or plan sponsor in the written agreement. (V.T.I.C. Art. 21.07-6, Sec. 18.)

Sec. 4151.112. MAINTENANCE OF BOOKS AND RECORDS. (a) An administrator shall maintain at the administrator's principal administrative office adequate books and records of each transaction in which the administrator engages with an insurer, plan, plan sponsor, insured, or plan participant.

(b) The administrator shall maintain the books and records:

(1) until the fifth anniversary of the end of the term of the written agreement to which the books and records relate; and

(2) in accordance with prudent standards of insurance recordkeeping. (V.T.I.C. Art. 21.07-6, Secs. 14(a), (b), (c).)

Sec. 4151.113. ACCESS TO BOOKS AND RECORDS. (a) For the

purpose of examination, audit, and inspection, the administrator shall provide to the commissioner and the commissioner's designee access to the books and records maintained as required by Section 4151.112.

(b) A trade secret, including the identity and address of a policyholder or certificate holder, is confidential, except the commissioner may use that information in a proceeding against the administrator.

(c) An insurer, plan, or plan sponsor is entitled to continuing access to the books and records sufficient to permit the insurer, plan, or plan sponsor to fulfill a contractual obligation to an insured or plan participant. The right provided by this subsection is subject to any restriction included in the written agreement relating to the parties' proprietary rights to the books and records. (V.T.I.C. Art. 21.07-6, Secs. 14(d), (e), (f).)

Sec. 4151.114. DISPOSITION OF BOOKS AND RECORDS ON TERMINATION OF WRITTEN AGREEMENT. On termination of the written agreement, an administrator may fulfill the requirements of Sections 4151.112 and 4151.113 by:

(1) delivering the books and records:

(A) to a successor administrator; or

(B) if there is not a successor administrator, to the insurer, plan, or plan sponsor; and

(2) giving written notice to the commissioner of the location of the books and records. (V.T.I.C. Art. 21.07-6, Sec. 14(g).)

Sec. 4151.115. CONFIDENTIALITY OF PERSONAL INFORMATION.

(a) Information that identifies an individual covered by a plan is confidential.

(b) During the time information described by Subsection (a) is in an administrator's custody or control, the administrator shall take all reasonable precautions to prevent disclosure or use of the information for a purpose unrelated to administration of the plan.

(c) The administrator shall disclose information described by Subsection (a) only:

(1) in response to a court order;

(2) for an examination conducted by the commissioner under this chapter;

(3) for an audit or investigation conducted under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.);

(4) to or at the request of the insurer or plan sponsor; or

(5) with the written consent of the identified individual or the individual's legal representative. (V.T.I.C. Art. 21.07-6, Sec. 14A.)

Sec. 4151.116. ADVERTISING. Before an administrator uses advertising relating to business underwritten by an insurer, plan, or plan sponsor, the insurer, plan, or plan sponsor must approve use of the advertising. (V.T.I.C. Art. 21.07-6, Sec. 15.)

Sec. 4151.117. COMPENSATION OF ADMINISTRATOR. An administrator's compensation may be determined:

(1) as a percentage of the premiums or charges the

administrator collects or the amount of claims the administrator pays or processes; or

(2) on another basis as specified in the written agreement. (V.T.I.C. Art. 21.07-6, Sec. 19.)

[Sections 4151.118-4151.150 reserved for expansion]

SUBCHAPTER D. PHARMACY BENEFIT PLANS

Sec. 4151.151. DEFINITION. In this subchapter, "pharmacy benefit manager" means a person, other than a pharmacy or pharmacist, who acts as an administrator in connection with pharmacy benefits. (V.T.I.C. Art. 21.07-6, Sec. 1(9).)

Sec. 4151.152. IDENTIFICATION CARDS. (a) Except as provided by rules adopted by the commissioner, an administrator for a plan that provides pharmacy benefits shall issue an identification card to each individual covered by the plan. The administrator shall issue the identification card not later than the 30th day after the date the administrator receives notice that the individual is eligible for the benefits.

(b) The commissioner by rule shall adopt standard information to be included on the identification card. The standard form identification card must include:

(1) the name or logo of the entity administering the pharmacy benefits;

(2) the international identification number assigned by the American National Standards Institute for the entity administering the pharmacy benefits;

(3) the group number applicable to the covered individual;

(4) the effective date of the coverage evidenced by the card;

(5) a telephone number to be used to contact an appropriate person to obtain information relating to the pharmacy benefits provided under the coverage; and

(6) copayment information for generic and brand-name prescription drugs. (V.T.I.C. Art. 21.07-6, Sec. 19A.)

Sec. 4151.153. DISCLOSURE OF CERTAIN PATIENT INFORMATION PROHIBITED. (a) A pharmacy benefit manager may not sell a list of patients that contains information through which the identity of an individual patient is disclosed.

(b) A pharmacy benefit manager shall maintain all data that identifies a patient in a confidential manner that prevents disclosure to a third party unless the disclosure is otherwise authorized by law or by the patient.

(c) This section does not prohibit:

(1) general advertising about a specific pharmaceutical product or service; or

(2) the request and receipt by a person of information regarding:

(A) a specific pharmaceutical product or service;

(B) the person's own records or claims; or

(C) the person's dependent's records or claims. (V.T.I.C. Art. 21.07-6, Sec. 19B.)

[Sections 4151.154-4151.200 reserved for expansion]

SUBCHAPTER E. REGULATION OF

THIRD-PARTY ADMINISTRATORS

Sec. 4151.201. EXAMINATION OF ADMINISTRATOR. (a) The commissioner may examine an administrator with regard to its business in this state.

(b) The commissioner may designate one or more employees to perform an examination. (V.T.I.C. Art. 21.07-6, Secs. 8(a), (b).)

Sec. 4151.202. CONTENTS OF EXAMINATION; ON-SITE EVALUATION. (a) An examination under Section 4151.201 must include a review of:

(1) each existing written agreement between the administrator and an insurer or plan sponsor; and

(2) the administrator's financial statements.

(b) The commissioner also may have examiners conduct an on-site evaluation of the administrator's personnel and facilities and any books and records of the administrator relating to the transaction of business by and the financial condition of the administrator.

(c) Before an examiner enters an administrator's property, the commissioner shall give notice to the administrator of the examiner's intent to conduct an on-site evaluation. The notice must:

(1) be in the form required by rule adopted by the commissioner; and

(2) include the date and estimated time that the examiner will enter the administrator's property.

(d) An examiner shall comply with operational rules of an administrator while on the administrator's property. (V.T.I.C.

Art. 21.07-6, Secs. 8(c), (d).)

Sec. 4151.203. COST OF EXAMINATION. The cost of an examination under Section 4151.201 shall be paid from the fee collected under Section 4151.206(a)(2) and with revenue from the maintenance tax levied under Chapter 259. (V.T.I.C. Art. 21.07-6, Sec. 8(f).)

Sec. 4151.204. EXAMINATION UNDER OATH. If necessary to make a complete evaluation of the activities and operations of an administrator, the commissioner may summon and examine under oath the administrator and the administrator's personnel. (V.T.I.C. Art. 21.07-6, Sec. 8(e).)

Sec. 4151.205. ANNUAL REPORT. (a) An administrator shall annually, not later than March 1, file with the commissioner a report on a form prescribed by the commissioner.

(b) The annual report must cover the preceding calendar year. (V.T.I.C. Art. 21.07-6, Sec. 9.)

Sec. 4151.206. FEES. (a) The commissioner shall collect and an applicant or administrator shall pay to the commissioner fees in an amount to be determined by the commissioner as follows:

(1) a filing fee not to exceed $1,000 for processing an original application for a certificate of authority for an administrator;

(2) a fee not to exceed $500 for an examination under Section 4201.201; and

(3) a filing fee not to exceed $200 for an annual report.

(b) The commissioner shall deposit a fee collected under

this section to the credit of the Texas Department of Insurance operating account. (V.T.I.C. Art. 21.07-6, Sec. 20.)

Sec. 4151.207. ADMINISTRATIVE SANCTIONS. An administrator or other person who violates this chapter is subject to the sanctions provided by Chapter 82. (V.T.I.C. Art. 21.07-6, Sec. 22.)

Sec. 4151.208. OFFENSE. (a) An administrator commits an offense if the administrator knowingly violates this chapter or a rule of the commissioner adopted under this chapter.

(b) An offense under this section is a misdemeanor punishable by a fine of not less than $500 or more than $5,000. (V.T.I.C. Art. 21.07-6, Sec. 7.)

CHAPTER 4152. REINSURANCE INTERMEDIARIES

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 4152.005-4152.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

DIRECTORS PROHIBITED

[Sections 4152.257-4152.300 reserved for expansion]

SUBCHAPTER G. DISCIPLINE AND ENFORCEMENT

Sec. 4152.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION

Sec. 4152.302. IMPOSITION OF SANCTIONS

CHAPTER 4152. REINSURANCE INTERMEDIARIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4152.001. DEFINITIONS. In this chapter:

(1) "Actuary" means a member in good standing of the American Academy of Actuaries.

(2) "Broker" means a person, other than an officer or employee of an insurer, who solicits, negotiates, or places reinsurance business on behalf of an insurer and who may not exercise the authority to bind reinsurance on behalf of that insurer.

(3) "Control" has the meaning described by Sections 823.005 and 823.151.

(4) "Insurer" means a commercially domiciled insurer or other person legally organized in this state to engage in the business of insurance as an insurance company, including:

(A) a capital stock insurance company;

(B) a mutual insurance company;

(C) a title insurance company;

(D) a fraternal benefit society;

(E) a local mutual aid association;

(F) a statewide mutual assessment company;

(G) a county mutual insurance company;

(H) a Lloyd's plan;

(I) a reciprocal or interinsurance exchange;

(J) a stipulated premium company;

(K) a group hospital service corporation;

(L) a farm mutual insurance company; and

(M) a risk retention group.

(5) "Manager" means a person who has the authority to bind reinsurance or who manages all or part of the reinsurance business of an insurer, including the management of a separate division, department, or underwriting office, and who acts as an agent for that insurer. The term does not include:

(A) an employee of the insurer;

(B) a manager of the United States branch of an alien insurer;

(C) an underwriting manager who, under a contract, manages all of the reinsurance operations of an insurer, who is under common control with the insurer under Chapter 823, and whose compensation is not based on the volume of premiums written; or

(D) a manager of a group, association, pool, or other organization of insurers who engages in joint underwriting or joint reinsurance and who is subject to examination by the insurance commissioner or other appropriate officer of the state in which the manager's principal business office is located.

(6) "Person" means an individual or a corporation, partnership, association, or other private legal entity.

(7) "Qualified United States financial institution" means an institution that is:

(A) organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or a state; and

(B) regulated, supervised, and examined by United States federal or state authorities who have regulatory authority over banks and trust companies.

(8) "Reinsurance" means a written contract that for consideration transfers an insurance risk of loss between insurers and indemnifies a ceding insurer against all or part of the loss that the ceding insurer may sustain under an insurance policy the ceding insurer has issued or assumed. The term does not include a contract for the bulk sale, transfer, and assumption of direct insurance policy liability to the insureds.

(9) "Reinsurance intermediary" means a broker or manager.

(10) "Reinsurer" means an insurer who has the authority to assume reinsurance, including retrocessions. The term includes a retrocessionaire. (V.T.I.C. Art. 21.07-7, Secs. 2(1), (2), (4), (5), (6), (7), (8), (9), (10), (11).)

Sec. 4152.002. CLASSIFICATION AS COMMERCIALLY DOMICILED INSURER. (a) For purposes of this chapter, a foreign or alien insurer authorized to engage in the business of insurance in this state is a commercially domiciled insurer if during the period described by Subsection (b) the average of the gross premiums written by the insurer in this state is:

(1) more than the average of the gross premiums written by the insurer in the insurer's state of domicile; and

(2) 20 percent or more of the total gross premiums written by the insurer in the United States, as reported in the insurer's three most recent annual statements.

(b) The period applicable to Subsection (a) is:

(1) the three most recent fiscal years of the insurer that precede the fiscal year in which the determination under this section is made; or

(2) if the insurer has been authorized to engage in the business of insurance in this state for less than the period described by Subdivision (1), the period for which the insurer has been authorized to engage in the business of insurance in this state. (V.T.I.C. Art. 21.07-7, Sec. 2(3).)

Sec. 4152.003. RIGHTS OF THIRD PARTIES NOT AFFECTED. This chapter does not restrict the rights of or confer any additional rights on a policyholder, claimant, creditor, or other third party. (V.T.I.C. Art. 21.07-7, Sec. 10(d).)

Sec. 4152.004. RULES. The commissioner may adopt reasonable rules as necessary to implement this chapter. (V.T.I.C. Art. 21.07-7, Sec. 11.)

[Sections 4152.005-4152.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4152.051. LICENSE REQUIRED. (a) A person may not act as a broker or manager in this state for an insurer engaged in the business of insurance or reinsurance in this state unless the person holds an appropriate license under this chapter.

(b) A person who holds a manager license is not required to obtain a broker license but must comply with Subchapter D to act as a broker. (V.T.I.C. Art. 21.07-7, Secs. 3(a), (h); Sec. 7(a).)

Sec. 4152.052. QUALIFICATIONS. The commissioner may establish qualifications for a reinsurance intermediary license as reasonably necessary to fulfill the requirements of this chapter. (V.T.I.C. Art. 21.07-7, Sec. 3(f).)

Sec. 4152.053. APPLICATION. (a) An application for a reinsurance intermediary license may not be accepted unless the application shows on its face that the applicant has been engaged in the business of insurance or reinsurance for at least three years.

(b) Each person authorized under Section 4152.057 to act as a reinsurance intermediary under a reinsurance intermediary license issued to an entity must be named in the application and any supplement to the application. (V.T.I.C. Art. 21.07-7, Secs. 3(c) (part), (g).)

Sec. 4152.054. SERVICE OF NOTICE, ORDERS, AND PROCESS. (a) An applicant for a reinsurance intermediary license who is not a resident of this state must:

(1) designate the commissioner as agent for service of process in the manner, and with the same legal effect, as provided by Chapter 804 for service of process on unauthorized insurers; and

(2) provide the commissioner with the name and address of a resident of this state on whom a notice or order of the commissioner or process affecting the applicant may be served.

(b) A license holder who is a nonresident shall notify the commissioner in writing of each change in the license holder's

designated agent under Subsection (a)(2) not later than the 30th day after the date on which the license holder makes the change. The change does not take effect until acknowledged by the commissioner. (V.T.I.C. Art. 21.07-7, Sec. 3(d).)

Sec. 4152.055. FEES. (a) The department shall collect a nonrefundable licensing fee from each reinsurance intermediary who applies for an original or renewal license in this state.

(b) The commissioner shall set the fees for original, renewal, and reciprocal licenses in amounts that are reasonable and necessary to cover the costs of the licensing program.

(c) The fees shall be deposited to the credit of the Texas Department of Insurance operating account. Money deposited in the account under this subsection may be used by the department only to enforce this chapter. (V.T.I.C. Art. 21.07-7, Secs. 4(a), (b).)

Sec. 4152.056. LICENSE ISSUANCE. The commissioner shall issue a reinsurance intermediary license to a person who complies with this chapter. (V.T.I.C. Art. 21.07-7, Sec. 3(c) (part).)

Sec. 4152.057. PERSONS AUTHORIZED TO ACT UNDER LICENSE. (a) A reinsurance intermediary license issued to a firm or association authorizes each member of the firm or association and any designated employee to act as a reinsurance intermediary under the license.

(b) A reinsurance intermediary license issued to a corporation authorizes each officer and any designated employee or director of the corporation to act as a reinsurance intermediary under the license. (V.T.I.C. Art. 21.07-7, Sec. 3(c) (part).)

Sec. 4152.058. BOND OR ERRORS AND OMISSIONS POLICY. (a)

The commissioner may require a reinsurance intermediary to:

(1) file a bond with the commissioner for the protection of all insurers represented; or

(2) maintain an errors and omissions policy.

(b) The issuer of the bond or the errors and omissions policy must be acceptable to the commissioner. The bond or the policy must be in an amount determined by the commissioner to be customary and adequate under the circumstances. (V.T.I.C. Art. 21.07-7, Sec. 3(b).)

Sec. 4152.059. LICENSE EXPIRATION AND RENEWAL. (a) A reinsurance intermediary license is valid for two years from the date of issuance and may be renewed for two-year terms.

(b) The commissioner may adopt standards for the renewal of a reinsurance intermediary license. (V.T.I.C. Art. 21.07-7, Sec. 3(i).)

[Sections 4152.060-4152.100 reserved for expansion]

SUBCHAPTER C. EXAMINATION OF REINSURANCE INTERMEDIARIES

Sec. 4152.101. EXAMINATION BY COMMISSIONER. (a) A reinsurance intermediary is subject to examination by the commissioner of the reinsurance intermediary's:

(1) financial condition; and

(2) compliance with the laws of this state affecting the conduct of the reinsurance intermediary's business.

(b) A manager may be examined as if the manager were an insurer. (V.T.I.C. Art. 21.07-7, Secs. 9(a) (part), (b), (c) (part).)

Sec. 4152.102. ACCESS TO AND MAINTENANCE OF BOOKS, BANK

ACCOUNTS, AND RECORDS. (a) The commissioner is entitled to access to all books, bank accounts, and records of a reinsurance intermediary.

(b) A reinsurance intermediary shall maintain books, bank accounts, and records in a form usable by the commissioner. (V.T.I.C. Art. 21.07-7, Sec. 9(a) (part).)

Sec. 4152.103. CONDUCT OF EXAMINATION. The commissioner, one or more commissioned examiners, a certified public accountant, or another person qualified to perform the examination shall conduct an examination under this subchapter as the commissioner considers necessary. (V.T.I.C. Art. 21.07-7, Sec. 9(c) (part).)

Sec. 4152.104. EXAMINATION EXPENSE. (a) A reinsurance intermediary who is examined under this subchapter shall pay an amount for the expense of the examination that the commissioner certifies as just and reasonable.

(b) Expenses relating to an examination conducted under this subchapter may be charged to the person examined in accordance with Article 1.16. (V.T.I.C. Art. 21.07-7, Secs. 4(c), 9(c) (part).)

[Sections 4152.105-4152.150 reserved for expansion]

SUBCHAPTER D. REQUIREMENTS RELATING TO BROKERS

Sec. 4152.151. CONTRACT BETWEEN BROKER AND INSURER. (a) A broker and an insurer represented by the broker may enter into a transaction only under a written contract that:

(1) is executed by a responsible officer of both the broker and the insurer; and

(2) specifies the responsibilities of each party.

(b) At a minimum, a contract entered into under this section must:

(1) authorize the insurer to terminate the broker's authority in writing at any time;

(2) require the broker to:

(A) provide accounts to the insurer at least quarterly that accurately detail all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the broker;

(B) pay all money due the insurer not later than the 30th day after the date of receipt;

(C) hold all money collected for the insurer's account in a fiduciary capacity in a bank that is a qualified United States financial institution; and

(D) if premiums or contributions are collected on behalf of or for more than one insurer:

(i) maintain records to identify the ownership interest of each insurer in money held in a fiduciary capacity; and

(ii) provide to each insurer on request a copy of the records relating to deposits and withdrawals on behalf of or for that insurer;

(3) state that the broker will:

(A) comply with:

(i) Section 4152.153; and

(ii) the written standards established by the insurer for the cession or retrocession of risks ceded;

(B) disclose to the insurer any relationship with a reinsurer to which business will be ceded or retroceded; and

(C) provide annually to each insurer with whom the broker transacts business an audited statement of the broker's financial condition prepared by a certified public accountant;

(4) identify:

(A) the name and address of the insurer;

(B) the kinds of insurance to be reinsured or retroceded;

(C) the type of reinsurance or retrocessions; and

(D) the limits of coverage; and

(5) state the effective date and expiration date of the contract. (V.T.I.C. Art. 21.07-7, Sec. 5(a) (part).)

Sec. 4152.152. PLACEMENT OF REINSURANCE WITH UNAUTHORIZED REINSURER. Unless the ceding insurer releases the broker in writing from the broker's obligations under this section, a broker who places reinsurance on behalf of an authorized ceding insurer with a reinsurer that is not authorized, accredited, or trusteed in this state under Article 3.10 or 5.75-1 shall:

(1) exercise due diligence in inquiring into the financial condition of the reinsurer;

(2) disclose to the ceding insurer the broker's findings in connection with the inquiry under Subdivision (1); and

(3) make available to the ceding insurer a copy of the current financial statement of the reinsurer. (V.T.I.C. Art. 21.07-7, Sec. 5(b).)

Sec. 4152.153. TRANSACTION RECORDS. (a) For at least 10

years after the expiration of each contract of reinsurance transacted by a broker, the broker shall maintain a complete record for each transaction that contains:

(1) the type of contract, limits, underwriting restrictions, classes of risks, and territory;

(2) the period of coverage, including effective and expiration dates, cancellation provisions, and notice requirements regarding cancellation;

(3) reporting and settlement requirements regarding balances;

(4) the rate used to compute the reinsurance premium;

(5) the name and address of each ceding or assuming insurer;

(6) the rates of all reinsurance commissions, including the commissions on any retrocessions handled by the broker;

(7) related correspondence and memoranda;

(8) proof of placement;

(9) details regarding retrocessions handled by the broker, including the identity and address of each retrocessionaire and the respective percentage of each contract assumed or ceded;

(10) financial records, including premium and loss accounts; and

(11) if the broker procures a reinsurance contract on behalf of an authorized ceding insurer:

(A) written evidence that the assuming insurer has agreed to assume the risk if the contract is procured directly

from an assuming insurer; or

(B) written evidence that the reinsurer has delegated binding authority to the representative who has agreed to assume the risk and that the representative is qualified to act as a manager under this chapter if the contract is procured through a representative of the assuming insurer, other than an employee.

(b) Each insurer subject to a contract of reinsurance transacted by a broker is entitled to access to the information maintained by the broker under Subsection (a) and may copy and audit all accounts and records maintained by the broker related to the insurer's business. The broker shall maintain the information in a form usable by the insurer. (V.T.I.C. Art. 21.07-7, Secs. 5(c), (d).)

Sec. 4152.154. EMPLOYMENT OF PERSON BY INSURER AND BROKER. A person may not be employed by an insurer and a broker with whom the insurer transacts business unless the broker is:

(1) under common control with the insurer; and

(2) subject to Chapter 823. (V.T.I.C. Art. 21.07-7, Sec. 5(e).)

[Sections 4152.155-4152.200 reserved for expansion]

SUBCHAPTER E. REQUIREMENTS RELATING TO MANAGERS

Sec. 4152.201. CONTRACT BETWEEN MANAGER AND INSURER. (a) A manager and an insurer represented by the manager may enter into a transaction only under a written contract that:

(1) is executed by a responsible officer of both the manager and the insurer;

(2) is approved by the insurer's board of directors or

attorney in fact;

(3) specifies the responsibilities of each party;

(4) identifies the rate, terms, and purpose of each commission, charge, or other fee the manager may assess the insurer; and

(5) at a minimum, incorporates the requirements of Sections 4152.202-4152.214.

(b) Not later than the 30th day before the date the insurer assumes or cedes business through the manager, a copy of the executed contract must be filed with the commissioner for approval. (V.T.I.C. Art. 21.07-7, Secs. 6(a), (j).)

Sec. 4152.202. TERMINATION OF CONTRACT. An insurer may:

(1) terminate a contract entered into under Section 4152.201 for cause on written notice to the manager by certified mail, return receipt requested; and

(2) suspend the authority of the manager to assume or cede business during any dispute regarding the cause for termination. (V.T.I.C. Art. 21.07-7, Sec. 6(b).)

Sec. 4152.203. ACCOUNTING FOR TRANSACTIONS. A manager who enters into a contract with an insurer under Section 4152.201 shall provide accounts to the insurer at least quarterly that accurately detail all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the manager. (V.T.I.C. Art. 21.07-7, Sec. 6(c) (part).)

Sec. 4152.204. MANAGEMENT OF MONEY. (a) A manager shall pay an insurer at least monthly all money due the insurer under a contract entered into under Section 4152.201.

(b) The manager must hold all money collected for the insurer's account in a fiduciary capacity in a bank that is a qualified United States financial institution. The manager may not retain more than three months of estimated claims payments and allocated loss adjustment expenses.

(c) If premiums or contributions are collected on behalf of or for more than one insurer, the manager shall:

(1) keep a separate account for each insurer;

(2) maintain a copy of the records for each account; and

(3) provide to each insurer on request a copy of the records relating to deposits and withdrawals on behalf of or for that insurer. (V.T.I.C. Art. 21.07-7, Secs. 6(c) (part), (d), (e).)

Sec. 4152.205. TRANSACTION RECORDS. (a) For at least 10 years after the expiration of each reinsurance contract transacted by a manager, the manager shall maintain a complete record for each transaction that contains:

(1) the type of contract, limits, underwriting restrictions, classes of risks, and territory;

(2) the period of coverage, including effective and expiration dates, cancellation provisions and notice requirements regarding cancellation, and disposition of outstanding reserves on covered risks;

(3) reporting and settlement requirements regarding balances;

(4) the rate used to compute the reinsurance premium;

(5) the name and address of each ceding or assuming insurer;

(6) the rates of all reinsurance commissions, including the commissions on any retrocessions handled by the manager;

(7) related correspondence and memoranda;

(8) proof of placement;

(9) details regarding retrocessions handled by the manager, as permitted by Section 4152.254, including the identity and address of each retrocessionaire and the respective percentage of each contract assumed;

(10) financial records, including premium and loss accounts; and

(11) if the manager procures a reinsurance contract on behalf of a ceding insurer:

(A) written evidence that the assuming insurer has agreed to assume the risk if the contract is procured directly from an assuming insurer; or

(B) written evidence that the reinsurer has delegated binding authority to the representative who has agreed to assume the risk and that the representative is qualified to act as a manager under this chapter if the contract is procured through a representative of the assuming insurer, other than an employee.

(b) Each insurer is entitled to access to the information maintained by the manager and may copy all accounts and records maintained by the manager related to the insurer's business. The manager shall maintain the information in a form usable by the

insurer. (V.T.I.C. Art. 21.07-7, Secs. 6(f), (g).)

Sec. 4152.206. CONTRACT ASSIGNMENT PROHIBITED. A manager may not assign in whole or in part a contract entered into under Section 4152.201. (V.T.I.C. Art. 21.07-7, Sec. 6(h).)

Sec. 4152.207. COMPLIANCE WITH UNDERWRITING AND RATING STANDARDS OF INSURER. A manager shall comply with the written underwriting and rating standards established by an insurer with whom the manager has entered into a contract under Section 4152.201 for the acceptance, rejection, or cession of all risks. (V.T.I.C. Art. 21.07-7, Sec. 6(i).)

Sec. 4152.208. SETTLEMENT OF CLAIMS. (a) This section applies only to a contract entered into under Section 4152.201 that permits a manager to settle claims on behalf of an insurer.

(b) All claims must be reported to the insurer at least quarterly.

(c) The manager shall send a copy of the claim file to the insurer at the insurer's request or as soon as it is known that the claim:

(1) has the potential to exceed the lesser of:

(A) an amount determined by the commissioner; or

(B) the limit set by the insurer;

(2) involves a coverage dispute;

(3) may exceed the manager's claims settlement authority;

(4) has been open for more than six months; or

(5) has been closed by payment of the lesser of:

(A) an amount determined by the commissioner; or

(B) the limit set by the insurer.

(d) A claim file is the joint property of the insurer and manager, except that on an order of liquidation of the insurer the file becomes the sole property of the insurer or the insurer's estate. The manager is entitled to reasonable access to the claim file and may copy the file on a timely basis.

(e) Any settlement authority granted to the manager may be terminated for cause on the insurer's written notice by certified mail, return receipt requested, to the manager or on the termination of the contract. The insurer may suspend the settlement authority during any dispute regarding the cause of termination. (V.T.I.C. Art. 21.07-7, Sec. 6(k).)

Sec. 4152.209. PAYMENT OF INTERIM PROFITS. If a contract entered into under Section 4152.201 provides for the sharing of interim profits by the manager, interim profits may not be paid until:

(1) the first anniversary of the end of each underwriting period for property business, the fifth anniversary of the end of each underwriting period for casualty business, or the expiration of the period set by the executive director for those or other specified kinds of insurance; and

(2) the adequacy of reserves on remaining claims has been verified under Section 4152.213. (V.T.I.C. Art. 21.07-7, Sec. 6(l).)

Sec. 4152.210. AUDITED STATEMENT OF MANAGER'S FINANCIAL CONDITION. (a) A manager shall provide annually to each insurer and reinsurer with whom the manager transacts business an audited

statement of the manager's financial condition.

(b) The statement must be prepared by an independent certified public accountant in a form acceptable to the commissioner. (V.T.I.C. Art. 21.07-7, Secs. 6(m), 8(b) (part).)

Sec. 4152.211. DISCLOSURE OF RELATIONSHIPS WITH OTHER INSURERS. Before ceding or assuming any business on behalf of an insurer under a contract entered into under Section 4152.201, a manager shall disclose to the insurer any relationship the manager has with another insurer. (V.T.I.C. Art. 21.07-7, Sec. 6(o).)

Sec. 4152.212. ACTS OF MANAGER CONSIDERED ACTS OF INSURER. The acts of a manager are considered to be the acts of the insurer on whose behalf the manager is acting. (V.T.I.C. Art. 21.07-7, Sec. 6(p).)

Sec. 4152.213. ACTUARY'S OPINION ON ADEQUACY OF LOSS RESERVES. In addition to any other required loss reserve certification, a manager who establishes loss reserves shall provide annually, or more frequently as required by other law, an opinion from an actuary attesting to the adequacy of the loss reserves established for losses incurred and outstanding on business produced by the manager. (V.T.I.C. Art. 21.07-7, Sec. 6(q).)

Sec. 4152.214. PLACEMENT OF REINSURANCE WITH UNAUTHORIZED REINSURER. (a) Unless the ceding insurer releases the manager in writing from the manager's obligations under this section, a manager who places reinsurance on behalf of an authorized ceding insurer with a reinsurer that is not authorized, accredited, or trusteed in this state under Article 3.10 or 5.75-1 shall:

(1) exercise due diligence in inquiring into the financial condition of the reinsurer;

(2) disclose to the ceding insurer the manager's findings in connection with the inquiry under Subdivision (1); and

(3) make available to the ceding insurer a copy of the current financial statement of the reinsurer.

(b) A ceding insurer that releases a manager from the manager's obligations under Subsection (a) assumes those obligations. (V.T.I.C. Art. 21.07-7, Sec. 6(r).)

Sec. 4152.215. PROHIBITIONS. (a) A reinsurance intermediary acting as a manager may not:

(1) bind retrocessions on behalf of an insurer, except that the manager may bind facultative retrocessions under obligatory retrocessional agreements if the contract entered into with the insurer under Section 4152.201 contains reinsurance underwriting guidelines for those retrocessions that include:

(A) a list of reinsurers with whom those automatic agreements are in effect; and

(B) for each reinsurer:

(i) the coverages and amounts or percentages that may be reinsured; and

(ii) commission schedules;

(2) commit an insurer to participate in a reinsurance syndicate;

(3) appoint or contract with a broker without ensuring that the broker is qualified to act as a manager under this chapter;

(4) without prior approval of the insurer, pay or

commit an insurer to pay a claim that exceeds the lesser of:

(A) an amount specified by the insurer; or

(B) one percent of the insurer's policyholders' surplus as of December 31 of the last complete calendar year; or

(5) collect a payment from a retrocessionaire or commit an insurer to a claim settlement with a retrocessionaire without prior approval of the insurer.

(b) If prior approval is given as provided by Subsection (a)(5), a report must be forwarded to the reinsurer as provided by Section 4152.203. (V.T.I.C. Art. 21.07-7, Sec. 7(b).)

Sec. 4152.216. EMPLOYMENT OF PERSON BY INSURER AND MANAGER. A person may not be employed by an insurer and a manager with whom the insurer transacts business unless the manager is:

(1) under common control with the insurer; and

(2) subject to Chapter 823. (V.T.I.C. Art. 21.07-7, Sec. 7(c).)

[Sections 4152.217-4152.250 reserved for expansion]

SUBCHAPTER F. REQUIREMENTS RELATING TO INSURERS

Sec. 4152.251. ENGAGEMENT OF SERVICES OF UNLICENSED BROKER OR MANAGER. (a) Except as provided by Subsection (b), an insurer may not engage the services of a person to act as a broker or manager on the insurer's behalf unless the person holds a license if required by Section 4152.051.

(b) An insurer, or an employee, attorney, or actuary of an insurer, may negotiate and obtain reinsurance for that insurer without holding a broker or manager license or without using the services of a broker or manager if that insurer, employee,

attorney, or actuary does not otherwise hold the person out as a broker or manager or perform the duties or provide the services of a broker or manager. (V.T.I.C. Art. 21.07-7, Sec. 8(a).)

Sec. 4152.252. AUDITED STATEMENT OF MANAGER'S FINANCIAL CONDITION. An insurer shall obtain annually an audited statement as provided by Section 4152.210 of the financial condition of each manager with whom the insurer transacts business. (V.T.I.C. Art. 21.07-7, Sec. 8(b) (part).)

Sec. 4152.253. REVIEW OF UNDERWRITING AND CLAIMS PROCESSING OPERATIONS. An insurer shall conduct at least semiannually an on-site review of the underwriting and claims processing operations of a manager with whom the insurer enters into a contract under Section 4152.201. (V.T.I.C. Art. 21.07-7, Sec. 6(n).)

Sec. 4152.254. AUTHORITY FOR RETROCESSIONAL CONTRACTS OR PARTICIPATION IN REINSURANCE SYNDICATES. Binding authority for all retrocessional contracts or participation in reinsurance syndicates rests with an officer of the insurer. That officer may not be affiliated with a manager acting for the insurer. (V.T.I.C. Art. 21.07-7, Sec. 8(c).)

Sec. 4152.255. NOTIFICATION OF TERMINATION OF MANAGER'S CONTRACT. (a) Not later than the 30th day after the date an insurer terminates a manager's contract, the insurer shall provide written notice to the commissioner of the termination, including the reasons for termination.

(b) The notice is a privileged communication and is not subject to public disclosure or admission into evidence in any proceeding. (V.T.I.C. Art. 21.07-7, Sec. 8(d).)

Sec. 4152.256. APPOINTMENT OF CERTAIN PERSONS TO BOARD OF DIRECTORS PROHIBITED. (a) This section does not apply to a relationship governed by Chapter 823.

(b) An insurer may not appoint to the insurer's board of directors an officer, director, employee, controlling shareholder, or submanager of a manager acting for that insurer. (V.T.I.C. Art. 21.07-7, Sec. 8(e).)

[Sections 4152.257-4152.300 reserved for expansion]

SUBCHAPTER G. DISCIPLINE AND ENFORCEMENT

Sec. 4152.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION. The department may deny an application for a license or discipline a license holder under Subchapter C, Chapter 4005, if the department determines that the applicant or license holder, or a person who would be authorized to act on behalf of the applicant or license holder under Section 4152.057, has:

(1) wilfully violated or participated in the violation of this chapter or another insurance law of this state;

(2) intentionally made a material misstatement in the license application;

(3) obtained or attempted to obtain the license by fraud or misrepresentation;

(4) misappropriated, converted to the person's own use, or illegally withheld money required to be held in a fiduciary capacity;

(5) materially misrepresented the terms or effect of any contract of insurance or reinsurance, or engaged in any fraudulent transaction; or

(6) been convicted of a felony or of a misdemeanor of which criminal fraud is an essential element. (V.T.I.C. Art. 21.07-7, Sec. 3(e).)

Sec. 4152.302. IMPOSITION OF SANCTIONS. (a) The commissioner may impose or seek any sanction authorized by law, including the penalties authorized by Chapters 82 and 83, against a reinsurance intermediary, insurer, or reinsurer who the commissioner determines, after notice and hearing as provided by this code, has violated this chapter.

(b) The commissioner may impose or seek any sanction authorized by law, including the penalties authorized by Chapter 101, against a nonlicensed reinsurance intermediary who violates this chapter. (V.T.I.C. Art. 21.07-7, Sec. 10(a).)

CHAPTER 4153. RISK MANAGERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4153.001. DEFINITION

Sec. 4153.002. EXEMPTIONS

Sec. 4153.003. RULES

[Sections 4153.004-4153.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4153.051. LICENSE REQUIRED

Sec. 4153.052. APPLICATION

Sec. 4153.053. QUALIFICATIONS

Sec. 4153.054. EXAMINATION

Sec. 4153.055. EXEMPTIONS FROM EXAMINATION REQUIREMENT

Sec. 4153.056. REEXAMINATION

Sec. 4153.057. FEES

CHAPTER 4153. RISK MANAGERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4153.001. DEFINITION. In this chapter, "risk manager" means a person who:

(1) represents to the public that the person is a risk manager; and

(2) for compensation examines or evaluates risks for and provides advice regarding reduction of risks to a person seeking to obtain or renew property and casualty insurance coverage in this state. (V.T.I.C. Art. 21.14-1, Sec. 1(1).)

Sec. 4153.002. EXEMPTIONS. This chapter does not apply to a person who is employed as a risk manager by:

(1) a liability insurance company authorized to engage in business in this state;

(2) a single employer; or

(3) a public self-insurance pool. (V.T.I.C. Art. 21.14-1, Sec. 3.)

Sec. 4153.003. RULES. The commissioner may adopt rules necessary to carry out this chapter and to regulate risk managers. (V.T.I.C. Art. 21.14-1, Sec. 15.)

[Sections 4153.004-4153.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4153.051. LICENSE REQUIRED. A person may not act as or represent that the person is a risk manager in this state unless the person:

(1) meets the requirements prescribed by this chapter and department rules; and

(2) holds a license issued by the department. (V.T.I.C. Art. 21.14-1, Sec. 2.)

Sec. 4153.052. APPLICATION. (a) To obtain a license to act as a risk manager in this state, an applicant must submit to the department an application on forms prescribed by the commissioner and provided by the department.

(b) An application must be accompanied by the license fee required by Section 4153.057 and include:

(1) information the department requires relating to the applicant's identity, personal history, experience, and business record; and

(2) any other information the department requires. (V.T.I.C. Art. 21.14-1, Secs. 4, 7(b).)

Sec. 4153.053. QUALIFICATIONS. To qualify for a risk

manager's license, an applicant must:

(1) be at least 18 years of age;

(2) maintain a place of business in this state;

(3) meet the application requirements prescribed by this chapter and department rules;

(4) take and pass the examination required by this chapter; and

(5) pay the examination and license fees. (V.T.I.C. Art. 21.14-1, Sec. 5.)

Sec. 4153.054. EXAMINATION. (a) Except as provided by Sections 4153.055 and 4153.058, an applicant for a risk manager's license must personally take and pass an examination to the satisfaction of the commissioner under this chapter and department rules.

(b) The commissioner shall prescribe the examination for a risk manager's license. The examination must:

(1) be designed to test the qualifications and competency of the applicant to be a risk manager; and

(2) be of sufficient scope to reasonably test the applicant's knowledge of risk management and the duties and responsibilities of a risk manager under the laws of this state and department rules.

(c) The department shall:

(1) determine the times and places for examinations; and

(2) give reasonable public notice of the examinations in the manner provided by department rules. (V.T.I.C. Art.

21.14-1, Secs. 6(a), (c), (d), (e).)

Sec. 4153.055. EXEMPTIONS FROM EXAMINATION REQUIREMENT. An applicant is not required to take an examination to obtain a risk manager's license if the applicant holds the designation of:

(1) chartered property casualty underwriter (CPCU) from the American Institute for Chartered Property Casualty Underwriters;

(2) certified insurance counselor (CIC) from the national Society of Certified Insurance Counselors; or

(3) associate in risk management (ARM) from the Insurance Institute of America. (V.T.I.C. Art. 21.14-1, Sec. 6(b).)

Sec. 4153.056. REEXAMINATION. (a) An applicant who fails the examination may retake the examination on payment of an additional examination fee.

(b) The commissioner may require the applicant to wait for a reasonable period determined by the commissioner before the applicant may retake the examination. (V.T.I.C. Art. 21.14-1, Secs. 6(g), (i).)

Sec. 4153.057. FEES. (a) The commissioner shall set and collect in advance a nonrefundable fee, in an amount not to exceed $50, for:

(1) an examination required by this chapter if the department administers the examination;

(2) a risk manager's license; and

(3) the renewal of a risk manager's license.

(b) A fee collected under this section shall be deposited to

the credit of the Texas Department of Insurance operating account. (V.T.I.C. Art. 21.14-1, Secs. 7(a), (c); Sec. 8 (part).)

Sec. 4153.058. RECIPROCAL LICENSE. On submission of an application and the license fee required by Section 4153.057, a person may receive a risk manager's license without examination if the person is licensed as a risk manager by another state, the licensing requirements of which were, on the date the license was issued, substantially equivalent to the requirements prescribed by this chapter. (V.T.I.C. Art. 21.14-1, Sec. 13.)

Sec. 4153.059. LICENSE EXPIRATION. Except as otherwise provided by a staggered renewal system adopted under Section 4003.002, a risk manager's license expires on the second anniversary of the date the license was issued. (V.T.I.C. Art. 21.14-1, Sec. 8 (part).)

Sec. 4153.060. LICENSE RENEWAL. (a) A license holder may renew an unexpired license by:

(1) filing with the department a completed renewal application; and

(2) paying the nonrefundable renewal fee.

(b) The commissioner shall issue a renewal certificate to the license holder if the commissioner determines the license holder continues to be eligible for the license. (V.T.I.C. Art. 21.14-1, Sec. 8 (part).)

[Sections 4153.061-4153.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF RISK MANAGERS

Sec. 4153.101. PLACE OF BUSINESS. A license holder shall maintain a place of business in this state that is:

(1) accessible to the public; and

(2) located at the place at which the license holder principally conducts business. (V.T.I.C. Art. 21.14-1, Sec. 9 (part).)

Sec. 4153.102. NOTIFICATION OF CHANGE OF PLACE OF BUSINESS. A license holder who changes the address of the license holder's place of business from the address that appears on the license shall notify the department of that change as provided by department rules. (V.T.I.C. Art. 21.14-1, Sec. 9 (part).)

[Sections 4153.103-4153.150 reserved for expansion]

SUBCHAPTER D. DISCIPLINARY ACTION

Sec. 4153.151. GROUNDS FOR DISCIPLINARY ACTION. The department may discipline a license holder or deny an applicant a license under Subchapter C, Chapter 4005:

(1) for any cause for which, if known by the department, issuance of the license could have been refused; or

(2) if the license holder or applicant:

(A) wilfully or knowingly violates this chapter, an insurance law of this state, or a department rule;

(B) obtains or attempts to obtain a license through wilful misrepresentation or fraud;

(C) fails the examination required by this chapter; or

(D) is convicted on final judgment of a felony. (V.T.I.C. Art. 21.14-1, Sec. 10.)

Sec. 4153.152. LICENSE SUSPENSION. (a) An order suspending a license must specify the duration of the suspension

period. The department may not suspend a license for a period of more than 12 months.

(b) A license holder whose license is revoked or suspended shall surrender the license to the commissioner at the commissioner's request. (V.T.I.C. Art. 21.14-1, Sec. 11.)

Sec. 4153.153. REINSTATEMENT OR REISSUANCE OF LICENSE. The commissioner may not reinstate the license of or reissue a license to a person whose license is suspended or revoked or to whom the department refuses to issue a renewal certificate until the first anniversary of the date of the suspension, revocation, or refusal to renew. (V.T.I.C. Art. 21.14-1, Sec. 12.)

SECTION 8. CONFORMING AMENDMENT. Article 1.10, Insurance Code, is amended to read as follows:

Art. 1.10. CERTAIN DUTIES OF THE DEPARTMENT. In addition to the other duties required of the department, the department shall perform duties as follows:

2. File Articles of Incorporation and Other Papers. File and preserve in its office all acts or articles of incorporation of insurance companies and all other papers required by law to be deposited with the Department and, upon application of any party interested therein, furnish certified copies thereof upon payment of the fees prescribed by 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.

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.

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. 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, (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.

6. Shall Publish Results of Investigation. The Department shall publish the result of an examination of the affairs of any company whenever the Commissioner deems it for the interest of the public.

17. Voluntary Deposits. (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. 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. 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. 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. 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. 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.

(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.

(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.

(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.

(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.

[~~18. Complaint File. The Department shall keep an information file about each complaint filed with the Department concerning an activity that is regulated by the Department or Commissioner.~~

[~~19. Notice of Complaint Status. If a written complaint is filed with the Department, the Department, at least quarterly and until final disposition of the complaint, shall notify the parties to the complaint of the status of the complaint unless the notice would jeopardize an undercover investigation.~~

[~~20. Electronic Transfer of Funds. The Commissioner shall adopt rules for the electronic transfer of any taxes, fees, guarantee funds, or other money owed to or held for the benefit of the state and for which the Department has the responsibility to administer under this code or another insurance law of this state. The Commissioner shall require the electronic transfer of any amounts held or owed in an amount exceeding $500,000.~~]

SECTION 9. CONFORMING AMENDMENT. Chapter 30, Insurance

Code, is amended to read as follows:

CHAPTER 30. GENERAL PROVISIONS

Sec. 30.001. PURPOSE OF TITLES 2, 3, 5, 6, 7, [~~AND~~] 8, 9, 11, AND 13. (a) This title and Titles 3, 5, 6, 7, [~~and~~] 8, 9, 11, and 13 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, 5, 6, 7, [~~and~~] 8, 9, 11, and 13 is to make the law encompassed by the titles more accessible and understandable by:

(1) rearranging the statutes into a more logical order;

(2) employing a format and numbering system designed to facilitate citation of the law and to accommodate future expansion of the law;

(3) eliminating repealed, duplicative, unconstitutional, expired, executed, and other ineffective provisions; and

(4) restating the law in modern American English to the greatest extent possible.

Sec. 30.002. CONSTRUCTION. Except as provided by Section 30.003 and as otherwise expressly provided in this code, Chapter 311, Government Code (Code Construction Act), applies to the

construction of each provision in this title and in Titles 3, 5, 6, 7, [~~and~~] 8, 9, 11, and 13.

Sec. 30.003. DEFINITION OF PERSON. The definition of "person" assigned by Section 311.005, Government Code, does not apply to any provision in this title or in Title 3, 5, 6, 7, [~~or~~] 8, 9, 11, or 13.

Sec. 30.004. REFERENCE IN LAW TO STATUTE REVISED BY TITLE 2, 3, 5, 6, 7, [~~OR~~] 8, 9, 11, OR 13. A reference in a law to a statute or a part of a statute revised by this title or by Title 3, 5, 6, 7, [~~or~~] 8, 9, 11, or 13 is considered to be a reference to the part of this code that revises that statute or part of that statute.

SECTION 10. CONFORMING AMENDMENT. Subchapter B, Chapter 36, Insurance Code, is amended by adding Section 36.108 to read as follows:

Sec. 36.108. FILING DATE OF REPORT, FINANCIAL STATEMENT, OR PAYMENT DELIVERED BY POSTAL SERVICE. Except as otherwise specifically provided, for a report, financial statement, or payment that is required to be filed or made in the offices of the commissioner and that is delivered by the United States Postal Service to the offices of the commissioner after the date on which the report, financial statement, or payment is required to be filed or made, the date of filing or payment is the date of:

(1) the postal service postmark stamped on the cover in which the report, financial statement, or payment is mailed; or

(2) any other evidence of mailing authorized by the postal service reflected on the cover in which the report, financial statement, or payment is mailed. (V.T.I.C. Art. 1.11

(part), as amended Acts 77th Leg., R.S., Ch. 1419.)

SECTION 11. CONFORMING AMENDMENT. Subchapter B, Chapter 36, Insurance Code, is amended by adding Section 36.109 to read as follows:

Sec. 36.109. RENEWAL EXTENSION FOR CERTAIN PERSONS PERFORMING MILITARY SERVICE. (a) The department may extend the renewal period for a license, permit, certificate of authority, certificate of registration, or other authorization issued by the department to engage in an activity regulated under this code or other insurance laws of this state for a person who is unable in a timely manner to comply with renewal requirements, including any applicable continuing education requirements, because the person was on active duty in a combat theater of operations in the United States armed forces.

(b) A person must submit a written application for an extension under this section to the department.

(c) The department shall exempt a person who receives an extension under this section from any increased fee or other penalty otherwise imposed for failure to renew in a timely manner.

(d) The commissioner may adopt rules as necessary to implement this section. (V.T.I.C. Art. 1.10-1.)

SECTION 12. CONFORMING AMENDMENT. Subchapter B, Chapter 37, Insurance Code, is amended by adding Section 37.053 to read as follows:

Sec. 37.053. EFFECTIVENESS OF RATE DURING APPEAL. (a) An order of the commissioner that determines, approves, or sets a rate under this code and that is appealed remains in effect during the

pendency of the appeal. An insurer shall use the rate provided in the order while the appeal is pending.

(b) The rate is lawful and valid during the appeal, and an insurer may not be required to make any refund from that rate after a decision on the appeal is rendered.

(c) If the order is vacated on appeal, the rate established by the commissioner before the vacated order was rendered remains in effect from the date of remand until the commissioner makes a further determination. The commissioner shall consider the court's order in setting a future rate. (V.T.I.C. Art. 1.35A, Sec. 5(d).)

SECTION 13. CONFORMING AMENDMENT. Section 101.053(b), Insurance Code, is amended to read as follows:

(b) Sections 101.051 and 101.052 do not apply to:

(1) the lawful transaction of surplus lines insurance under Chapter 981;

(2) the lawful transaction of reinsurance by insurers;

(3) a transaction in this state that:

(A) involves a policy that:

(i) is lawfully solicited, written, and delivered outside this state; and

(ii) covers, at the time the policy is issued, only subjects of insurance that are not resident, located, or expressly to be performed in this state; and

(B) takes place after the policy is issued;

(4) a transaction:

(A) that involves an insurance contract independently procured through negotiations occurring entirely

outside this state;

(B) that is reported; and

(C) on which premium tax is paid in accordance with Chapter 226 [~~this chapter~~];

(5) a transaction in this state that:

(A) involves group life, health, or accident insurance, other than credit insurance, and group annuities in which the master policy for the group was lawfully issued and delivered in a state in which the insurer or person was authorized to do insurance business; and

(B) is authorized by a statute of this state;

(6) an activity in this state by or on the sole behalf of a nonadmitted captive insurance company that insures solely:

(A) directors' and officers' liability insurance for the directors and officers of the company's parent and affiliated companies;

(B) the risks of the company's parent and affiliated companies; or

(C) both the individuals and entities described by Paragraphs (A) and (B);

(7) the issuance of a qualified charitable gift annuity under Chapter 102; or

(8) a lawful transaction by a servicing company of the Texas workers' compensation employers' rejected risk fund under Section 4.08, Article 5.76-2, as that article existed before its repeal.

SECTION 14. CONFORMING AMENDMENT. Section 101.103(a),

Insurance Code, is amended to read as follows:

(a) If the commissioner has reason to believe a person, including an insurer, has violated or is threatening to violate this chapter or Chapter 226 or a rule adopted under this chapter or Chapter 226, or that a person, including an insurer, violating this chapter or Chapter 226 has engaged in or is threatening to engage in an unfair act, the commissioner may:

(1) issue a cease and desist order under Subchapter D;

(2) seek injunctive relief under Section 101.105;

(3) request the attorney general to recover a civil penalty under Section 101.105; or

(4) take any combination of those actions.

SECTION 15. CONFORMING AMENDMENT. Sections 101.105(a) and (b), Insurance Code, are amended to read as follows:

(a) A person or entity, including an insurer, that violates this chapter or Chapter 226 is subject to a civil penalty of not more than $10,000 for each act of violation and for each day of violation.

(b) The commissioner may request that the attorney general institute a civil suit in a district court in Travis County for injunctive relief to restrain a person or entity, including an insurer, from continuing a violation or threat of violation described by Section 101.103(a). On application for injunctive relief and a finding that a person or entity, including an insurer, is violating or threatening to violate this chapter or Chapter 226, the district court shall grant the injunctive relief and issue an injunction without bond.

SECTION 16. CONFORMING AMENDMENT. Section 101.201(b), Insurance Code, is amended to read as follows:

(b) This section does not apply to insurance procured by a licensed surplus lines agent from an eligible surplus lines insurer as defined by Chapter 981 [~~Article 1.14-2~~] and independently procured contracts of insurance, as described in Section 101.053(b)(4), that are reported and on which premium tax is paid in accordance with Chapter 225 or 226 [~~this chapter or Article 1.14-2~~].

SECTION 17. CONFORMING AMENDMENT. Subchapter C, Chapter 841, Insurance Code, is amended by adding Section 841.104 to read as follows:

Sec. 841.104. TAX PAYMENT REQUIRED FOR ISSUANCE OF CERTAIN CERTIFICATES OF AUTHORITY. (a) This section applies to a life insurance company that:

(1) has previously held a certificate of authority to engage in the business of life insurance in this state;

(2) ceased to write new business in this state under that certificate of authority; and

(3) after ceasing to write new business, continued to collect from residents of this state renewal or other premiums on policies written under that certificate of authority.

(b) A life insurance company to which this section applies may not obtain a new certificate of authority to engage in the business of life insurance in this state until the company:

(1) files with the department under oath a report that discloses the gross amount of renewal or other premiums received

each calendar year from residents of this state after the period covered by the company's last tax report of gross premium receipts filed under this code; and

(2) pays to the state occupation taxes on those premiums.

(c) The life insurance company shall pay the occupation tax for each year of nonpayment. The company shall pay the tax for each year at the same rate for that year as a company engaged in the business of life insurance in this state during that year.

(d) The life insurance company shall remit the penalties for failure to pay the taxes and file required reports when the company pays the taxes and receives a certificate of authority. (V.T.I.C. Art. 3.59.)

SECTION 18. CONFORMING AMENDMENT. The heading to Subchapter C, Chapter 982, Insurance Code, is amended to read as follows:

SUBCHAPTER C. [~~REQUIREMENTS FOR~~] CERTIFICATE OF AUTHORITY

SECTION 19. CONFORMING AMENDMENT. Subchapter C, Chapter 982, Insurance Code, is amended by adding Section 982.114 to read as follows:

Sec. 982.114. PAYMENT OF TAX BY FOREIGN OR ALIEN LIFE INSURANCE COMPANY. (a) A foreign or alien life insurance company that obtains a certificate of authority under this subchapter on or after April 2, 1909, accepts that certificate and agrees to engage in the business of insurance in this state subject to a requirement that, if the company ceases to transact new insurance business in this state but continues to collect renewal premiums from residents

of this state, the company shall continue to pay an occupation tax based on gross premiums for each year from residents of this state.

(b) The rate of the tax imposed by this section may not exceed the rate imposed by law on insurance companies transacting new insurance business in this state.

(c) The foreign or alien life insurance company shall pay the tax and make reports relating to its gross premium receipts in the same manner as a foreign or alien life insurance company that is transacting new insurance business in this state.

(d) The foreign or alien life insurance company is subject to examination by the department or by a department designee in the same manner and to the same extent as a company that is transacting new insurance business in this state. (V.T.I.C. Art. 3.25 (part).)

SECTION 20. CONFORMING AMENDMENT. Section 181.051, Health and Safety Code, is amended to read as follows:

Sec. 181.051. PARTIAL EXEMPTION. Except for Subchapter D, this chapter does not apply to:

(1) a covered entity as defined by Section 602.001 [~~licensee as defined in Article 28B.01~~], Insurance Code;

(2) an entity established under Article 5.76-3, Insurance Code; or

(3) an employer.

SECTION 21. CONFORMING AMENDMENT. Section 403.002(b), Labor Code, is amended to read as follows:

(b) The assessment may not exceed an amount equal to two percent of the correctly reported gross workers' compensation insurance premiums, including the modified annual premium of a

policyholder that purchases an optional deductible plan under Article 5.55C, Insurance Code. The rate of assessment shall be applied to the modified annual premium before application of a deductible premium credit. (V.T.I.C. Art. 5.68, Sec. (b) (part).)

SECTION 22. CONFORMING AMENDMENT. Subtitle A, Title 3, Occupations Code, is amended by adding Chapter 107 to read as follows:

CHAPTER 107. TELEMEDICINE AND TELEHEALTH

Sec. 107.001. DEFINITIONS. In this chapter:

(1) "Health professional" and "physician" have the meanings assigned by Section 1455.001, Insurance Code.

(2) "Telehealth service" and "telemedicine medical service" have the meanings assigned by Section 57.042, Utilities Code. (V.T.I.C. Art. 21.53F, Secs. 1(2), (3), (4), (5), as added Acts 75th Leg., R.S., Ch. 880.)

Sec. 107.002. INFORMED CONSENT. A treating physician or health professional who provides or facilitates the use of telemedicine medical services or telehealth services shall ensure that the informed consent of the patient, or another appropriate individual authorized to make health care treatment decisions for the patient, is obtained before telemedicine medical services or telehealth services are provided. (V.T.I.C. Art. 21.53F, Sec. 4, as added Acts 75th Leg., R.S., Ch. 880.)

Sec. 107.003. CONFIDENTIALITY. A treating physician or health professional who provides or facilitates the use of telemedicine medical services or telehealth services shall ensure that the confidentiality of the patient's medical information is

maintained as required by Chapter 159 or other applicable law. (V.T.I.C. Art. 21.53F, Sec. 5, as added Acts 75th Leg., R.S., Ch. 880.)

Sec. 107.004. RULES. The Texas State Board of Medical Examiners, in consultation with the commissioner of insurance, as appropriate, may adopt rules necessary to:

(1) ensure that patients using telemedicine medical services receive appropriate, quality care;

(2) prevent abuse and fraud in the use of telemedicine medical services, including rules relating to the filing of claims and records required to be maintained in connection with telemedicine medical services;

(3) ensure adequate supervision of health professionals who are not physicians and who provide telemedicine medical services;

(4) establish the maximum number of health professionals who are not physicians that a physician may supervise through a telemedicine medical service; and

(5) require a face-to-face consultation between a patient and a physician providing a telemedicine medical service within a certain number of days following an initial telemedicine medical service only if the physician has never seen the patient. (V.T.I.C. Art. 21.53F, Sec. 6(b), as added Acts 75th Leg., R.S., Ch. 880.)

SECTION 23. CONFORMING AMENDMENT. Subchapter B, Chapter 171, Tax Code, is amended by adding Section 171.0525 to read as follows:

Sec. 171.0525. EXEMPTION--CERTAIN INSURANCE COMPANIES. A corporation that is a farm mutual insurance company, local mutual aid association, or burial association is exempted from the franchise tax. (V.T.I.C. Art. 4.10, Sec. 14.)

SECTION 24. CONFORMING AMENDMENT. Subchapter B, Chapter 171, Tax Code, is amended by adding Section 171.0527 to read as follows:

Sec. 171.0527. EXEMPTION--TITLE INSURANCE COMPANIES AND TITLE INSURANCE AGENTS. (a) In this section, "title insurance company" and "title insurance agent" have the meanings assigned by Section 2501.003, Insurance Code.

(b) A corporation that is a title insurance company or title insurance agent whose principal activity is the business of title insurance as described by Section 2501.005, Insurance Code, is exempted from the franchise tax. (V.T.I.C. Art. 9.59, Sec. 16(d) (part); (New).)

SECTION 25. CONFORMING AMENDMENT. Chapter 171, Tax Code, is amended by adding Subchapter U to read as follows:

SUBCHAPTER U. TAX CREDIT FOR CERTAIN PREMIUM TAXES

Sec. 171.891. APPLICABILITY OF DEFINITIONS. In this subchapter:

(1) "Control" has the meaning described by Sections 823.005 and 823.151, Insurance Code.

(2) "Controlled insurer," "domestic insurer," and "holding company" have the meanings assigned by Section 823.002, Insurance Code.

(3) "Title insurance," "title insurance agent," and

"title insurance company" have the meanings assigned by Section 2501.003, Insurance Code. (V.T.I.C. Art. 9.59, Sec. 16(a); (New).)

Sec. 171.892. ELIGIBILITY. A corporation is entitled to a credit as provided by this subchapter against the tax imposed under this chapter if the corporation:

(1) is a title insurance holding company subject to Chapter 823, Insurance Code; and

(2) controls one or more domestic title insurance companies that are subject to the tax on premiums imposed under Chapter 223, Insurance Code. (V.T.I.C. Art. 9.59, Sec. 16(b) (part).)

Sec. 171.893. AMOUNT; LIMITATIONS. (a) The amount of the credit for each controlled domestic title insurance company is computed by multiplying the amount of tax on premiums paid by that company in the most recent calendar year ending before the franchise tax report is due by the percentage ownership of the title insurance holding company in the controlled domestic title insurance company. The percentage of ownership of a controlled domestic title insurance company is determined as of the accounting year-end on which the report is based.

(b) The total credit claimed under this subchapter may not exceed the amount of tax due for the report.

(c) A corporation may not carry a credit forward or backward to apply the credit to another year's report. (V.T.I.C. Art. 9.59, Secs. 16(b) (part), (c).)

Sec. 171.894. EFFECT ON OTHER TAXES. This subchapter does not exempt a title insurance holding company, title insurance

company, or title insurance agent from another tax imposed under this code. (V.T.I.C. Art. 9.59, Sec. 16(d) (part).)

SECTION 26. REPEALER. (a) The following Acts and articles as compiled in Vernon's Texas Insurance Code are repealed:

(1) 1.04B, 1.10C, 1.10D, 1.10-1, 1.11, 1.14-2, 1.20, 1.21, 1.22, 1.31, 1.31A, 1.31B, 1.35, 1.35A, 1.35B, 1.35D, 1.35E, 1.37, 3.25, 3.42, 3.42B, 3.42-1, 3.51-5A, 3.51-6, 3.51-6A, 3.51-6B, 3.51-6C, 3.51-6D, 3.51-8, 3.51-9, 3.51-10, 3.51-12, 3.51-13, 3.51-14, 3.59, 3.64, 3.70-1, 3.70-1A, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, 3.70-11, 3.70-12, 3.70-13, 3.71, 3.72, 3.74, 3.76, 3.77, 3.78, 3.79, 4.02, 4.03, 4.04, 4.05, 4.06, 4.07, 4.10, 4.11, 4.11B, 4.11C, 4.12, 4.17, 4.18, 4.19, 5.12, 5.24, 5.49, 5.68, 5.91, 20A.01A, 20A.01B, 20A.02, 20A.09B, 20A.09E, 20A.09F, 20A.09Y, 20A.09Z, 20A.18C, 20A.18E, 20A.18F, 20A.18G, 20A.33, 20A.39, 21.01, 21.01-1, 21.01-2, 21.02, 21.03, 21.04, 21.07, 21.07-2, 21.07-3, 21.07-4, 21.07-6, 21.07-7, 21.08, 21.09, 21.10, 21.11, 21.11-1, 21.12, 21.14, 21.14-1, 21.14-2, 21.15-1, 21.15-5, 21.15-6, 21.16, 21.17, 21.18, 21.19, 21.20, 21.21, 21.21A, 21.21B, 21.21-1, 21.21-2, 21.21-4, 21.21-5, 21.21-7, 21.21-8, 21.24-1, 21.24-2, 21.24-3, 21.29, 21.35, 21.35A, 21.35B, 21.36, 21.46, 21.48, 21.48A, 21.48B, 21.49-2, 21.49-2A, 21.49-2B, 21.49-2D, 21.49-2E, 21.49-9, 21.49-10, 21.49-12, 21.49-19, 21.52, 21.52A, 21.52C, 21.52D, 21.52J, 21.52K, 21.53, 21.53A, 21.53B, 21.53C, 21.53G, 21.53I, 21.53K, 21.53L, 21.53M, 21.53N, 21.53Q, 21.53S, 21.53W, 21.55, 21.56, 21.57, 21.58, 21.58D, 21.59, 21.60, 21.71, 21.73, 21.74, 21.78, 21.79D, 21.79F, 21.79G, and 23.08A;

(2) 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997;

(3) 3.70-3C, as added by Chapter 1260, Acts of the 75th Legislature, Regular Session, 1997;

(4) 20A.09, as amended by Chapters 163, 837, 905, 1023, and 1026, Acts of the 75th Legislature, Regular Session, 1997;

(5) 20A.09H, as redesignated and amended by Chapter 396, Acts of the 77th Legislature, Regular Session, 2001;

(6) 20A.09H, as redesignated and amended by Chapter 1027, Acts of the 77th Legislature, Regular Session, 2001;

(7) 20A.18D, as added by Chapter 550, Acts of the 77th Legislature, Regular Session, 2001;

(8) 21.07-1, as added by Chapter 213, Acts of the 54th Legislature, Regular Session, 1955;

(9) 21.07-1, as added by Chapter 703, Acts of the 77th Legislature, Regular Session, 2001;

(10) 21.21-6, as added by Chapter 415, Acts of the 74th Legislature, Regular Session, 1995;

(11) 21.21-6, as added by Chapter 522, Acts of the 74th Legislature, Regular Session, 1995;

(12) 21.21-9, as added by Chapter 596, Acts of the 75th Legislature, Regular Session, 1997;

(13) 21.21-9, as added by Chapter 1007, Acts of the 75th Legislature, Regular Session, 1997;

(14) 21.52G, as added by Chapter 725, Acts of the 75th Legislature, Regular Session, 1997;

(15) 21.52G, as added by Chapter 955, Acts of the 75th Legislature, Regular Session, 1997;

(16) 21.52L, as added by Chapter 1074, Acts of the 77th Legislature, Regular Session, 2001;

(17) 21.52L, as added by Chapter 1106, Acts of the 77th Legislature, Regular Session, 2001;

(18) 21.53D, as added by Chapter 912, Acts of the 75th Legislature, Regular Session, 1997;

(19) 21.53D, as added by Chapter 1285, Acts of the 75th Legislature, Regular Session, 1997;

(20) 21.53F, as added by Chapter 683, Acts of the 75th Legislature, Regular Session, 1997;

(21) 21.53F, as added by Chapter 832, Acts of the 75th Legislature, Regular Session, 1997;

(22) 21.53F, as added by Chapter 880, Acts of the 75th Legislature, Regular Session, 1997; and

(23) 21.53F, as added by Chapter 1287, Acts of the 75th Legislature, Regular Session, 1997.

(b) The following laws are repealed:

(1) Subsections (a), (c), and (d), Article 1.04D, Insurance Code;

(2) Section 8, Article 1.14-3, Insurance Code;

(3) Subchapters J and K, Chapter 3, Insurance Code;

(4) Chapters 9, 24, 26, 27, 28A, and 28B, Insurance Code;

(5) Subchapter F, Chapter 101, Insurance Code; and

(6) Article 9031, Revised Statutes.

SECTION 27. LEGISLATIVE INTENT. This Act is enacted under Section 43, Article III, Texas Constitution. This Act is intended as a recodification only, and no substantive change in law is intended by this Act.

SECTION 28. EFFECTIVE DATE. This Act takes effect April 1, 2005.

President of the Senate

Speaker of the House

I certify that H.B. No. 2922 was passed by the House on April 30, 2003, by a non-record vote; and that the House concurred in Senate amendments to H.B. No. 2922 on May 22, 2003, by a non-record vote.

Chief Clerk of the House

I certify that H.B. No. 2922 was passed by the Senate, with amendments, on May 20, 2003, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor