SENATE AMENDMENTS

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A BILL TO BE ENTITLED

AN ACT

relating to independent audits of insurer financial statements and insurer internal controls.

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

SECTION 1. Section 401.001, Insurance Code, is amended by adding Subdivisions (2-a), (2-b), (4-a), (4-b), (6), (7), (8), and (9) and amending Subdivision (4) to read as follows:

(2-a) "Audit committee" means a committee established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers and auditing financial statements of the insurer or group of insurers. At the election of the controlling person, the audit committee of an entity that controls a group of insurers may be the audit committee for one or more of the controlled insurers solely for the purposes of this subchapter. If an audit committee is not designated by the insurer, the insurer's entire board of directors constitutes the audit committee.

(2-b) "Group of insurers" means those authorized insurers included in the reporting requirements of Chapter 823, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

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

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

(B) a fire and marine insurance company;

(C) a general casualty company;

(D) a title insurance company;

(E) a fraternal benefit society;

(F) a mutual life insurance company;

(G) a local mutual aid association;

(H) a statewide mutual assessment company;

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

(J) a farm mutual insurance company;

(K) a county mutual insurance company;

(L) a Lloyd's plan;

(M) a reciprocal or interinsurance exchange;

(N) a group hospital service corporation;

(O) a stipulated premium company; [~~and~~]

(P) a nonprofit legal services corporation; and

(Q) a health maintenance organization.

(4-a) "Internal control over financial reporting" means a process implemented by an entity's board of directors, management, and other personnel designed to provide reasonable assurance regarding the reliability of the entity's financial statements. The term includes policies and procedures that:

(A) relate to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(B) provide reasonable assurance that:

(i) transactions are recorded as necessary to permit preparation of the financial statements; and

(ii) receipts and expenditures are made only in accordance with authorizations of management and directors; and

(C) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of assets that could have a material effect on the financial statements.

(4-b) "Management" means the management of an insurer or group of insurers subject to this subchapter.

(6) "SEC" means the United States Securities and Exchange Commission.

(7) "Section 404" means Section 404, Sarbanes-Oxley Act of 2002 (15 U.S.C. Section 7262), and rules adopted under that section.

(8) "Section 404 report" means management's report on internal control over financial reporting as determined by the SEC and the related attestation report of an accountant.

(9) "SOX-compliant entity" means an entity that is required to comply with or voluntarily complies with:

(A) the preapproval requirements provided by 15 U.S.C. Section 78j-1(i);

(B) the audit committee independence requirements provided by 15 U.S.C. Section 78j-1(m)(3); and

(C) the internal control over financial

reporting requirements provided by 15 U.S.C. Section 7262(b) and Item 308, SEC Regulation S-K.

SECTION 2. Sections 401.002, 401.003, and 401.004, Insurance Code, are amended to read as follows:

Sec. 401.002. PURPOSE OF SUBCHAPTER. The purpose of this subchapter is to:

(1) require an annual audit by an independent certified public accountant of the financial statements reporting the financial condition and the results of operations of each insurer;

(2) require communication of internal control related matters noted in an audit; and

(3) require management to report on internal control over financial reporting [~~or health maintenance organization~~].

Sec. 401.003. EFFECT OF SUBCHAPTER ON AUTHORITY TO EXAMINE. This subchapter does not limit the commissioner's authority to order or the department's authority to conduct an examination of an insurer [~~or health maintenance organization~~] under this code or the commissioner's rules.

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

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

(2) file with the commissioner on or before June 30 an

audited financial report for the preceding calendar year.

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

(c) An insurer [~~or health maintenance organization~~] may request an extension of the filing date by submitting the request in writing before the 10th day preceding the filing date. The request must include sufficient detail for the commissioner to make an informed decision on the requested extension. The commissioner may extend the filing date for one or more 30-day periods if the commissioner determines that there is good cause for the extension based on a showing by the insurer [~~or health maintenance organization~~] and the insurer's [~~or health maintenance organization's~~] accountant of the reasons for requesting the extension. An extension granted under this subsection also applies to the filing of management's report on internal control over financial reporting.

(d) An insurer required to file an annual audited financial report under this subchapter shall designate a group of individuals to serve as its audit committee. The audit committee of an entity that controls an insurer may, at the election of the controlling person, be the insurer's audit committee for purposes of this subchapter.

SECTION 3. The heading to Section 401.005, Insurance Code, is amended to read as follows:

Sec. 401.005. ALTERNATIVE FILING FOR CANADIAN OR BRITISH INSURERS [~~OR HEALTH MAINTENANCE ORGANIZATIONS~~].

SECTION 4. Section 401.005(a), Insurance Code, is amended to read as follows:

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

SECTION 5. Section 401.006, Insurance Code, is amended to read as follows:

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

(b) Notwithstanding Subsection (a), the commissioner may require an insurer [~~or health maintenance organization~~], other than a fraternal benefit society that does not have any direct premiums written in this state for accident and health insurance during a

calendar year, to comply with this subchapter if the commissioner finds that the insurer's [~~or health maintenance organization's~~] compliance is necessary for the commissioner to fulfill the commissioner's statutory responsibilities.

(c) An insurer [~~or health maintenance organization~~] that has assumed premiums of at least $1 million under reinsurance agreements is not exempt under Subsection (a).

SECTION 6. The heading to Section 401.007, Insurance Code, is amended to read as follows:

Sec. 401.007. EXEMPTION FOR CERTAIN FOREIGN OR ALIEN INSURERS [~~OR HEALTH MAINTENANCE ORGANIZATIONS~~].

SECTION 7. Sections 401.007(a) and (b), Insurance Code, are amended to read as follows:

(a) A foreign or alien insurer [~~or health maintenance organization~~] that files an audited financial report in another state in accordance with that state's requirements for audited financial reports may be exempt from filing a report under this subchapter if the commissioner finds that the other state's requirements are substantially similar to the requirements prescribed by this subchapter.

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

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

(2) any notification of adverse financial conditions

report filed with the other state.

SECTION 8. Section 401.008, Insurance Code, is amended to read as follows:

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

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

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

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

(2) the insurer [~~or health maintenance organization~~]:

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

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

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

(iii) has been subject to a significant

number of complaints, as determined by the commissioner;

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

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

(D) is not complying with the law or with a rule adopted by the commissioner.

SECTION 9. Sections 401.009(a), (b), and (c), Insurance Code, are amended to read as follows:

(a) An audited financial report required under Section 401.004 must:

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

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

(3) include:

(A) the report of an accountant;

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

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

(D) a statement of cash flows;

(E) a statement of changes in capital and

surplus;

(F) any notes to financial statements;

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

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

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

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

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

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

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

in the first-year report and label the statements as unaudited. The insurer [~~or health maintenance organization~~] must include in the first-year report all other reports described by Section 401.004.

SECTION 10. Section 401.010, Insurance Code, is amended to read as follows:

Sec. 401.010. REQUIREMENTS FOR FINANCIAL STATEMENTS IN AUDITED FINANCIAL REPORT. (a) An accountant must audit the financial reports provided by an insurer [~~or health maintenance organization~~] for purposes of an audit under this subchapter. The accountant who audits the reports must conduct the audit in accordance with generally accepted auditing standards or with standards adopted by the Public Company Accounting Oversight Board, as applicable, and must consider the standards specified in the Financial Condition Examiner's Handbook adopted by the National Association of Insurance Commissioners or other analogous nationally recognized standards adopted by commissioner rule.

(a-1) In accordance with "Consideration of Internal Control in a Financial Statement Audit," AU Section 319, Professional Standards of the American Institute of Certified Public Accountants, the accountant shall obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU Section 319, for those insurers required to file a management's report of internal control over financial reporting under Section 401.024, the accountant shall consider the most recently available report in planning and performing the audit of the statutory financial statements. In this subsection, "consider"

has the meaning assigned by Statement on Auditing Standards No. 102, "Defining Professional Requirements in Statements on Auditing Standards," or a successor document.

(b) The financial statements included in the audited financial report must be prepared in a form and using language and groupings substantially the same as those of the relevant sections of the insurer's [~~or health maintenance organization's~~] annual statement filed with the commissioner. Beginning in the second year in which an insurer [~~or health maintenance organization~~] is required to file an audited financial report, the financial statements must also be comparative, presenting the amounts as of December 31 of the reported year and the amounts as of December 31 of the preceding year.

SECTION 11. Section 401.011, Insurance Code, is amended by amending Subsections (a), (b), and (c) and adding Subsections (c-1), (e), (f), (g), (h), (i), (j), (k), (l), and (m) to read as follows:

(a) Except as provided by Subsections (c), [~~and~~] (d), (e), (f), (g), and (l), the commissioner shall accept an audited financial report from an independent certified public accountant or accounting firm that:

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

(2) conforms to the American Institute of Certified Public Accountants Code of Professional Conduct and to the rules of

professional conduct and other rules of the Texas State Board of Public Accountancy or a similar code.

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

(c) A lead partner or other person responsible for rendering a report for an insurer [~~or health maintenance organization~~] for five [~~seven~~] consecutive years may not, during the five-year [~~two-year~~] period after that fifth [~~seventh~~] year, render a report for the insurer [~~or health maintenance organization~~] or for a subsidiary or affiliate of the insurer [~~or health maintenance organization~~] that is engaged in the business of insurance. On application made at least 30 days before the end of the calendar year, the [~~The~~] commissioner may determine that the limitation provided by this subsection does not apply to an accountant for a particular insurer [~~or health maintenance organization~~] if the insurer [~~or health maintenance organization~~] demonstrates to the satisfaction of the commissioner that the limitation's application to the insurer [~~or health maintenance organization~~] would be unfair because of unusual circumstances. In making the determination, the commissioner may consider:

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

clients;

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

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

(c-1) On filing its annual statement, an insurer for which the commissioner has approved an exception under Subsection (c) shall file the approval with the states in which it is doing or is authorized to do business and with the National Association of Insurance Commissioners. If a state other than this state accepts electronic filing with the National Association of Insurance Commissioners, the insurer shall file the approval in an electronic format acceptable to the National Association of Insurance Commissioners.

(e) In providing services, the accountant shall not function in the role of management, audit the accountant's own work, or serve in an advocacy role for the insurer.

(f) The commissioner may not recognize as qualified an accountant, or accept an annual audited financial report that was prepared wholly or partly by an accountant, who provides an insurer at the time of the audit:

(1) bookkeeping or other services related to the accounting records or financial statements of the insurer;

(2) services related to financial information systems design and implementation;

(3) appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

(4) actuarially oriented advisory services involving the determination of amounts recorded in the financial statements;

(5) internal audit outsourcing services;

(6) management or human resources services;

(7) broker or dealer, investment adviser, or investment banking services;

(8) legal services or other expert services unrelated to the audit; or

(9) any other service that the commissioner determines to be inappropriate.

(g) Notwithstanding Subsection (f)(4), an accountant may assist an insurer in understanding the methods, assumptions, and inputs used in the determination of amounts recorded in the financial statement if it is reasonable to believe that the advisory service will not be the subject of audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification on an insurer's reserves if:

(1) the accountant or the accountant's actuary has not performed management functions or made any management decisions;

(2) the insurer has competent personnel, or engages a third-party actuary, to estimate the reserves for which management takes responsibility; and

(3) the accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves.

(h) An insurer that has direct written and assumed premiums

of less than $100 million in any calendar year may request an exemption from the requirements of Subsection (f) by filing with the commissioner a written statement explaining why the insurer should be exempt. The commissioner may grant the exemption if the commissioner finds that compliance with Subsection (f) would impose an undue financial or organizational hardship on the insurer.

(i) An accountant who performs an audit may perform nonaudit services, including tax services, that are not described in Subsection (f) or that do not conflict with Subsection (e) only if the activity is approved in advance by the audit committee in accordance with Subsection (j).

(j) The audit committee must approve in advance all auditing services and nonaudit services that an insurer's accountant provides to the insurer. The prior approval requirement is waived with respect to nonaudit services if the insurer is a SOX-compliant entity or a direct or indirect wholly owned subsidiary of a SOX-compliant entity or:

(1) the aggregate amount of all nonaudit services provided to the insurer is not more than five percent of the total amount of fees paid by the insurer to its accountant during the fiscal year in which the nonaudit services are provided;

(2) the services were not recognized by the insurer at the time of the engagement to be nonaudit services; and

(3) the services are promptly brought to the attention of the audit committee and approved before the completion of the audit by the audit committee or by one or more members of the audit committee who are the members of the board of directors to whom the

audit committee has delegated authority to grant approvals.

(k) The audit committee may delegate to one or more designated members of the audit committee the authority to grant the prior approval required by Subsection (i). The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

(l) The commissioner may not recognize an accountant as qualified for a particular insurer if a member of the board, the president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for the insurer, was employed by the accountant and participated in the audit of that insurer during the one-year period preceding the date on which the most current statutory opinion is due. This subsection applies only to partners and senior managers involved in the audit. An insurer may apply to the commissioner for an exemption from the requirements of this subsection on the basis of unusual circumstances.

(m) The insurer shall file, with its annual statement filing, the approval of an exemption granted under Subsection (h) or (l) with the states in which it does or in which it is authorized to do business and the National Association of Insurance Commissioners. If a state other than this state in which the insurer does or in which it is authorized to do business accepts electronic filing, the insurer shall file the approval in an electronic format acceptable to the National Association of Insurance Commissioners.

SECTION 12. Section 401.012, Insurance Code, is amended to read as follows:

Sec. 401.012. HEARING ON ACCOUNTANT QUALIFICATIONS; REPLACEMENT OF ACCOUNTANT. The commissioner may hold a hearing to determine if an accountant is qualified and independent. If, after considering the evidence presented, the commissioner determines that an accountant is not qualified and independent for purposes of expressing an opinion on the financial statements in an audited financial report filed under this subchapter, the commissioner shall issue an order directing the insurer [~~or health maintenance organization~~] to replace the accountant with a qualified and independent accountant.

SECTION 13. Section 401.013(a), Insurance Code, is amended to read as follows:

(a) The audited financial report required under Section 401.004 must be accompanied by a letter provided by the accountant who performed the audit stating:

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

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

(3) that the accountant:

(A) is properly licensed by an appropriate state licensing authority, is a member in good standing of the American Institute of Certified Public Accountants, and is otherwise qualified under Section 401.011;

(B) is independent from the insurer [~~or health~~

~~maintenance organization~~] and conforms to the standards of the profession contained in the American Institute of Certified Public Accountants Code of Professional Conduct, the statements of that institute, and the rules of professional conduct adopted by the Texas State Board of Public Accountancy, or a similar code;

(C) understands that:

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

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

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

SECTION 14. Sections 401.014(a) and (b), Insurance Code, are amended to read as follows:

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

(b) The insurer [~~or health maintenance organization~~] must include with the registration a statement signed by the accountant:

(1) indicating that the accountant is aware of the requirements of this subchapter and of the rules of the insurance department of the insurer's [~~or health maintenance organization's~~]

state of domicile that relate to accounting and financial matters; and

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

SECTION 15. Sections 401.015(a), (b), and (d), Insurance Code, are amended to read as follows:

(a) If an accountant who signed an audited financial report for an insurer [~~or health maintenance organization~~] resigns as accountant for the insurer [~~or health maintenance organization~~] or is dismissed by the insurer [~~or health maintenance organization~~] after the report is filed, the insurer [~~or health maintenance organization~~] shall notify the department not later than the fifth business day after the date of the resignation or dismissal.

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

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

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

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

(d) The insurer [~~or health maintenance organization~~] shall file with the statement required by Subsection (b) a letter signed by the accountant stating whether the accountant agrees with the insurer's [~~or health maintenance organization's~~] statement and, if not, the reasons why the accountant does not agree. If the accountant fails to provide the letter, the insurer [~~or health maintenance organization~~] shall file with the commissioner a copy of a written request to the accountant for the letter.

SECTION 16. Sections 401.016 and 401.017, Insurance Code, are amended to read as follows:

Sec. 401.016. AUDITED COMBINED OR CONSOLIDATED FINANCIAL STATEMENTS. (a) An insurer [~~or health maintenance organization~~] described by Section 401.001 [~~401.001(3) or (4)~~] that is required to file an audited financial report under this subchapter may apply in writing to the commissioner for approval to file audited combined or consolidated financial statements instead of separate audited financial reports if the insurer [~~or health maintenance organization~~]:

(1) is part of a group of insurers [~~or health maintenance organizations~~] that uses a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and

integrity of the insurer's [~~or health maintenance organization's~~] reserves; and

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

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

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

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

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

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

(4) explanations of consolidating and eliminating entries; and

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

(d) An insurer [~~or health maintenance organization~~] that

does not receive approval from the commissioner to file audited combined or consolidated financial statements for the insurer [~~or health maintenance organization~~] and any of the insurer's [~~or health maintenance organization's~~] subsidiaries or affiliates shall file a separate audited financial report.

Sec. 401.017. NOTICE OF ADVERSE FINANCIAL CONDITION OR MISSTATEMENT OF FINANCIAL CONDITION. (a) An insurer [~~or health maintenance organization~~] required to file an audited financial report under this subchapter shall require the insurer's [~~or health maintenance organization's~~] accountant to immediately notify the board of directors of the insurer [~~or health maintenance organization~~] or the insurer's [~~or health maintenance organization's~~] audit committee in writing of any determination by that accountant that:

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

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

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

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

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

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

(d) An accountant is not liable to an insurer [~~or health maintenance organization~~] or the insurer's [~~or health maintenance organization's~~] policyholders, shareholders, officers, employees, directors, creditors, or affiliates for a statement made under this section if the statement was made in good faith to comply with this section.

SECTION 17. Section 401.019, Insurance Code, is amended to read as follows:

Sec. 401.019. COMMUNICATION OF [~~REPORT ON SIGNIFICANT DEFICIENCIES IN~~] INTERNAL CONTROL MATTERS NOTED IN AUDIT. (a) In addition to the audited financial report required by this subchapter, each insurer [~~or health maintenance organization~~] shall provide to the commissioner a written communication prepared by an accountant in accordance [~~report of significant deficiencies required and prepared by an accountant in accordance~~] with the Professional Standards of the American Institute of Certified Public Accountants that describes any unremediated material weaknesses in its internal controls over financial reporting noted

during the audit.

(b) The insurer [~~or health maintenance organization~~] shall annually file with the commissioner the communication [~~report~~] required by this section not later than the 60th day after the date the audited financial report is filed. The communication must contain a description of any unremediated material weaknesses, as defined by Statement on Auditing Standards No. 60, "Communication of Internal Control Related Matters Noted in an Audit," or a successor document, as of the immediately preceding December 31, in the insurer's internal control over financial reporting that was noted by the accountant during the course of the audit of the financial statements. The communication must affirmatively state if unremediated material weaknesses were not noted by the accountant.

(c) The insurer [~~or health maintenance organization~~] shall also provide a description of remedial actions taken or proposed to be taken to correct unremediated material weaknesses [~~significant deficiencies~~], if the actions are not described in the accountant's communication [~~report~~].

(d) [~~(c)~~] The report must follow generally the form for communication of internal control structure matters noted in an audit described in Statement on Auditing Standard (SAS) No. 60, AU Section 325, Professional Standards of the American Institute of Certified Public Accountants.

SECTION 18. Sections 401.020(a) and (b), Insurance Code, are amended to read as follows:

(a) In this section, "work papers" means the records kept by

an accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached that are pertinent to the accountant's audit of an insurer's [~~or health maintenance organization's~~] financial statements. The term includes work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules, and commentaries prepared or obtained by the accountant in the course of auditing the financial statements that support the accountant's opinion.

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

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

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

SECTION 19. The heading to Section 401.021, Insurance Code, is amended to read as follows:

Sec. 401.021. COMMISSIONER-ORDERED AUDIT [~~PENALTY FOR FAILURE TO COMPLY~~].

SECTION 20. Sections 401.021(a), (b), and (c), Insurance Code, are amended to read as follows:

(a) If an insurer [~~or health maintenance organization~~] fails to comply with this subchapter, the commissioner shall order that the insurer's [~~or health maintenance organization's~~] annual audit be performed by a qualified independent certified public accountant.

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

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

SECTION 21. Subchapter A, Chapter 401, Insurance Code, is amended by adding Sections 401.022, 401.023, 401.024, and 401.025 to read as follows:

Sec. 401.022. REQUIREMENTS FOR AUDIT COMMITTEES. (a) This section does not apply to foreign or alien insurers authorized in this state or to an insurer that is a SOX-compliant entity or a direct or indirect wholly owned subsidiary of a SOX-compliant entity.

(b) An insurer to which this subchapter applies shall establish an audit committee conforming to the following criteria:

(1) an insurer with over $500 million in direct written and assumed premiums for the preceding calendar year shall

establish an audit committee with an independent membership of at least 75 percent; and

(2) an insurer with $300 million to $500 million in direct written and assumed premiums for the preceding calendar year shall establish an audit committee with an independent membership of at least 50 percent.

(c) The commissioner may require the insurer's board to enact improvements to the independence of the audit committee membership if the insurer:

(1) is in a risk-based capital action level event;

(2) meets one or more of the standards of an insurer considered to be in hazardous financial condition; or

(3) otherwise exhibits qualities of a troubled insurer.

(d) An insurer with direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of less than $500 million may apply to the commissioner for a waiver from the requirements of this section based on hardship. The insurer shall file, with its annual statement filing, the approval of a waiver under this subsection with the states in which it does or is authorized to do business and with the National Association of Insurance Commissioners. If a state other than this state accepts electronic filing, the insurer shall file the approval in an electronic format acceptable to the National Association of Insurance Commissioners.

(e) In this section, premiums that are assumed from

affiliates in the same group of insurers are excluded in determining whether an insurer has less than $500 million in direct written premiums and assumed premiums.

(f) The audit committee is directly responsible for the appointment, compensation, and oversight of the work of any accountant, including the resolution of disagreements between the management of the insurer and the accountant regarding financial reporting, for the purpose of preparing or issuing the audited financial report or related work under this subchapter. Each accountant shall report directly to the audit committee.

(g) Each member of the audit committee must be a member of the board of directors of the insurer or a member of the board of directors of an entity elected under Subsection (j) and described under Section 401.001(2-a).

(h) To be independent for purposes of this section, a member of the audit committee may not, other than in the person's capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory, or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary of the entity. To the extent of any conflict with another statute requiring an otherwise nonindependent board member to participate in the audit committee, the other statute prevails and controls, and the member may participate in the audit committee unless the member is an officer or employee of the insurer or an affiliate of the insurer.

(i) If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control,

the member may remain an audit committee member of the responsible entity if the responsible entity gives notice to the commissioner until the earlier of:

(1) the next annual meeting of the responsible entity; or

(2) the first anniversary of the occurrence of the event that caused the member to be no longer independent.

(j) To exercise the election of the controlling person to designate the audit committee under this subchapter, the ultimate controlling person must provide written notice of the affected insurers to the commissioner. Notice must be made before the issuance of the statutory audit report and must include a description of the basis for the election. The election may be changed through a notice to the commissioner by the insurer, which must include a description of the basis for the change. An election remains in effect until changed by later election.

(k) The audit committee shall require the accountant who performs an audit required by this subchapter to report to the audit committee in accordance with the requirements of Statement on Auditing Standards No. 61, "Communication with Audit Committees," or a successor document, including:

(1) all significant accounting policies and material permitted practices;

(2) all material alternative treatments of financial information in statutory accounting principles that have been discussed with the insurer's management officials;

(3) ramifications of the use of the alternative

disclosures and treatments, if applicable, and the treatment preferred by the accountant; and

(4) other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(l) If an insurer is a member of an insurance holding company system, the report required by Subsection (k) may be provided to the audit committee on an aggregate basis for insurers in the holding company system if any substantial differences among insurers in the system are identified to the audit committee.

Sec. 401.023. PROHIBITED CONDUCT IN CONNECTION WITH PREPARATION OF REQUIRED REPORTS AND DOCUMENTS. (a) A director or officer of an insurer may not, directly or indirectly:

(1) make or cause to be made a materially false or misleading statement to an accountant in connection with an audit, review, or communication required by this subchapter; or

(2) omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review, or communication required under this subchapter.

(b) An officer or director of an insurer, or another person acting under the direction of an officer or director of an insurer, may not directly or indirectly coerce, manipulate, mislead, or fraudulently influence an accountant performing an audit under this subchapter if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial

statements materially misleading.

(c) For purposes of Subsection (b), actions that could result in rendering the insurer's financial statements materially misleading include actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead, or fraudulently influence an accountant:

(1) to issue or reissue a report on an insurer's financial statements that is not warranted and would result in material violations of statutory accounting principles prescribed by the commissioner, generally accepted auditing standards, or other professional or regulatory standards;

(2) not to perform an audit, review, or other procedure required by generally accepted auditing standards or other professional standards;

(3) not to withdraw an issued report; or

(4) not to communicate matters to an insurer's or health maintenance organization's audit committee.

Sec. 401.024. MANAGEMENT'S REPORT OF INTERNAL CONTROL OVER FINANCIAL REPORTING. (a) Each insurer required to file an audited financial report under this subchapter that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of $500 million or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting. The report must be filed with the commissioner with the communication described by Section 401.019. The report of internal control over financial reporting shall be as of the immediately

preceding December 31.

(b) Notwithstanding the premium threshold under Subsection (a), the commissioner may require an insurer to file the management's report of internal control over financial reporting if the insurer is in any risk-based capital level event or meets one or more of the standards of an insurer considered to be in hazardous financial condition as described by Chapter 404.

(c) An insurer or a group of insurers may file the insurer's or the insurer's parent's Section 404 report and an addendum if the insurer or group of insurers is:

(1) directly subject to Section 404;

(2) part of a holding company system whose parent is directly subject to Section 404;

(3) not directly subject to Section 404 but is a SOX-compliant entity; or

(4) a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX-compliant entity.

(d) A Section 404 report described by Subsection (c) must include those internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements, including those items listed in Sections 401.009(a)(3)(B)-(H) and (b). The addendum must be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements, including those items listed in Sections

401.009(a)(3)(B)-(H) and (b), excluded from the Section 404 report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls are not included in the Section 404 report, the insurer or group of insurers may either file:

(1) a report under this section; or

(2) the Section 404 report and a report under this section for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 report.

(e) The insurer's management report of internal control over financial reporting must include:

(1) a statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

(2) a statement that management has established internal control over financial reporting and an opinion concerning whether, to the best of management's knowledge and belief, after diligent inquiry, its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(3) a statement that briefly describes the approach or processes by which management evaluates the effectiveness of its internal control over financial reporting;

(4) a statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(5) disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of the immediately preceding December 31;

(6) a statement regarding the inherent limitations of internal control systems; and

(7) signatures of the chief executive officer and the chief financial officer or an equivalent position or title.

(f) For purposes of Subsection (e)(5), an insurer's management may not conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weaknesses in its internal control over financial reporting.

(g) Management shall document, and make available on financial condition examination, the basis of the opinions required by Subsection (e). Management may base opinions, in part, on its review, monitoring, and testing of internal controls undertaken in the normal course of its activities.

(h) Management has discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to form its opinion in a cost-effective manner and may include an assembly of or reference to existing

documentation.

(i) The department shall maintain the confidentiality of the management's report of internal control over financial reporting required by this section and any supporting documentation provided in the course of a financial condition examination.

Sec. 401.025. TRANSITION DATES. (a) An insurer or group of insurers whose audit committee as of January 1, 2010, is not subject to the independence requirements of Section 401.022 because the total written and assumed premium is below the threshold under that section, and that later becomes subject to one of the independence requirements because of changes in the amount of written and assumed premium, has one year following the year in which the written and assumed premium exceeds the threshold amount to comply with the independence requirements. An insurer that becomes subject to one of the independence requirements as a result of a business combination must comply with the independence requirements not later than the first anniversary of the date of the acquisition or combination.

(b) An insurer or group of insurers that is not required by Section 401.024 to file a report as of January 1, 2010, because the total written premium is below the threshold amount, and that later becomes subject to the reporting requirements, has two years after the year in which the written premium exceeds the threshold amount to file a report. An insurer acquired in a business combination must comply with the reporting requirements not later than the second anniversary of the date of the acquisition or combination.

SECTION 22. Section 401.001(3), Insurance Code, is

repealed.

SECTION 23. (a) Section 401.011(c), Insurance Code, as amended by this Act, takes effect January 1, 2010.

(b) Section 401.022, Insurance Code, as added by this Act, takes effect January 1, 2010.

(c) Except as provided by Subsections (a) and (b) of this section, Chapter 401, Insurance Code, as amended by this Act, takes effect beginning with the reporting period ending December 31, 2010.

SECTION 24. Except as otherwise provided by this Act, this Act takes effect September 1, 2009.

ADOPTED

MAY 26 2009

Secretary of the Senate

By: Eiland/Averitt H.B. No. 2762

Substitute the following for ___.B. No. _____:

By: Craig Estes C.S.H.B. No. 2762

A BILL TO BE ENTITLED

AN ACT

relating to independent audits of insurer financial statements and insurer internal controls.

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

SECTION 1. Section 401.001, Insurance Code, is amended by adding Subdivisions (2-a), (2-b), (4-a), (4-b), (6), (7), (8), and (9) and amending Subdivision (4) to read as follows:

(2-a) "Audit committee" means a committee established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers and audits of financial statements of the insurer or group of insurers. At the election of the controlling person, the audit committee of an entity that controls a group of insurers may be the audit committee for one or more of the controlled insurers solely for the purposes of this subchapter. If an audit committee is not designated by the insurer, the insurer's entire board of directors constitutes the audit committee.

(2-b) "Group of insurers" means those authorized insurers included in the reporting requirements of Chapter 823, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

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

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

(B) a fire and marine insurance company;

(C) a general casualty company;

(D) a title insurance company;

(E) a fraternal benefit society;

(F) a mutual life insurance company;

(G) a local mutual aid association;

(H) a statewide mutual assessment company;

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

(J) a farm mutual insurance company;

(K) a county mutual insurance company;

(L) a Lloyd's plan;

(M) a reciprocal or interinsurance exchange;

(N) a group hospital service corporation;

(O) a stipulated premium company; [~~and~~]

(P) a nonprofit legal services corporation; and

(Q) a health maintenance organization.

(4-a) "Internal control over financial reporting" means a process implemented by an entity's board of directors, management, and other personnel designed to provide reasonable assurance regarding the reliability of the entity's financial statements. The term includes policies and procedures that:

(A) relate to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(B) provide reasonable assurance that:

(i) transactions are recorded as necessary to permit preparation of the financial statements; and

(ii) receipts and expenditures are made only in accordance with authorizations of management and directors; and

(C) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of assets that could have a material effect on the financial statements.

(4-b) "Management" means the management of an insurer or group of insurers subject to this subchapter.

(6) "SEC" means the United States Securities and Exchange Commission.

(7) "Section 404" means Section 404, Sarbanes-Oxley Act of 2002 (15 U.S.C. Section 7262), and rules adopted under that section.

(8) "Section 404 report" means management's report on internal control over financial reporting as determined by the SEC and the related attestation report of an accountant.

(9) "SOX-compliant entity" means an entity that is required to comply with or voluntarily complies with:

(A) the preapproval requirements provided by 15 U.S.C. Section 78j-1(i);

(B) the audit committee independence requirements provided by 15 U.S.C. Section 78j-1(m)(3); and

(C) the internal control over financial

reporting requirements provided by 15 U.S.C. Section 7262(b) and Item 308, SEC Regulation S-K.

SECTION 2. Sections 401.002, 401.003, and 401.004, Insurance Code, are amended to read as follows:

Sec. 401.002. PURPOSE OF SUBCHAPTER. The purpose of this subchapter is to:

(1) require an annual audit by an independent certified public accountant of the financial statements reporting the financial condition and the results of operations of each insurer;

(2) require communication of internal control related matters noted in an audit; and

(3) require management to report on internal control over financial reporting [~~or health maintenance organization~~].

Sec. 401.003. EFFECT OF SUBCHAPTER ON AUTHORITY TO EXAMINE. This subchapter does not limit the commissioner's authority to order or the department's authority to conduct an examination of an insurer [~~or health maintenance organization~~] under this code or the commissioner's rules.

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

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

(2) file with the commissioner on or before June 1 [~~30~~]

an audited financial report for the preceding calendar year.

(b) The commissioner may require an insurer [~~or health maintenance organization~~] to file an audited financial report on a date that precedes June 1 [~~30~~]. The commissioner must notify the insurer [~~or health maintenance organization~~] of the filing date not later than the 90th day before that date.

(c) An insurer [~~or health maintenance organization~~] may request an extension of the filing date by submitting the request in writing before the 10th day preceding the filing date. The request must include sufficient detail for the commissioner to make an informed decision on the requested extension. The commissioner may extend the filing date for one or more 30-day periods if the commissioner determines that there is good cause for the extension based on a showing by the insurer [~~or health maintenance organization~~] and the [~~insurer's or health maintenance organization's~~] accountant of the reasons for requesting the extension. An extension granted under this subsection also applies to the filing of management's report on internal control over financial reporting.

(d) An insurer required to file an annual audited financial report under this subchapter shall designate a group of individuals to serve as its audit committee. The audit committee of an entity that controls an insurer may, at the election of the controlling person, be the insurer's audit committee for purposes of this subchapter.

SECTION 3. The heading to Section 401.005, Insurance Code, is amended to read as follows:

Sec. 401.005. ALTERNATIVE FILING FOR CANADIAN OR BRITISH INSURERS [~~OR HEALTH MAINTENANCE ORGANIZATIONS~~].

SECTION 4. Section 401.005(a), Insurance Code, is amended to read as follows:

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

SECTION 5. Section 401.006, Insurance Code, is amended to read as follows:

Sec. 401.006. EXEMPTION FOR CERTAIN SMALL INSURERS [~~AND HEALTH MAINTENANCE ORGANIZATIONS~~]. (a) An insurer [~~or health maintenance organization~~] that has less than $1 million in direct premiums written in this state during a calendar year and fewer than 1,000 policyholders or certificate holders of direct written premiums nationwide at the end of the calendar year is exempt from the requirement to file an audited financial report if the insurer [~~or health maintenance organization~~] submits an affidavit, made under oath by one of the insurer's [~~or health maintenance organization's~~] officers, that specifies the amount of direct premiums written in this state during that period and the number of policyholders or certificate holders of direct written premiums nationwide at the end of the calendar year.

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

(c) An insurer [~~or health maintenance organization~~] that has assumed premiums of at least $1 million under reinsurance agreements is not exempt under Subsection (a).

SECTION 6. The heading to Section 401.007, Insurance Code, is amended to read as follows:

Sec. 401.007. EXEMPTION FOR CERTAIN FOREIGN OR ALIEN INSURERS [~~OR HEALTH MAINTENANCE ORGANIZATIONS~~].

SECTION 7. Section 401.007, Insurance Code, is amended by amending Subsections (a) and (b) and adding Subsection (c) to read as follows:

(a) A foreign or alien insurer [~~or health maintenance organization~~] that files an audited financial report in another state in accordance with that state's requirements for audited financial reports may be exempt from filing a report under this subchapter if the commissioner finds that the other state's requirements are substantially similar to the requirements prescribed by this subchapter.

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

(1) the audited financial report, the communication of internal control-related matters noted in the audit [~~report on significant deficiencies in internal controls~~], and the accountant's letter of qualifications filed with the other state; and

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

(c) A foreign or alien insurer required to file management's report of internal control over financial reporting in another state is exempt from filing the report in this state if the other state has substantially similar reporting requirements and the report is filed with the commissioner in that state in the time specified.

SECTION 8. Section 401.008, Insurance Code, is amended to read as follows:

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

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

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

section if:

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

(2) the insurer [~~or health maintenance organization~~]:

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

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

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

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

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

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

(D) is not complying with the law or with a rule adopted by the commissioner.

SECTION 9. Sections 401.009(a), (b), and (c), Insurance Code, are amended to read as follows:

(a) An audited financial report required under Section 401.004 must:

(1) describe the financial condition of the insurer [~~or health maintenance organization~~] as of the end of the most recent calendar year and the results of the insurer's [~~or health maintenance organization's~~] operations, changes in financial

position, and changes in capital and surplus for that year;

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

(3) include:

(A) the report of an accountant;

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

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

(D) a statement of cash flows;

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

(F) any notes to financial statements;

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

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

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

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

(2) any notes required by the appropriate National

Association of Insurance Commissioners annual statement instructions [~~or by generally accepted accounting principles~~]; and

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

(c) The financial statements included in the audited financial report must be prepared in a form and use language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the commissioner. The financial statements must be comparative, including amounts on December 31 of the current year and amounts as of the immediately preceding December 31, except for the first year in which an insurer is required to file the report. [~~An insurer or health maintenance organization required under Section 401.004 to file an audited financial report that does not retain an independent certified public accountant to perform an annual audit for the previous year may not be required to include in the report audited statements of operations, cash flows, or changes in capital and surplus for the first year. The insurer or health maintenance organization must include those statements in the first-year report and label the statements as unaudited. The insurer or health maintenance organization must include in the first-year report all other reports described by Section 401.004.~~]

SECTION 10. Section 401.010, Insurance Code, is amended to read as follows:

Sec. 401.010. REQUIREMENTS FOR FINANCIAL STATEMENTS IN AUDITED FINANCIAL REPORT. (a) An accountant must audit the

financial reports provided by an insurer [~~or health maintenance organization~~] for purposes of an audit under this subchapter. The accountant who audits the reports must conduct the audit in accordance with generally accepted auditing standards or with standards adopted by the Public Company Accounting Oversight Board, as applicable, and must consider the standards specified in the Financial Condition Examiner's Handbook adopted by the National Association of Insurance Commissioners or other analogous nationally recognized standards adopted by commissioner rule.

(a-1) In accordance with "Consideration of Internal Control in a Financial Statement Audit," AU Section 319, Professional Standards of the American Institute of Certified Public Accountants, the accountant shall obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU Section 319, for those insurers required to file a management's report of internal control over financial reporting under Section 401.024, the accountant shall consider the most recently available report in planning and performing the audit of the statutory financial statements. In this subsection, "consider" has the meaning assigned by Statement on Auditing Standards No. 102, "Defining Professional Requirements in Statements on Auditing Standards," or a successor document.

(b) The financial statements included in the audited financial report must be prepared in a form and using language and groupings substantially the same as those of the relevant sections of the insurer's [~~or health maintenance organization's~~] annual statement filed with the commissioner. Beginning in the second

year in which an insurer [~~or health maintenance organization~~] is required to file an audited financial report, the financial statements must also be comparative, presenting the amounts as of December 31 of the reported year and the amounts as of December 31 of the preceding year.

SECTION 11. Section 401.011, Insurance Code, is amended by amending Subsections (a), (b), and (c) and adding Subsections (c-1), (e), (f), (g), (h), (i), (j), (k), (l), and (m) to read as follows:

(a) Except as provided by Subsections (c), [~~and~~] (d), (e), (f), (g), and (l), the commissioner shall accept an audited financial report from an independent certified public accountant or accounting firm that:

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

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

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

(c) A lead partner or other person responsible for rendering a report for an insurer may not act in that capacity [~~or health maintenance organization~~] for more than five [~~seven~~] consecutive years and may not, during the five-year [~~two-year~~] period after that fifth [~~seventh~~] year, render a report for the insurer [~~or health maintenance organization~~] or for a subsidiary or affiliate of the insurer [~~or health maintenance organization~~] that is engaged in the business of insurance. On application made at least 30 days before the end of the calendar year, the [~~The~~] commissioner may determine that the limitation provided by this subsection does not apply to an accountant for a particular insurer [~~or health maintenance organization~~] if the insurer [~~or health maintenance organization~~] demonstrates to the satisfaction of the commissioner that the limitation's application to the insurer [~~or health maintenance organization~~] would be unfair because of unusual circumstances. In making the determination, the commissioner may consider:

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

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

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

(c-1) On filing its annual statement, an insurer for which the commissioner has approved an exception under Subsection (c)

shall file the approval with the states in which it is doing or is authorized to do business and with the National Association of Insurance Commissioners. If a state other than this state accepts electronic filing with the National Association of Insurance Commissioners, the insurer shall file the approval in an electronic format acceptable to the National Association of Insurance Commissioners.

(e) In providing services, the accountant shall not:

(1) function in the role of management, audit the accountant's own work, or serve in an advocacy role for the insurer; or

(2) directly or indirectly enter into an agreement of indemnity or release from liability regarding the audit of the insurer.

(f) The commissioner may not recognize as qualified an accountant, or accept an annual audited financial report that was prepared wholly or partly by an accountant, who provides an insurer at the time of the audit:

(1) bookkeeping or other services related to the accounting records or financial statements of the insurer;

(2) services related to financial information systems design and implementation;

(3) appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

(4) actuarially oriented advisory services involving the determination of amounts recorded in the financial statements;

(5) internal audit outsourcing services;

(6) management or human resources services;

(7) broker or dealer, investment adviser, or investment banking services;

(8) legal services or other expert services unrelated to the audit; or

(9) any other service that the commissioner determines to be inappropriate.

(g) Notwithstanding Subsection (f)(4), an accountant may assist an insurer in understanding the methods, assumptions, and inputs used in the determination of amounts recorded in the financial statement if it is reasonable to believe that the advisory service will not be the subject of audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification on an insurer's reserves if:

(1) the accountant or the accountant's actuary has not performed management functions or made any management decisions;

(2) the insurer has competent personnel, or engages a third-party actuary, to estimate the reserves for which management takes responsibility; and

(3) the accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves.

(h) An insurer that has direct written and assumed premiums of less than $100 million in any calendar year may request an exemption from the requirements of Subsection (f) by filing with the commissioner a written statement explaining why the insurer

should be exempt. The commissioner may grant the exemption if the commissioner finds that compliance with Subsection (f) would impose an undue financial or organizational hardship on the insurer.

(i) An accountant who performs an audit may perform nonaudit services, including tax services, that are not described in Subsection (f) or that do not conflict with Subsection (e), only if the activity is approved in advance by the audit committee in accordance with Subsection (j).

(j) The audit committee must approve in advance all auditing services and nonaudit services that an accountant provides to the insurer. The prior approval requirement is waived with respect to nonaudit services if the insurer is a SOX-compliant entity or a direct or indirect wholly owned subsidiary of a SOX-compliant entity or:

(1) the aggregate amount of all nonaudit services provided to the insurer is not more than five percent of the total amount of fees paid by the insurer to its accountant during the fiscal year in which the nonaudit services are provided;

(2) the services were not recognized by the insurer at the time of the engagement to be nonaudit services; and

(3) the services are promptly brought to the attention of the audit committee and approved before the completion of the audit by the audit committee or by one or more members of the audit committee who are the members of the board of directors to whom the audit committee has delegated authority to grant approvals.

(k) The audit committee may delegate to one or more designated members of the audit committee the authority to grant

the prior approval required by Subsection (i). The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

(l) The commissioner may not recognize an accountant as qualified for a particular insurer if a member of the board, the president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for the insurer, was employed by the accountant and participated in the audit of that insurer during the one-year period preceding the date on which the most current statutory opinion is due. This subsection applies only to partners and senior managers involved in the audit. An insurer may apply to the commissioner for an exemption from the requirements of this subsection on the basis of unusual circumstances.

(m) The insurer shall file, with its annual statement filing, the approval of an exemption granted under Subsection (h) or (l) with the states in which it does or is authorized to do business and with the National Association of Insurance Commissioners. If a state, other than this state, in which the insurer does or is authorized to do business accepts electronic filing, the insurer shall file the approval in an electronic format acceptable to the National Association of Insurance Commissioners.

SECTION 12. Section 401.012, Insurance Code, is amended to read as follows:

Sec. 401.012. HEARING ON ACCOUNTANT QUALIFICATIONS; REPLACEMENT OF ACCOUNTANT. The commissioner may hold a hearing to determine if an accountant is qualified and independent. If, after

considering the evidence presented, the commissioner determines that an accountant is not qualified and independent for purposes of expressing an opinion on the financial statements in an audited financial report filed under this subchapter, the commissioner shall issue an order directing the insurer [~~or health maintenance organization~~] to replace the accountant with a qualified and independent accountant.

SECTION 13. Section 401.013(a), Insurance Code, is amended to read as follows:

(a) The audited financial report required under Section 401.004 must be accompanied by a letter provided by the accountant who performed the audit stating:

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

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

(3) that the accountant:

(A) is properly licensed by an appropriate state licensing authority, is a member in good standing of the American Institute of Certified Public Accountants, and is otherwise qualified under Section 401.011;

(B) is independent from the insurer [~~or health maintenance organization~~] and conforms to the standards of the profession contained in the American Institute of Certified Public Accountants Code of Professional Conduct, the statements of that

institute, and the rules of professional conduct adopted by the Texas State Board of Public Accountancy, or a similar code;

(C) understands that:

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

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

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

SECTION 14. Sections 401.014(a) and (b), Insurance Code, are amended to read as follows:

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

(b) The insurer [~~or health maintenance organization~~] must include with the registration a statement signed by the accountant:

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

(2) affirming that the accountant will express the

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

SECTION 15. Sections 401.015(a), (b), and (d), Insurance Code, are amended to read as follows:

(a) If an accountant who signed an audited financial report for an insurer [~~or health maintenance organization~~] resigns as accountant for the insurer [~~or health maintenance organization~~] or is dismissed by the insurer [~~or health maintenance organization~~] after the report is filed, the insurer [~~or health maintenance organization~~] shall notify the department not later than the fifth business day after the date of the resignation or dismissal.

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

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

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

(3) would have caused the accountant to note the

disagreement in connection with the audited financial report if the disagreement were not resolved to the satisfaction of the accountant.

(d) The insurer [~~or health maintenance organization~~] shall file with the statement required by Subsection (b) a letter signed by the accountant stating whether the accountant agrees with the insurer's [~~or health maintenance organization's~~] statement and, if not, the reasons why the accountant does not agree. If the accountant fails to provide the letter, the insurer [~~or health maintenance organization~~] shall file with the commissioner a copy of a written request to the accountant for the letter.

SECTION 16. Sections 401.016 and 401.017, Insurance Code, are amended to read as follows:

Sec. 401.016. AUDITED COMBINED OR CONSOLIDATED FINANCIAL STATEMENTS. (a) An insurer [~~or health maintenance organization~~] described by Section 401.001 [~~401.001(3) or (4)~~] that is required to file an audited financial report under this subchapter may apply in writing to the commissioner for approval to file audited combined or consolidated financial statements instead of separate audited financial reports if the insurer [~~or health maintenance organization~~]:

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

(2) cedes all of the insurer's [~~or health maintenance~~

~~organization's~~] direct and assumed business to the pool.

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

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

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

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

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

(4) explanations of consolidating and eliminating entries; and

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

(d) An insurer [~~or health maintenance organization~~] that does not receive approval from the commissioner to file audited combined or consolidated financial statements for the insurer [~~or health maintenance organization~~] and any of the insurer's [~~or~~

~~health maintenance organization's~~] subsidiaries or affiliates shall file a separate audited financial report.

Sec. 401.017. NOTICE OF ADVERSE FINANCIAL CONDITION OR MISSTATEMENT OF FINANCIAL CONDITION. (a) An insurer [~~or health maintenance organization~~] required to file an audited financial report under this subchapter shall require the [~~insurer's or health maintenance organization's~~] accountant to immediately notify the board of directors of the insurer [~~or health maintenance organization~~] or the insurer's [~~or health maintenance organization's~~] audit committee in writing of any determination by that accountant that:

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

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

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

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

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

(c) If the accountant does not receive the evidence required

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

(d) An accountant is not liable to an insurer [~~or health maintenance organization~~] or the insurer's [~~or health maintenance organization's~~] policyholders, shareholders, officers, employees, directors, creditors, or affiliates for a statement made under this section if the statement was made in good faith to comply with this section.

SECTION 17. Section 401.019, Insurance Code, is amended to read as follows:

Sec. 401.019. COMMUNICATION OF [~~REPORT ON SIGNIFICANT DEFICIENCIES IN~~] INTERNAL CONTROL MATTERS NOTED IN AUDIT. (a) In addition to the audited financial report required by this subchapter, each insurer [~~or health maintenance organization~~] shall provide to the commissioner a written communication prepared by an accountant in accordance [~~report of significant deficiencies required and prepared by an accountant in accordance~~] with the Professional Standards of the American Institute of Certified Public Accountants that describes any unremediated material weaknesses in its internal controls over financial reporting noted during the audit.

(b) The insurer [~~or health maintenance organization~~] shall annually file with the commissioner the communication [~~report~~]

required by this section not later than the 60th day after the date the audited financial report is filed. The communication must contain a description of any unremediated material weaknesses, as defined by Statement on Auditing Standards No. 112, "Communicating Internal Control Related Matters Identified in an Audit," or a successor document, as of the immediately preceding December 31, in the insurer's internal control over financial reporting that was noted by the accountant during the course of the audit of the financial statements. The communication must affirmatively state if unremediated material weaknesses were not noted by the accountant.

(c) The insurer [~~or health maintenance organization~~] shall also provide a description of remedial actions taken or proposed to be taken to correct unremediated material weaknesses [~~significant deficiencies~~], if the actions are not described in the accountant's communication [~~report~~].

[~~(c) The report must follow generally the form for communication of internal control structure matters noted in an audit described in Statement on Auditing Standard (SAS) No. 60, AU Section 325, Professional Standards of the American Institute of Certified Public Accountants.~~]

SECTION 18. Sections 401.020(a) and (b), Insurance Code, are amended to read as follows:

(a) In this section, "work papers" means the records kept by an accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached that are pertinent to the accountant's audit of an insurer's [~~or health~~

~~maintenance organization's~~] financial statements. The term includes work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules, and commentaries prepared or obtained by the accountant in the course of auditing the financial statements that support the accountant's opinion.

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

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

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

SECTION 19. The heading to Section 401.021, Insurance Code, is amended to read as follows:

Sec. 401.021. COMMISSIONER-ORDERED AUDIT [~~PENALTY FOR FAILURE TO COMPLY~~].

SECTION 20. Sections 401.021(a), (b), and (c), Insurance Code, are amended to read as follows:

(a) If an insurer [~~or health maintenance organization~~]

fails to comply with this subchapter, the commissioner shall order that the insurer's [~~or health maintenance organization's~~] annual audit be performed by a qualified independent certified public accountant.

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

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

SECTION 21. Subchapter A, Chapter 401, Insurance Code, is amended by adding Sections 401.022, 401.023, 401.024, and 401.025 to read as follows:

Sec. 401.022. REQUIREMENTS FOR AUDIT COMMITTEES. (a) This section does not apply to foreign or alien insurers authorized in this state or to an insurer that is a SOX-compliant entity or a direct or indirect wholly owned subsidiary of a SOX-compliant entity.

(b) An insurer to which this subchapter applies shall establish an audit committee conforming to the following criteria:

(1) an insurer with over $500 million in direct written and assumed premiums for the preceding calendar year shall establish an audit committee with an independent membership of at least 75 percent; and

(2) an insurer with $300 million to $500 million in

direct written and assumed premiums for the preceding calendar year shall establish an audit committee with an independent membership of at least 50 percent.

(c) The commissioner may require the insurer's board to enact improvements to the independence of the audit committee membership if the insurer:

(1) is in a risk-based capital action level event;

(2) meets one or more of the standards of an insurer considered to be in hazardous financial condition; or

(3) otherwise exhibits qualities of a troubled insurer.

(d) An insurer with direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of less than $500 million may apply to the commissioner for a waiver from the requirements of this section based on hardship. The insurer shall file, with its annual statement filing, the approval of a waiver under this subsection with the states in which it does or is authorized to do business and with the National Association of Insurance Commissioners. If a state other than this state accepts electronic filing, the insurer shall file the approval in an electronic format acceptable to the National Association of Insurance Commissioners.

(e) In this section, premiums that are assumed from affiliates in the same group of insurers are excluded in determining whether an insurer has less than $500 million in direct written premiums and assumed premiums.

(f) The audit committee is directly responsible for the appointment, compensation, and oversight of the work of any accountant, including the resolution of disagreements between the management of the insurer and the accountant regarding financial reporting, for the purpose of preparing or issuing the audited financial report or related work under this subchapter. Each accountant shall report directly to the audit committee.

(g) Each member of the audit committee must be a member of the board of directors of the insurer or a member of the board of directors of an entity elected under Subsection (j) and described under Section 401.001(2-a).

(h) To be independent for purposes of this section, a member of the audit committee may not, other than in the person's capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory, or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary of the entity. To the extent of any conflict with another statute requiring an otherwise nonindependent board member to participate in the audit committee, the other statute prevails and controls, and the member may participate in the audit committee unless the member is an officer or employee of the insurer or an affiliate of the insurer.

(i) If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, the member may remain an audit committee member of the responsible entity, if the responsible entity gives notice to the commissioner, until the earlier of:

(1) the next annual meeting of the responsible entity; or

(2) the first anniversary of the occurrence of the event that caused the member to be no longer independent.

(j) To exercise the election of the controlling person to designate the audit committee under this subchapter, the ultimate controlling person must provide written notice of the affected insurers to the commissioner. Notice must be made before the issuance of the statutory audit report and must include a description of the basis for the election. The election may be changed through a notice to the commissioner by the insurer, which must include a description of the basis for the change. An election remains in effect until changed by later election.

(k) The audit committee shall require the accountant who performs an audit required by this subchapter to report to the audit committee in accordance with the requirements of Statement on Auditing Standards No. 114, "The Auditor's Communication With Those Charged With Governance," or a successor document, including:

(1) all significant accounting policies and material permitted practices;

(2) all material alternative treatments of financial information in statutory accounting principles that have been discussed with the insurer's management officials;

(3) ramifications of the use of the alternative disclosures and treatments, if applicable, and the treatment preferred by the accountant; and

(4) other material written communications between the

accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(l) If an insurer is a member of an insurance holding company system, the report required by Subsection (k) may be provided to the audit committee on an aggregate basis for insurers in the holding company system if any substantial differences among insurers in the system are identified to the audit committee.

Sec. 401.023. PROHIBITED CONDUCT IN CONNECTION WITH PREPARATION OF REQUIRED REPORTS AND DOCUMENTS. (a) A director or officer of an insurer may not, directly or indirectly:

(1) make or cause to be made a materially false or misleading statement to an accountant in connection with an audit, review, or communication required by this subchapter; or

(2) omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review, or communication required under this subchapter.

(b) An officer or director of an insurer, or another person acting under the direction of an officer or director of an insurer, may not directly or indirectly coerce, manipulate, mislead, or fraudulently influence an accountant performing an audit under this subchapter if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

(c) For purposes of Subsection (b), actions that could result in rendering the insurer's financial statements materially

misleading include actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead, or fraudulently influence an accountant:

(1) to issue or reissue a report on an insurer's financial statements that is not warranted and would result in material violations of statutory accounting principles prescribed by the commissioner, generally accepted auditing standards, or other professional or regulatory standards;

(2) not to perform an audit, review, or other procedure required by generally accepted auditing standards or other professional standards;

(3) not to withdraw an issued report; or

(4) not to communicate matters to an insurer's audit committee.

Sec. 401.024. MANAGEMENT'S REPORT OF INTERNAL CONTROL OVER FINANCIAL REPORTING. (a) Each insurer required to file an audited financial report under this subchapter that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of $500 million or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting. The report must be filed with the commissioner with the communication described by Section 401.019. The report of internal control over financial reporting shall be as of the immediately preceding December 31.

(b) Notwithstanding the premium threshold under Subsection (a), the commissioner may require an insurer to file the

management's report of internal control over financial reporting if the insurer is in any risk-based capital level event or meets one or more of the standards of an insurer considered to be in hazardous financial condition as described by Chapter 404.

(c) An insurer or a group of insurers may file the insurer's or the insurer's parent's Section 404 report and an addendum if the insurer or group of insurers is:

(1) directly subject to Section 404;

(2) part of a holding company system whose parent is directly subject to Section 404;

(3) not directly subject to Section 404 but is a SOX-compliant entity; or

(4) a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX-compliant entity.

(d) A Section 404 report described by Subsection (c) must include those internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements, including those items listed in Sections 401.009(a)(3)(B)-(H) and (b). The addendum must be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements, including those items listed in Sections 401.009(a)(3)(B)-(H) and (b), excluded from the Section 404 report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or

group of insurers' audited statutory financial statements and those internal controls are not included in the Section 404 report, the insurer or group of insurers may either file:

(1) a report under this section; or

(2) the Section 404 report and a report under this section for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 report.

(e) The insurer's management report of internal control over financial reporting must include:

(1) a statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

(2) a statement that management has established internal control over financial reporting and an opinion concerning whether, to the best of management's knowledge and belief, after diligent inquiry, its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(3) a statement that briefly describes the approach or processes by which management evaluates the effectiveness of its internal control over financial reporting;

(4) a statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(5) disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of the immediately preceding December 31;

(6) a statement regarding the inherent limitations of internal control systems; and

(7) signatures of the chief executive officer and the chief financial officer or an equivalent position or title.

(f) For purposes of Subsection (e)(5), an insurer's management may not conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weaknesses in its internal control over financial reporting.

(g) Management shall document, and make available on financial condition examination, the basis of the opinions required by Subsection (e). Management may base opinions, in part, on its review, monitoring, and testing of internal controls undertaken in the normal course of its activities.

(h) Management has discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to form its opinion in a cost-effective manner and may include an assembly of or reference to existing documentation.

(i) The department shall maintain the confidentiality of the management's report of internal control over financial

reporting required by this section and any supporting documentation provided in the course of a financial condition examination.

Sec. 401.025. TRANSITION DATES. (a) An insurer or group of insurers whose audit committee as of January 1, 2010, is not subject to the independence requirements of Section 401.022 because the total written and assumed premium is below the threshold under that section, and that later becomes subject to one of the independence requirements because of changes in the amount of written and assumed premium, has one year following the year in which the written and assumed premium exceeds the threshold amount to comply with the independence requirements. An insurer that becomes subject to one of the independence requirements as a result of a business combination must comply with the independence requirements not later than the first anniversary of the date of the acquisition or combination.

(b) An insurer or group of insurers that is not required by Section 401.024 to file a report beginning with the reporting period ending December 31, 2010, because the total written premium is below the threshold amount, and that later becomes subject to the reporting requirements, has two years after the year in which the written premium exceeds the threshold amount to file a report. An insurer acquired in a business combination must comply with the reporting requirements not later than the second anniversary of the date of the acquisition or combination.

SECTION 22. Section 401.001(3), Insurance Code, is repealed.

SECTION 23. (a) Section 401.011(c), Insurance Code, as

amended by this Act, takes effect January 1, 2010.

(b) Section 401.022, Insurance Code, as added by this Act, takes effect January 1, 2010.

(c) Except as provided by Subsections (a) and (b) of this section, Chapter 401, Insurance Code, as amended by this Act, takes effect beginning with the reporting period ending December 31, 2010.

SECTION 24. Except as otherwise provided by this Act, this Act takes effect September 1, 2009.

ADOPTED

MAY 2 6 2009

Secretary of the Senate

FLOOR AMENDMENT NO. 1 BY: [signature]

Amend C.S.H.B. No. 2752 (senate committee report) as follows:

(1) In SECTION 7 of the bill, in amended Section 401.007, Insurance Code (page 3, line 52), amend the introductory language by striking "Subsection (c)" and substituting "Subsection (d)".

(2) In SECTION 7 of the bill, in proposed Section 401.007(c), Insurance Code (page 4, line 1), strike "(c)" and substitute "(d)".

Floor Amendment No. 2 ADOPTED MAY 26 2009 By: Averitt

Secretary of the Senate

Amend H.B. 2752 (Senate Committee Printing) with the following appropriately numbered new sections into the bill and renumbering remaining sections accordingly:

SECTION __. Title 8, Insurance Code, is amended by adding Subchapter K to read as follows:

SUBCHAPTER K. NONINSURANCE HEALTH COVERAGES

CHAPTER 1680. HEALTH CARE SHARING ORGANIZATIONS.

Sec. 1680.001. SHORT TITLE. This subchapter may be cited as the Health Care Sharing Organizations Freedom to Share Act.

Sec. 1680.002. TREATMENT AS HEALTH CARE SHARING ORGANIZATION. An organization that administers a health care sharing arrangement among individuals of the same religion based on the individuals' sincerely held religious belief qualifies for treatment as a health care sharing organization under this subchapter if:

(1) the organization is a bona fide religious organization, the primary purpose and function of which is religious, that is entitled to tax exempt status under Section 501(c)(3) Internal Revenue Code of 1986; and

(2) in operating the health care sharing arrangement, the organization:

(A) does not bear risk but facilitates payments to participants who have financial or medical-related needs from participants with the present ability to assist those with financial or medical-related needs, all in accordance with the organization's criteria;

(B) notifies a participant of sharing amounts;

(C) provides a written monthly statement to all participants listing the total dollar amount of qualified needs

submitted to the organization as well as the total dollar amount actually assigned to participants for sharing;

(D) maintains a complaint log to track complaints by participants and retains information regarding each complaint until the third anniversary of the date the complaint is made;

(E) provides, on each application for participation in a health care sharing arrangement distributed directly or on behalf of the organization, a notice that complies with Section 1680.003; and

(F) requires each adult member to sign on behalf of the participant or, in the case of a minor or dependent child, on behalf of the minor or dependent child an acknowledgment that the member has read and understands the notice described by Section 1680.003 and retains the signed acknowledgment until the second anniversary of the last date of the member's participation in the health care sharing arrangement.

Sec. 1680.003. NOTICE. The notice described by Section 1680.002(2)(E) must be printed in no smaller than 12-point font and must read substantially as follows:

"This health care sharing organization is not offering an insurance product, and the health care sharing arrangement is not being offered by or through an insurance company. Participation in the health care sharing organization may limit your future options to purchase insurance if your health condition changes. Participation in the health care sharing organization does not provide creditable coverage, and, therefore, future insurance coverage you obtain may limit or exclude benefits for your preexisting conditions.

"This health care sharing organization is also not offering a discount health care program.

"Whether anyone chooses to assist you with your medical bills

is voluntary, as no other participant may be compelled to share payment of your medical bills.

"This health care sharing arrangement is not insurance or a substitute for insurance. Whether you receive any payments for medical expenses and whether this health care sharing organization or arrangement continues to operate, you remain, to the extent allowable under law, personally and fully responsible for the payment of your own medical bills. Complaints concerning this health care sharing organization may be reported to the Texas Office of the Attorney General."

Sec. 1680.004. AUTHORITY; LIMITATIONS. (a) A health care sharing organization may:

(1) establish additional qualifications for participation in the health care sharing arrangement;

(2) limit the financial or medical-related needs that may be eligible for payment among the participants;

(3) cancel a participant's participation in the health care sharing arrangement if the participant fails to make a specific payment to another participant before the 60th day after the date the payment is due; and

(4) issue participant membership cards.

(b) If a health care sharing organization issues participant membership cards, the cards must include the statement "Not Insurance."

(c) A health care sharing organization may not require that participants speak English.

Sec. 1680.005. CONSTRUCTION WITH OTHER LAW. (a) Chapter 76, Health and Safety Code, does not apply to a health care sharing organization.

(b) Notwithstanding any other provision of this code, a health care sharing organization is exempt from the operation of

the insurance laws of this state and is not subject to the commissioner's oversight.

Sec. 1680.006. ENFORCEMENT AND ADMINISTRATION BY ATTORNEY GENERAL. (a) Notwithstanding any other law, the office of the attorney general has jurisdiction over health care sharing organization to ensure compliance with this subchapter and for:

(1) the prevention and prosecution of deceptive trade practices and fraud; and

(2) consumer protection.

(b) A health care sharing organization shall provide to the attorney general, on the request of the attorney general, any audit conducted of the organization and any original or amended annual filing made by the organization with the United States Internal Revenue Service.

(c) The attorney general may adopt rules to implement this subchapter.

Sec. 1680.007. CONSUMER PROTECTION. A participant in a health care sharing organization is a consumer for purposes of Chapter 17.46(a), Business & Commerce Code, and is entitled to the protections of the office of the attorney general as provided by that section.

Sec. 1680.008. NO ASSUMPTION OF RISK. (a) Participants in a health care sharing arrangement and the health care sharing organization:

(1) do not assume any risk or make any promise to pay the financial or medical-related needs of other participants; and

(2) are not risk-bearing entities.

(b) None of the activities in this subchapter give rise to an assumption of risk or promise to pay by either the participants or the health care sharing organization.

Sec. 1680.009. COLLATERAL SHARING ACTIVITIES. A health care

sharing organization may:

(1) arrange for participants to share bills when a participant experiences disability; and

(2) provide health counseling, education, and resources to participants in the health care sharing arrangement.

Sec. 1680.010. CONTRACTUAL ARRANGEMENTS WITH OTHER ENTITIES. (a) A health care sharing organization may contract with an administrator as defined by Chapter 4151, Insurance Code, or a preferred provider organization or similar entity to facilitate the operation of the organization.

(b) A health care sharing organization that enters into a contractual arrangement under Subsection (a) remains exempt from the operation of the insurance laws of this state as described by Section 1680.005.

Sec. 1680.011. ANNUAL REPORT. Not later than January 1 of each year, the organization shall file an annual report regarding its operations in this state during that fiscal year with the governor, attorney general, lieutenant governor, and speaker of the house of representatives.

SECTION __. Subsection (a), Section 101.055, Insurance Code, is amended to read as follows:

(a) Section 101.051(b)(7) does not apply to:

(1) a program otherwise authorized by law that is established:

(A) by a political subdivision of this state;

(B) by a state agency; or

(C) under Chapter 791, Government Code; [~~or~~]

(2) a multiple employer welfare arrangement that is fully insured as defined by 29 U.S.C. Section 1144(b)(6); or

(3) a health care sharing organization operated under Chapter 1680.

SECTION __. Section 76.002, Health and Safety Code, is amended to read as follows:

Sec. 76.002. CONSTRUCTION WITH [~~APPLICABILITY OF~~] OTHER LAW.

(a) In addition to the requirements of this chapter, a program operator or marketer is subject to the applicable consumer protection laws under Chapter 17, Business & Commerce Code.

(b) This chapter does not apply to a health care sharing organization operated under Chapter 1680, Insurance Code.

ADOPTED

MAY 2 6 2009

Secretary of the Senate

FLOOR AMENDMENT NO. 3 BY: [signature]

Amend H.B. No. 2752 by adding the following appropriately numbered SECTIONS to the bill and renumbering subsequent SECTIONS of the bill accordingly:

ARTICLE 1. RESCISSION OF HEALTH BENEFIT PLAN

SECTION 1.001. Subchapter B, Chapter 541, Insurance Code, is amended by adding Section 541.062 to read as follows:

Sec. 541.062. BAD FAITH RESCISSION. (a) For purposes of this section, "rescission" has the meaning assigned by Section 1202.101.

(b) It is an unfair method of competition or an unfair or deceptive act or practice for a health benefit plan issuer to:

(1) set rescission goals, quotas, or targets;

(2) pay compensation of any kind, including a bonus or award, that varies according to the number of rescissions;

(3) set, as a condition of employment, a number or volume of rescissions to be achieved; or

(4) set a performance standard, for employees or by contract with another entity, based on the number or volume of rescissions.

SECTION 1.002. Chapter 1202, Insurance Code, is amended by

adding Subchapter C to read as follows:

SUBCHAPTER C. INDEPENDENT REVIEW OF CERTAIN RESCISSION DECISIONS

Sec. 1202.101. DEFINITIONS. In this subchapter:

(1) "Affected individual" means an individual who is otherwise entitled to benefits under a health benefit plan that is subject to a decision to rescind.

(2) "Independent review organization" means an organization certified under Chapter 4202.

(3) "Rescission" means the termination of an insurance agreement, contract, evidence of coverage, insurance policy, or other similar coverage document in which the health benefit plan issuer refunds premium payments or, if applicable, demands the restitution of any benefit paid under the plan, on the ground that the issuer is entitled to restoration of the issuer's precontractual position.

(4) "Screening criteria" means the elements or factors used in a determination of whether to subject an issued health benefit plan to additional review for possible rescission, including any applicable dollar amount or number of claims submitted.

Sec. 1202.102. APPLICABILITY. (a) This subchapter applies only to a health benefit plan, including a small or large 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.

(b) 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 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;

(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 described by Subsection (a);

(6) a Medicaid managed care plan offered under

Chapter 533, Government Code;

(7) any policy or contract of insurance with a state agency, department, or board providing health services to eligible individuals under Chapter 32, Human Resources Code; or

(8) a child health plan offered under Chapter 62, Health and Safety Code, or a health benefits plan offered under Chapter 63, Health and Safety Code.

Sec. 1202.103. RESCISSION FOR MISREPRESENTATION OR PREEXISTING CONDITION. Notwithstanding any other law, a health benefit plan issuer may not rescind a health benefit plan on the basis of a misrepresentation or a preexisting condition except as provided by this subchapter.

Sec. 1202.104. NOTICE OF INTENT TO RESCIND. (a) A health benefit plan issuer may not rescind a health benefit plan on the basis of a misrepresentation or a preexisting condition without first notifying an affected individual in writing of the issuer's intent to rescind the health benefit plan and the individual's entitlement to an independent review.

(b) The notice required under Subsection (a) must include, as applicable:

(1) the principal reasons for the decision to rescind the health benefit plan;

(2) the clinical basis for a determination that a preexisting condition exists;

(3) a description of any general screening criteria used to evaluate issued health benefit plans and determine eligibility for a decision to rescind;

(4) a statement that the individual is entitled to appeal a rescission decision to an independent review organization;

(5) a statement that the individual has at least 45 days in which to appeal the rescission decision to an independent review organization, and a description of the consequences of failure to appeal within that time limit;

(6) a statement that there is no cost to the individual to appeal the rescission decision to an independent review organization; and

(7) a description of the independent review process under Chapters 4201 and 4202.

Sec. 1202.105. INDEPENDENT REVIEW PROCESS; PAYMENT OF CLAIMS. (a) An affected individual may appeal a health benefit plan issuer's rescission decision to an independent review organization not later than the 45th day after the date the individual receives notice under Section 1202.104.

(b) A health benefit plan issuer shall comply with all requests for information made by the independent review organization and with the independent review organization's determination regarding the appropriateness of the issuer's

decision to rescind.

(c) A health benefit plan issuer shall pay all otherwise valid medical claims under an individual's plan until the later of:

(1) the date on which an independent review organization determines that the decision to rescind is appropriate; or

(2) the time to appeal to an independent review organization has expired without an affected individual initiating an appeal.

Sec. 1202.106. RESCISSION AUTHORIZED; RECOVERY OF CLAIMS PAID. (a) A health benefit plan issuer may rescind a health benefit plan covering an affected individual on the later of:

(1) the date an independent review organization determines that rescission is appropriate; or

(2) the 45th day after the date an affected individual receives notice under Section 1202.104, if the individual has not initiated an appeal.

(b) An issuer that rescinds a health benefit plan under this section may seek to recover from an affected individual amounts paid for the individual's medical claims under the rescinded health benefit plan.

(c) An issuer that rescinds a health benefit plan under this section may not offset against or recoup or recover from a

physician or health care provider amounts paid for medical claims under a rescinded health benefit plan. This subsection may not be waived, voided, or modified by contract.

Sec. 1202.107. RESCISSION RELATED TO PREEXISTING CONDITION; STANDARDS. (a) For purposes of this subchapter, a rescission for a preexisting condition is appropriate if, within the 18-month period immediately preceding the date on which an application for coverage under a health benefit plan is made, an affected individual received or was advised by a physician or health care provider to seek medical advice, diagnosis, care, or treatment for a physical or mental condition, regardless of the cause, and the individual's failure to disclose the condition:

(1) affects the risks assumed under the health benefit plan; and

(2) is undertaken with the intent to deceive the health benefit plan issuer.

(b) A health benefit plan issuer may not rescind a health benefit plan based on a preexisting condition of a newborn delivered after the application for coverage is made or as may otherwise be prohibited by law.

Sec. 1202.108. RESCISSION FOR MISREPRESENTATION; STANDARDS. For purposes of this subchapter, a rescission for a misrepresentation not related to a preexisting condition is inappropriate unless the misrepresentation:

(1) is of a material fact;

(2) affects the risks assumed under the health benefit plan; and

(3) is made with the intent to deceive the health benefit plan issuer.

Sec. 1202.109. REMEDIES NOT EXCLUSIVE. The remedies provided by this subchapter are not exclusive and are in addition to any other remedy or procedure provided by law or at common law.

Sec. 1202.110. RULES. The commissioner shall adopt rules necessary to implement and administer this subchapter.

Sec. 1202.111. SANCTIONS AND PENALTIES. A health benefit plan issuer that violates this subchapter commits an unfair practice in violation of Chapter 541 and is subject to sanctions and penalties under Chapter 82.

Sec. 1202.112. CONFIDENTIALITY. (a) A record, report, or other information received or maintained by a health benefit plan issuer, including any material received or developed during a review of a rescission decision under this subchapter, is confidential.

(b) A health benefit plan issuer may not disclose the identity of an individual or a decision to rescind an individual's health benefit plan unless:

(1) an independent review organization determines the

decision to rescind is appropriate; or

(2) the time to appeal has expired without an affected individual initiating an appeal.

SECTION 1.003. Subtitle G, Title 8, Insurance Code, is amended by adding Chapter 1515 to read as follows:

CHAPTER 1515. INFORMATION CONCERNING RESCINDED HEALTH BENEFIT PLANS

Sec. 1515.001. DEFINITION. In this chapter, "coverage document" means a policy or certificate evidencing the coverage of an individual or group under a health benefit plan described by Section 1515.002.

Sec. 1515.002. APPLICABILITY. (a) This chapter applies only to a health benefit plan, including a small or large 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.

(b) This chapter does not apply to:

(1) a health benefit plan that provides coverage only:

(A) for a specified disease or diseases or under an individual limited benefit policy;

(B) for accidental death or dismemberment;

(C) as a supplement to a liability insurance policy; or

(D) for dental or vision care;

(2) disability income insurance coverage or a combination of accident only and disability income insurance coverage;

(3) credit insurance coverage;

(4) a hospital confinement indemnity policy;

(5) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(6) a workers' compensation insurance policy;

(7) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(8) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefits so comprehensive that the policy is a health benefit plan described by Subsection (a) and is not exempted from the application of this chapter.

Sec. 1515.003. REPORT. (a) Each health benefit plan issuer authorized to issue coverage documents in this state shall submit a report to the department containing the rescission rates of coverage documents issued by the issuer.

(b) In addition to the rescission rates described by Subsection (a), the report must contain:

(1) the number of individuals whose coverage document was rescinded by the health benefit plan issuer during the reporting period for each type of health benefit plan to which this chapter applies;

(2) the total number of enrollees that were covered

by rescinded coverage documents before those documents were rescinded; and

(3) the reasons for rescission of rescinded coverage documents for each type of health benefit plan to which this chapter applies.

(c) The commissioner shall adopt rules necessary to implement this section, including rules concerning any applicable reporting period and the form of the report required under Subsection (a).

Sec. 1515.004. INTERNET POSTING; CONSUMER HOTLINE. (a) The department shall post on the department's Internet website:

(1) the information contained in the reports received under Section 1515.003 that is not confidential or proprietary; and

(2) a form through which consumers may report rescission of a health benefit plan and complaints or suspected violations of the law governing the rescission of health benefit plans.

(b) For purposes of Subsection (a), aggregated information regarding a health benefit plan issuer's rescission rates is not confidential or proprietary.

(c) The department shall operate a toll-free telephone hotline to:

(1) respond to consumer inquiries concerning the rescission of health benefit plans; and

(2) provide information to consumers concerning the rescission of health benefit plans and technical assistance with the completion of the form described by Subsection (a)(2).

SECTION 1.004. Section 4202.002, Insurance Code, is amended to read as follows:

Sec. 4202.002. ADOPTION OF STANDARDS FOR INDEPENDENT REVIEW ORGANIZATIONS. (a) The commissioner shall adopt standards and rules for:

(1) the certification, selection, and operation of independent review organizations to perform independent review described by Subchapter C, Chapter 1202, or Subchapter I, Chapter 4201; and

(2) the suspension and revocation of the certification.

(b) The standards adopted under this section must ensure:

(1) the timely response of an independent review organization selected under this chapter;

(2) the confidentiality of medical records transmitted to an independent review organization for use in conducting an independent review;

(3) the qualifications and independence of each physician or other health care provider making a review

determination for an independent review organization;

(4) the fairness of the procedures used by an independent review organization in making review determinations; [~~and~~]

(5) the timely notice to an enrollee of the results of an independent review, including the clinical basis for the review determination; and

(6) that review of a rescission decision based on a preexisting condition be conducted under the direction of a physician.

SECTION 1.005. Sections 4202.003, 4202.004, and 4202.006, Insurance Code, are amended to read as follows:

Sec. 4202.003. REQUIREMENTS REGARDING TIMELINESS OF DETERMINATION. The standards adopted under Section 4202.002 must require each independent review organization to make the organization's determination:

(1) for a life-threatening condition as defined by Section 4201.002, not later than the earlier of:

(A) the fifth day after the date the organization receives the information necessary to make the determination; or

(B) the eighth day after the date the organization receives the request that the determination be made; and

(2) for a condition other than a life-threatening condition or of the appropriateness of a rescission under Subchapter C, Chapter 1202, not later than the earlier of:

(A) the 15th day after the date the organization receives the information necessary to make the determination; or

(B) the 20th day after the date the organization receives the request that the determination be made.

Sec. 4202.004. CERTIFICATION. To be certified as an independent review organization under this chapter, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(1) for an applicant that is publicly held, the name of each shareholder or owner of more than five percent of any of the applicant's stock or options;

(2) the name of any holder of the applicant's bonds or notes that exceed $100,000;

(3) the name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the control or affiliation;

(4) the name and a biographical sketch of each director, officer, and executive of the applicant and of any entity listed under Subdivision (3) and a description of any

relationship the named individual has with:

(A) a health benefit plan;

(B) a health maintenance organization;

(C) an insurer;

(D) a utilization review agent;

(E) a nonprofit health corporation;

(F) a payor;

(G) a health care provider; or

(H) a group representing any of the entities described by Paragraphs (A) through (G);

(5) the percentage of the applicant's revenues that are anticipated to be derived from independent reviews conducted under Subchapter I, Chapter 4201;

(6) a description of the areas of expertise of the physicians or other health care providers making review determinations for the applicant; and

(7) the procedures to be used by the applicant in making independent review determinations under Subchapter C, Chapter 1202, or Subchapter I, Chapter 4201.

Sec. 4202.006. PAYORS FEES. (a) The commissioner shall charge payors fees in accordance with this chapter as necessary to fund the operations of independent review organizations.

(b) A health benefit plan issuer shall pay for an independent review of a rescission decision under Subchapter C,

Chapter 1202.

SECTION 1.006. Section 4202.009, Insurance Code, is amended to read as follows:

Sec. 4202.009. CONFIDENTIAL INFORMATION. (a) Information that reveals the identity of a physician or other individual health care provider who makes a review determination for an independent review organization is confidential.

(b) A record, report, or other information received or maintained by an independent review organization, including any material received or developed during a review of a rescission decision under Subchapter C, Chapter 1202, is confidential.

(c) An independent review organization may not disclose the identity of an affected individual or an issuer's decision to rescind a health benefit plan under Subchapter C, Chapter 1202, unless:

(1) an independent review organization determines the decision to rescind is appropriate; or

(2) the time to appeal a rescission under that subchapter has expired without an affected individual initiating an appeal.

SECTION 1.007. Subsection (a), Section 4202.010, Insurance Code, is amended to read as follows:

(a) An independent review organization conducting an independent review under Subchapter C, Chapter 1202, or

Subchapter I, Chapter 4201, is not liable for damages arising from the review determination made by the organization.

SECTION 1.008. The commissioner of insurance shall adopt rules under Subsection (c), Section 1515.003, Insurance Code, as added by this article, not later than January 1, 2010. The rules must require health benefit plan issuers to submit the first report under Section 1515.003, Insurance Code, as added by this article, not later than April 1, 2010.

SECTION 1.009. The change in law made by this article applies only to an insurance policy that is delivered, issued for delivery, or renewed on or after the effective date of this Act. An insurance policy that is delivered, issued for delivery, or renewed before the effective date of this Act is governed by the law as it existed before the effective date of this Act, and that law is continued in effect for that purpose.

ARTICLE 2. MEDICAL LOSS RATIO

SECTION 2.001. Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1223 to read as follows:

CHAPTER 1223. MEDICAL LOSS RATIO

Sec. 1223.001. DEFINITIONS. In this chapter:

(1) "Enrollee" has the meaning assigned by Section 1457.001.

(2) "Evidence of coverage" has the meaning assigned by Section 843.002.

(3) "Market segment" means, as applicable, one of the following categories of health benefit plans issued by a health benefit plan issuer:

(A) individual evidences of coverage issued by a health maintenance organization;

(B) individual preferred provider benefit plans;

(C) evidences of coverage issued by a health maintenance organization to small employers as defined by Section 1501.002;

(D) preferred provider benefit plans issued to small employers as defined by Section 1501.002;

(E) evidences of coverage issued by a health maintenance organization to large employers as defined by Section 1501.002; and

(F) preferred provider benefit plans issued to large employers as defined by Section 1501.002.

(4) "Medical loss ratio" means direct losses incurred for all preferred provider benefit plans issued by an insurer divided by direct premiums earned for all preferred provider benefit plans issued by that insurer. This amount may not include home office and overhead costs, advertising costs, network development costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

Sec. 1223.002. APPLICABILITY OF CHAPTER. (a) This chapter applies to 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 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) an 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.

(b) Notwithstanding any other law, this chapter applies to a health benefit plan issuer with respect to a standard health

benefit plan provided under Chapter 1507.

(c) Notwithstanding Section 1501.251 or any other law, this chapter applies to a health benefit plan issuer with respect to coverage under a small employer health benefit plan subject to Chapter 1501.

Sec. 1223.003. EXCEPTIONS. This chapter does not apply with respect to:

(1) a plan that provides coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses; or

(F) 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 Medicaid managed care program operated under Chapter 533, Government Code;

(4) Medicaid programs operated under Chapter 32, Human Resources Code;

(5) the state child health plan operated under Chapter 62 or 63, Health and Safety Code;

(6) a workers' compensation insurance policy; or

(7) medical payment insurance coverage provided under a motor vehicle insurance policy.

Sec. 1223.004. NOTIFICATION OF MEDICAL LOSS RATIO, MEDICAL COST MANAGEMENT, AND HEALTH EDUCATION COST. (a) A health benefit plan issuer shall report its medical loss ratio for each market segment, as applicable, with the annual report required under Section 843.155 or 1301.009. Beginning in the fourth year during which a health benefit plan issuer is required to make a report under this section, the issuer may report the medical loss ratio as a three-year rolling average.

(b) Each health benefit plan issuer shall include in the report described by Subsection (a), for each market segment, a separate report of costs attributed to medical cost management and health education. The commissioner by rule shall prescribe the reporting requirements for the costs, which may include:

(1) case management activities;

(2) utilization review;

(3) detection and prevention of payment of fraudulent requests for reimbursement;

(4) network access fees to preferred provider organizations and other network-based health benefit plans,

including prescription drug networks, and allocated internal salaries and related costs associated with network development or provider contracting;

(5) consumer education solely relating to health improvement and relying on the direct involvement of health personnel, including smoking cessation and disease management programs and other programs that involve medical education;

(6) telephone hotlines, including nurse hotlines, that provide enrollees health information and advice regarding medical care; and

(7) expenses for internal and external appeals processes.

(c) The department shall post on the department's Internet website or another website maintained by the department for the benefit of consumers or enrollees:

(1) the information received under Subsections (a) and (b);

(2) an explanation of the meaning of the term "medical loss ratio," how the medical loss ratio is calculated, and how the ratio may affect consumers or enrollees; and

(3) an explanation of the types of activities and services classified as medical cost management and health education, how the costs for these activities and services are calculated, what those costs, when aggregated with a medical

loss ratio, mean, and how the costs might affect consumers or enrollees.

(d) A health benefit plan issuer shall provide each enrollee or the plan sponsor, as applicable, with the Internet website address at which the enrollee or plan sponsor may access the information described by Subsection (c). A health benefit plan issuer must provide the information required under this subsection:

(1) to an enrollee, at the time of the initial enrollment of the enrollee in a health benefit plan issued by the health benefit plan issuer; and

(2) at the time of renewal of a health benefit plan to:

(A) each enrollee, if the health benefit plan is an individual health benefit plan; or

(B) the plan sponsor, if the health benefit plan is a group health benefit plan.

(e) The commissioner shall adopt rules necessary to implement this section.

SECTION 2.002. The change in law made by this article applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2011. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2011, is covered by the law in effect at the

time the health benefit plan was delivered, issued for delivery, or renewed, and that law is continued in effect for that purpose.

ARTICLE 3. PREMIUM RATE INCREASES FOR SMALL EMPLOYER HEALTH BENEFIT PLANS

SECTION 3.001. Subchapter D, Chapter 501, Insurance Code, is amended by amending Sections 501.151 and 501.153 and adding Section 501.160 to read as follows:

Sec. 501.151. POWERS AND DUTIES OF OFFICE. (a) 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; and

(3) shall accept from a small employer, an eligible employee, or an eligible employee's dependent and, if appropriate, refer to the commissioner, a complaint described by Section 501.160.

(b) The decision to refer a complaint to the commissioner under Subsection (a) is at the public counsel's sole discretion.

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; and

(5) may appear before the commissioner on behalf of a small employer, eligible employee, or eligible employee's dependent in a complaint the office refers to the commissioner under Section 501.160.

Sec. 501.160. COMPLAINT RESOLUTION FOR CERTAIN PREMIUM RATE INCREASES. (a) A small employer, an eligible employee, or an eligible employee's dependent may file a complaint with the office alleging that a rate is excessive for the risks to which the rate applies, if the percentage increase in the premium rate charged to a small employer under Subchapter E, Chapter 1501,

for a new rating period exceeds 20 percent.

(b) The office shall refer a complaint received under Subsection (a) to the commissioner if the office determines that the complaint substantially attests to a rate charged that is excessive for the risks to which the rate applies. A rate may not be considered excessive for the risks to which the rate applies solely because the percentage increase in the premium rate charged exceeds the percentage described by Subsection (a).

(c) With respect to a complaint filed under Subsection (a), the office may issue a subpoena applicable throughout the state that requires the production of records.

(d) On application of the office in the case of disobedience of a subpoena, a district court may issue an order requiring any individual or person, including a small employer health benefit plan issuer described by Section 1501.002, that is subpoenaed to obey the subpoena and produce records, if the individual or person has refused to do so. An application under this subsection must be made in a district court in Travis County.

SECTION 3.002. Section 1501.205, Insurance Code, is amended by adding Subsection (d) to read as follows:

(d) On the request of a small employer, a small employer health benefit plan issuer shall disclose the percentage change in the risk load assessed to a small employer group to the

group, along with the percentage change attributable exclusively to any change in case characteristics.

SECTION 3.003. Subchapter E, Chapter 1501, Insurance Code, is amended by adding Section 1501.2131 and amending Section 1501.214 to read as follows:

Sec. 1501.2131. COMPLAINT FACILITATION FOR PREMIUM RATE ADJUSTMENTS. If the percentage increase in the premium rate charged to a small employer for a new rating period exceeds 20 percent, the small employer, an eligible employee, or an eligible employee's dependent may file a complaint with the office of public insurance counsel as provided by Section 501.160. The complaint facilitation under this section and Chapter 501 is not exclusive and is in addition to any other remedy or complaint procedure provided by law or rule.

Sec. 1501.214. ENFORCEMENT. (a) Subject to Subsection (b), if [~~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.

(b) The commissioner shall enter an order under this section if the commissioner makes the finding described by Section 1501.653.

SECTION 3.004. Chapter 1501, Insurance Code, is amended by

adding Subchapter N to read as follows:

SUBCHAPTER N. RESOLUTION OF CERTAIN COMPLAINTS AGAINST SMALL EMPLOYER HEALTH BENEFIT PLAN ISSUERS

Sec. 1501.651. DEFINITIONS. In this subchapter:

(1) "Honesty-in-premium account" means the account established under Section 1501.656.

(2) "Office" means the office of public insurance counsel.

Sec. 1501.652. COMPLAINT RESOLUTION PROCEDURE. (a) On the receipt of a referral of a complaint from the office of public insurance counsel under Section 501.160, the commissioner shall request written memoranda from the office and the small employer health benefit plan issuer that is the subject of the complaint.

(b) After receiving the initial memoranda described by Subsection (a), the commissioner may request one rebuttal memorandum from the office.

(c) The commissioner may by rule limit the number of exhibits submitted with or the time frame allowed for the submittal of the memoranda described by Subsection (a) or (b).

Sec. 1501.653. ORDER; FINDINGS. The commissioner shall issue an order under Section 1501.214(b) if the commissioner determines that the rate complained of is excessive for the risks to which the rate applies.

Sec. 1501.654. COSTS. The office may request, and the commissioner may award to the office, reasonable costs and fees associated with the investigation and resolution of a complaint filed under Section 501.160 and disposed of in accordance with this subchapter.

Sec. 1501.655. ASSESSMENT. (a) The commissioner may make an assessment against each small employer health benefit plan issuer in an amount that is sufficient to cover the costs of investigating and resolving a complaint filed under Section 501.160 and disposed of in accordance with this subchapter.

(b) The commissioner shall deposit assessments collected under this section to the credit of the honesty-in-premium account.

Sec. 1501.656. HONESTY-IN-PREMIUM ACCOUNT. (a) The honesty-in-premium account is an account in the general revenue fund that may be appropriated only to cover the cost associated with the investigation and resolution of a complaint filed under Section 501.160 and disposed of in accordance with this subchapter.

(b) Interest earned on the honesty-in-premium account shall be credited to the account. The account is exempt from the application of Section 403.095, Government Code.

Sec. 1501.657. RATE CHANGE NOT PROHIBITED. Nothing in this subchapter prohibits a small employer health benefit plan

issuer from, at any time, offering a different rate to the group whose rate is the subject of a complaint.

SECTION 3.005. The change in law made by Chapter 1501, Insurance Code, as amended by this article, applies only to a small employer health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2010. A small employer health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2010, is covered by the law in effect at the time the health benefit plan was delivered, issued for delivery, or renewed, and that law is continued in effect for that purpose.

STRIKE ARTICLE 4

ARTICLE 4. PHYSICIAN RANKING BY HEALTH BENEFIT PLAN ISSUERS

SECTION 4.001. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1460 to read as follows:

CHAPTER 1460. STANDARDS REQUIRED REGARDING CERTAIN PHYSICIAN RANKINGS BY HEALTH BENEFIT PLANS

Sec. 1460.001. DEFINITIONS. In this chapter:

(1) "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.

(2) "Physician" means an individual licensed to practice medicine in this state or another state of the United States.

Sec. 1460.002. EXEMPTION. This chapter does not apply to:

(1) a Medicaid managed care program operated under Chapter 533, Government Code;

(2) a Medicaid program operated under Chapter 32, Human Resources Code;

(3) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(4) a Medicare supplement benefit plan, as defined by Chapter 1652.

Sec. 1460.003. PHYSICIAN RANKING REQUIREMENTS. (a) A health benefit plan issuer, including a subsidiary or affiliate, may not rank physicians, classify physicians into tiers based on performance, or publish physician-specific information that includes rankings, tiers, ratings, or other comparisons of a physician's performance against standards, measures, or other physicians, unless:

(1) the standards used by the health benefit plan issuer conform to nationally recognized standards and guidelines as required by rules adopted under Section 1460.005;

(2) the standards and measurements to be used by the health benefit plan issuer are disclosed to each affected physician before any evaluation period used by the health benefit plan issuer; and

(3) each affected physician is afforded, before any publication or other public dissemination, an opportunity to dispute the ranking or classification through a process that includes due process protections that conform to protections described by 42 U.S.C. Section 11112.

(b) This section does not apply to the publication of a list of network physicians and providers if ratings or comparisons are not made.

Sec. 1460.004. DUTIES OF PHYSICIANS. A physician may not require or request that a patient of the physician enter into an agreement under which the patient agrees not to:

(1) rank or otherwise evaluate the physician;

(2) participate in surveys regarding the physician; or

(3) in any way comment on the patient's opinion of the physician.

Sec. 1460.005. RULES; STANDARDS. (a) The commissioner

shall adopt rules in the manner prescribed by Subchapter A, Chapter 36, as necessary to implement this chapter.

(b) The commissioner shall adopt rules as necessary to ensure that a health benefit plan issuer that uses a physician ranking system complies with the standards and guidelines described by Subsection (c).

(c) In adopting rules under this section, the commissioner shall consider the standards and guidelines prescribed by nationally recognized organizations that establish or promote guidelines and performance measures emphasizing quality of health care, including the National Quality Forum and the AQA Alliance. If neither the National Quality Forum nor the AQA Alliance has established standards or guidelines regarding an issue, the commissioner shall consider the standards and guidelines prescribed by the National Committee for Quality Assurance and other similar national organizations.

Sec. 1460.006. DUTIES OF HEALTH BENEFIT PLAN ISSUER. A health benefit plan issuer shall ensure that:

(1) physicians being measured are actively involved in the development of the standards used under this chapter; and

(2) the measures and methodology used in the comparison programs described by Section 1460.003 are transparent and valid.

Sec. 1460.007. SANCTIONS; DISCIPLINARY ACTIONS. (a) A

health benefit plan issuer that violates this chapter or a rule adopted under this chapter is subject to sanctions and disciplinary actions under Chapters 82 and 84.

(b) A violation of this chapter by a physician constitutes grounds for disciplinary action by the Texas Medical Board, including imposition of an administrative penalty.

SECTION 4.002. (a) A health benefit plan issuer shall comply with Chapter 1460, Insurance Code, as added by this article, not later than December 31, 2009.

(b) A health benefit plan issuer is not subject to sanctions or disciplinary actions under Section 1460.007, Insurance Code, as added by this article, before January 1, 2010.

ARTICLE 5. NO APPROPRIATION; EFFECTIVE DATE

SECTION 5.001. This Act does not make an appropriation. A provision in this Act that creates a new governmental program, creates a new entitlement, or imposes a new duty on a governmental entity is not mandatory during a fiscal period for which the legislature has not made a specific appropriation to implement the provision.

SECTION 5.002. Except as otherwise provided by this Act, this Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does

not receive the vote necessary for immediate effect, this Act takes effect September 1, 2009.

ADOPTED

FLOOR AMENDMENT NO. 4 MAY 2 6 2009 BY: Deuell

Secretary of the Senate

Amend **CSHB 2752** by adding the following appropriately numbered SECTION and renumbering subsequent SECTIONS accordingly:

SECTION ___. Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1223 to read as follows:

CHAPTER 1223. MEDICAL LOSS RATIO

Sec. 1223.001. DEFINITIONS. In this chapter:

(1) "Enrollee" has the meaning assigned by Section 1457.001.

(2) "Evidence of coverage" has the meaning assigned by Section 843.002.

(3) "Market segment" means, as applicable, one of the following categories of health benefit plans issued by a health benefit plan issuer:

(A) individual evidences of coverage issued by a health maintenance organization;

(B) individual preferred provider benefit plans;

(C) evidences of coverage issued by a health maintenance organization to small employers as defined by Section 1501.002;

(D) preferred provider benefit plans issued to small employers as defined by Section 1501.002;

(E) evidences of coverage issued by a health maintenance organization to large employers as defined by Section 1501.002; and

(F) preferred provider benefit plans issued to large employers as defined by Section 1501.002.

(4) "Medical loss ratio" means direct losses incurred and direct losses paid for all preferred provider benefit plans

issued by an insurer, divided by direct premiums earned for all preferred provider benefit plans issued by that insurer. This amount may not include home office and overhead costs, advertising costs, network development costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, utilization review costs, or claims processing costs.

Sec. 1223.002. APPLICABILITY OF CHAPTER. (a) This chapter applies to 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 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) an exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843; or

(7) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) Notwithstanding any other law, this chapter applies to a health benefit plan issuer with respect to a standard health benefit plan provided under Chapter 1507.

(c) Notwithstanding Section 1501.251 or any other law, this chapter applies to a health benefit plan issuer with

respect to coverage under a small employer health benefit plan subject to Chapter 1501.

Sec. 1223.003. EXCEPTIONS. This chapter does not apply with respect to:

(1) a plan that provides coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses; or

(F) 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 Medicaid managed care program operated under Chapter 533, Government Code;

(4) Medicaid programs operated under Chapter 32, Human Resources Code;

(5) the state child health plan operated under Chapter 62 or 63, Health and Safety Code;

(6) a workers' compensation insurance policy; or

(7) medical payment insurance coverage provided under a motor vehicle insurance policy.

Sec. 1223.004. NOTIFICATION OF MEDICAL LOSS RATIO, MEDICAL COST MANAGEMENT, AND HEALTH EDUCATION COST. (a) A health benefit plan issuer shall report its medical loss ratio for each market segment, as applicable, with the annual report required under Section 843.155 or 1301.009. Beginning in the fourth year

during which a health benefit plan issuer is required to make a report under this section, the issuer may report the medical loss ratio as a three-year rolling average.

(b) Each health benefit plan issuer shall include in the report described by Subsection (a), for each market segment, a separate report of costs attributed to medical cost management and health education. The commissioner by rule shall prescribe the reporting requirements for the costs, which may include:

(1) case management activities;

(2) utilization review;

(3) detection and prevention of payment of fraudulent requests for reimbursement;

(4) network access fees to preferred provider organizations and other network-based health benefit plans, including prescription drug networks, and allocated internal salaries and related costs associated with network development or provider contracting;

(5) consumer education solely relating to health improvement and relying on the direct involvement of health personnel, including smoking cessation and disease management programs and other programs that involve medical education;

(6) telephone hotlines, including nurse hotlines, that provide enrollees health information and advice regarding medical care; and

(7) expenses for internal and external appeals processes.

(c) The department shall post on the department's Internet website or another website maintained by the department for the benefit of consumers or enrollees:

(1) the information received under Subsections (a) and (b);

(2) an explanation of the meaning of the term "medical loss ratio," how the medical loss ratio is calculated, and how the ratio may affect consumers or enrollees; and

(3) an explanation of the types of activities and services classified as medical cost management and health education, how the costs for these activities and services are calculated, what those costs, when aggregated with a medical loss ratio, mean, and how the costs might affect consumers or enrollees.

(d) A health benefit plan issuer shall provide each enrollee or the plan sponsor, as applicable, with the Internet website address at which the enrollee or plan sponsor may access the information described by Subsection (c). A health benefit plan issuer must provide the information required under this subsection:

(1) to an enrollee, at the time of the initial enrollment of the enrollee in a health benefit plan issued by the health benefit plan issuer; and

(2) at the time of renewal of a health benefit plan to:

(A) each enrollee, if the health benefit plan is an individual health benefit plan; or

(B) the plan sponsor, if the health benefit plan is a group health benefit plan.

(e) The commissioner shall adopt rules necessary to implement this section.

SECTION __. The change in law made by this Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2011. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2011, is covered by the law in effect at the

time the health benefit plan was delivered, issued for delivery, or renewed, and that law is continued in effect for that purpose.

ADOPTED

MAY 2 6 2009

Secretary of the Senate

FLOOR AMENDMENT NO. 5 BY: Rodney Ellis

Amend House Bill 2752 by inserting the flowing new sections and renumber accordingly:

SECTION __. Section 102.001, Insurance Code, is amended by amending Subdivision (1) and adding Subdivision (3) to read as follows:

(1) "Charitable gift annuity" means an annuity:

(A) that is payable over the lives of one or two individuals;

(B) that is made in return for the transfer of cash or other property to a charitable organization or qualified educational organization; and

(C) the actuarial value of which is less than the value of the cash or other property transferred, with the difference in those values being a charitable deduction for federal tax purposes.

(3) "Qualified educational organization" means an issuer of a charitable gift annuity that is:

(A) an institution of higher education as defined by Section 61.003, Education Code;

(B) a private or independent institution of higher education as defined by Section 61.003, Education Code; or

(C) a foundation designated in writing by an institution described by Paragraph (A) or (B) to issue charitable gift annuities for the benefit of the institution.

SECTION __. Section 102.002, Insurance Code, is amended to read as follows:

Sec. 102.002. QUALIFIED CHARITABLE GIFT ANNUITY. (a) A

charitable gift annuity is a qualified charitable gift annuity for purposes of this chapter if it was issued before September 1, 1995, or if it is:

(1) described by Section 501(m)(5), Internal Revenue Code of 1986; and

(2) issued by a charitable organization that on the date of the annuity agreement:

(A) has, exclusive of the assets funding the annuity agreement, a minimum of $300,000 [~~$100,000~~] in unrestricted cash, cash equivalents, or publicly traded securities; and

(B) has been in continuous operation for at least three years or is a successor or affiliate of a charitable organization that has been in continuous operation for at least three years.

(b) A charitable gift annuity is a qualified charitable gift annuity if it is issued by a qualified educational organization that, on the date of the annuity agreement:

(1) has, exclusive of the assets funding the annuity agreement, a minimum of $300,000 in unrestricted cash, cash equivalents, or publicly traded securities; and

(2) has been in continuous operation for at least three years or is a successor or affiliate of an institution or foundation described by Section 102.001(3) that has been in continuous operation for at least three years.

SECTION __. Subchapter C, Chapter 102, Insurance Code, is amended by amending Section 102.102 and adding Section 102.105 to read as follows:

Sec. 102.102. NOTICE AND APPROVAL OF QUALIFIED STATUS OF CHARITABLE ORGANIZATION [~~TO DEPARTMENT~~]. (a) Not later than the 60th day before the date on which a charitable organization

sells the organization's first qualified charitable gift annuity, the [~~A~~] charitable organization [~~that issues qualified charitable gift annuities~~] shall:

(1) notify the department's annuities division in writing of the organization's intention to issue a charitable gift annuity; and

(2) request in writing the department's approval of the organization as a qualified charitable organization under this chapter [~~not later than the date on which the organization enters into the organization's first qualified charitable gift annuity agreement~~].

(b) The notice required by this section must:

(1) be signed by an officer or director of the organization;

(2) identify the organization; [~~and~~]

(3) certify that:

(A) the organization is a charitable organization; and

(B) the annuities issued by the organization are [~~qualified~~] charitable gift annuities; and

(4) be submitted in a form and manner adopted by the commissioner by rule under Subsection (c).

(c) The commissioner may adopt rules that establish the form and manner of information that a charitable organization must [~~may not be required to~~] submit to request approval under this section [~~additional information except to determine appropriate penalties under Section 102.104~~].

(d) On receipt of notice and request for approval under this section, the department may:

(1) approve a request for a charitable organization to issue charitable gift annuities; or

(2) disapprove a request and notify the issuer in writing of the grounds for the disapproval in sufficient detail to allow remediation.

(e) A request under Subsection (b) is considered approved if the commissioner does not act on the request on or before the 60th day after the date the department received the request.

(f) The department may withdraw the approval of a request for qualified status of a charitable organization if the organization no longer satisfies the requirements for approval. The department shall notify the organization in writing of the grounds for the withdrawal of approval in sufficient detail to allow remediation.

(g) A proceeding under this chapter for the disapproval or withdrawal of approval is a contested case under Chapter 2001, Government Code.

Sec. 102.105. NOTICE OF QUALIFIED EDUCATIONAL ORGANIZATION STATUS. (a) Not later than the 60th day before the date on which a qualified educational organization sells the organization's first qualified charitable gift annuity, the organization shall:

(1) notify the department's annuities division in writing of the organization's intention to issue a charitable gift annuity; and

(2) request in writing the department's acknowledgment of the organization as a qualified educational organization under this chapter.

(b) The notice required by this section must:

(1) be signed by an officer or director of the organization;

(2) identify the organization; and

(3) certify that:

(A) the organization is an institution of higher education or a private or independent institution of higher education as defined by Section 61.003, Education Code, or a foundation designated by the institution as described by Section 102.001(3); and

(B) the annuities issued by the organization are charitable gift annuities.

(c) On receipt of notice and request for acknowledgment under this section, the department shall acknowledge that the organization may issue a charitable gift annuity.

SECTION __. Section 102.152, Insurance Code, is amended to read as follows:

Sec. 102.152. TREATMENT OF ANNUITY AS CHARITABLE GIFT ANNUITY; ESTOPPEL. In any litigation or other proceeding brought by or on behalf of a donor or the donor's heirs or distributees, an annuity that the donor has treated as a charitable gift annuity in a filing with the United States Internal Revenue Service shall be considered to be a qualified charitable gift annuity issued by a charitable organization or a qualified educational organization, as described by Subchapters A and B and Section 101.053(b).

SECTION __. Section 1107.006, Insurance Code, is amended to read as follows:

Sec. 1107.006. MATURITY DATE. [~~(a)~~] In determining the value of benefits under Sections 1107.102, 1107.103, and 1107.104, [~~and subject to Subsection (b), if an annuity contract permits an election to have annuity payments begin on optional maturity dates,~~] the maturity date is [~~considered to be~~] the latest date on which an election is permitted by the contract, but[~~:~~

[~~(b) A maturity date determined under this section may~~]

not [~~be~~] later than the later of:

(1) the next anniversary of the annuity contract that follows the annuitant's 70th birthday; or

(2) the 10th anniversary of the contract.

SECTION __. Section 1115.102, Insurance Code, is amended by adding Subsections (c) and (d) to read as follows:

(c) In addition to any other remedy available for a violation of this chapter, if the commissioner finds a pattern or practice of unsuitable sales of annuities, or such a pattern or practice is reasonably expected, because of the compensation offered by an insurer for the sale of annuities, the commissioner may, after notice and hearing, order the insurer to cease and desist or modify the compensation offered.

(d) An order issued under Subsection (c) may not include a regular salaried officer or employee of a licensed insurer, a jointly managed affiliate of a licensed insurer, or a licensed insurance agent if the officer or employee does not receive a commission or other compensation for the services of the officer or employee that is directly dependent on the amount of business done.

SECTION __. Sections 2 and 3 of this Act apply only to an annuity that is delivered or issued for delivery on or after January 1, 2010. An annuity that is delivered or issued for delivery before January 1, 2010, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION __. Section 1107.006, Insurance Code, as amended by this Act, applies only to an annuity that is delivered or issued for delivery on or after June 1, 2010. An annuity that is delivered or issued for delivery before June 1, 2010, is governed by the law as it existed immediately before the

effective date of this Act, and that law is continued in effect for that purpose.

SECTION __. Section 1115.102, Insurance Code, as amended by this Act, applies only to conduct that occurs on or after the effective date of this Act. Conduct that occurs before the effective date of this Act is covered by the law in effect when the conduct occurred, and the former law is continued in effect for that purpose.

ADOPTED

MAY 2 6 2009

Secretary of the Senate

FLOOR AMENDMENT NO. 6 BY: _____

Amend Committee Substitute H.B. No. 2752 by adding the following appropriately numbered SECTIONS and renumbering subsequent SECTIONS of the bill accordingly:

SECTION ___. Section 463.153(c), Insurance Code, is amended to read as follows:

(c) The total amount of assessments on a member insurer for each account under Section 463.105 may not exceed two percent of the insurer's average annual premiums on the policies covered by the account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If two or more assessments are authorized in a calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation described by this subsection shall be equal to the higher of the three-year average annual premiums for the applicable subaccount or account as computed in accordance with this section. If the maximum assessment and the other assets of the association do not provide in a year an amount sufficient to carry out the association's responsibilities, the association shall make necessary additional assessments as soon as this chapter permits.

SECTION ___. Section 463.203(b), Insurance Code, is amended to read as follows:

(b) This chapter does not provide coverage for:

(1) any part of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy or contract owner;

(2) a policy or contract of reinsurance, unless an

assumption certificate has been issued;

(3) any part of a policy or contract to the extent that the rate of interest on which that part is based:

(A) as averaged over the period of four years before the date the member insurer becomes impaired or insolvent under this chapter, whichever is earlier, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for the same four-year period or for a lesser period if the policy or contract was issued less than four years before the date the member insurer becomes impaired or insolvent under this chapter, whichever is earlier; and

(B) on and after the date the member insurer becomes impaired or insolvent under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(4) a portion of a policy or contract issued to a plan or program of an employer, association, similar entity, or other person to provide life, health, or annuity benefits to the entity's employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or similar entity under:

(A) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002);

(B) a minimum premium group insurance plan;

(C) a stop-loss group insurance plan; or

(D) an administrative services-only contract;

(5) any part of a policy or contract to the extent that the part provides dividends, experience rating credits, or

voting rights, or provides that fees or allowances be paid to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(6) a policy or contract issued in this state by a member insurer at a time the insurer was not authorized to issue the policy or contract in this state;

(7) an unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the Pension Benefit Guaranty Corporation has not yet become liable to make any payments with respect to the benefit plan;

(8) any part of an unallocated annuity contract that is not issued to or in connection with a specific employee, a benefit plan for a union or association of individuals, or a governmental lottery;

(9) any part of a financial guarantee, funding agreement, or guaranteed investment contract that:

(A) does not contain a mortality guarantee; and

(B) is not issued to or in connection with a specific employee, a benefit plan, or a governmental lottery;

(10) a part of a policy or contract to the extent that the assessments required by Subchapter D with respect to the policy or contract are preempted by federal or state law;

(11) a contractual agreement that established the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or the plan's trustee in a case in which neither the benefit plan sponsor nor its trustee is an affiliate of the member insurer; [~~or~~]

(12) a part of a policy or contract to the extent the policy or contract provides for interest or other changes in value that are to be determined by the use of an index or external reference stated in the policy or contract, but that have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever date is earlier, subject to Subsection (c); or

(13) a policy or contract providing any hospital, medical, prescription drug, or other health care benefits under Part C or Part D, Subchapter XVIII, Chapter 7, Title 42, United States Code (Medicare Part C or Part D) or any regulations issued under those parts.

SECTION ___. Section 463.204, Insurance Code, is amended to read as follows:

Sec. 463.204. OBLIGATIONS EXCLUDED. A contractual obligation does not include:

(1) death benefits in an amount in excess of $300,000 or a net cash surrender or net cash withdrawal value in an amount in excess of $100,000 under one or more policies on a single life;

(2) an amount in excess of:

(A) $250,000 [~~$100,000~~] in the present value under one or more annuity contracts issued with respect to a single life under individual annuity policies or group annuity policies; or

(B) $5 million in unallocated annuity contract benefits with respect to a single contract owner regardless of the number of those contracts;

(3) an amount in excess of the following amounts,

including any net cash surrender or cash withdrawal values, under one or more accident, health, accident and health, or long-term care insurance policies on a single life:

(A) $500,000 for basic hospital, medical-surgical, or major medical insurance, as those terms are defined by this code or rules adopted by the commissioner;

(B) $300,000 for disability and long-term care insurance, as those terms are defined by this code or rules adopted by the commissioner; or

(C) $200,000 for coverages that are not defined as basic hospital, medical-surgical, major medical, disability, or long-term care insurance;

(4) an amount in excess of $250,000 [~~$100,000~~] in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values, with respect to each individual participating in a governmental retirement benefit plan established under Section 401, 403(b), or 457, Internal Revenue Code of 1986 (26 U.S.C. Sections 401, 403(b), and 457), covered by an unallocated annuity contract or the beneficiary or beneficiaries of the individual if the individual is deceased;

(5) an amount in excess of $250,000 [~~$100,000~~] in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values, with respect to each payee of a structured settlement annuity or the beneficiary or beneficiaries of the payee if the payee is deceased;

(6) aggregate benefits in an amount in excess of $300,000 with respect to a single life, except with respect to:

(A) benefits paid under basic hospital, medical-surgical, or major medical insurance policies, described by

Subdivision (3)(A), in which case the aggregate benefits are $500,000; and

(B) benefits paid to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, in which case the maximum benefits are $5 million regardless of the number of policies and contracts held by the owner;

(7) an amount in excess of $5 million in benefits, with respect to either one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in Subdivision (4) irrespective of the number of contracts with respect to the contract owner or plan sponsor or one contract owner provided coverage under Section 463.201(a)(3)(B), except that, if one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state, and in no event shall the association be obligated to cover more than $5 million in benefits with respect to all these unallocated contracts;

(8) any contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic value of economic benefits of the covered policy or contract; or

(9) punitive, exemplary, extracontractual, or bad faith damages, regardless of whether the damages are:

(A) agreed to or assumed by an insurer or

insured; or

(B) imposed by a court.

SECTION ___. Section 463.263(b), Insurance Code, is amended to read as follows:

(b) The association is entitled to retain a portion of any amount paid to the association under this section equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency, and shall remit to the domiciliary receiver the amount paid to the association less the amount [~~and~~] retained under this section.

SECTION ___. Chapter 463, Insurance Code, is amended by adding Subchapter K to read as follows:

SUBCHAPTER K. REINSURANCE

Sec. 463.501. DEFINITIONS. In this subchapter:

(1) "Election date" means the date on which the association elects to make an assumption under Section 463.503.

(2) "Order of liquidation" means an order described by Section 443.151.

Sec. 463.502. APPLICABILITY. (a) Except as otherwise provided by this subchapter, this subchapter does not alter or modify the terms and conditions of any reinsurance contract.

(b) This subchapter does not:

(1) abrogate or limit any right of a reinsurer to claim that the reinsurer is entitled to rescind a reinsurance contract;

(2) give a policyholder or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract;

(3) limit or affect the association's rights as a creditor of the estate against the assets of the estate; or

(4) apply to reinsurance agreements covering property or casualty risks.

Sec. 463.503. ASSUMPTION BY ASSOCIATION OF RIGHTS AND OBLIGATIONS OF CEDING MEMBER INSURER. (a) Not later than the 180th day after the date of the order of liquidation, the association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies or annuities covered wholly or partially by the association under one or more reinsurance contracts entered into by the insolvent insurer and the insolvent insurer's reinsurers and selected by the association. An assumption by the association under this subsection takes effect on the date of the order of liquidation.

(b) The election under Subsection (a) takes effect when the association, or the National Organization of Life and Health Insurance Guaranty Associations on behalf of the association, sends written notice, return receipt requested, to the affected reinsurers.

(c) To facilitate the earliest practicable decision about whether to assume any of the reinsurance contracts, and to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available on request to the association, or to the National Organization of Life and Health Insurance Guaranty Associations on the association's behalf, as soon as possible after the commencement of formal delinquency proceedings:

(1) copies of reinsurance contracts in force, and all related files and records relevant to the determination of whether those contracts should be assumed; and

(2) notices of:

(A) any defaults under the reinsurance contracts; or

(B) any known event or condition that, with the passage of time, could become a default under the reinsurance contracts.

Sec. 463.504. ASSOCIATION OBLIGATIONS UNDER REINSURANCE CONTRACTS. (a) With respect to the reinsurance contracts assumed by the association that relate to policies or annuities covered wholly or partially by the association, the association is responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation.

(b) The association may charge a policy or annuity covered partially by the association, through reasonable allocation methods, the costs for reinsurance in excess of the association's obligations, and shall provide notice and an accounting of those charges to the liquidator.

Sec. 463.505. LOSS PAYMENTS. (a) The association is entitled to any amount payable by the reinsurer under a reinsurance contract with respect to a loss or event that:

(1) occurs after the date of the order of liquidation; and

(2) relates to a policy or annuity covered wholly or partially by the association.

(b) On receipt of an amount described by Subsection (a), the association is obliged to pay to the beneficiary under the affected policy or annuity an amount equal to the lesser of:

(1) the amount received by the association under

Subsection (a); or

(2) the excess of the amount received by the association under Subsection (a) over the amount equal to the benefits paid by the association on account of the policy or annuity, less the retention of the insurer applicable to the loss or event.

Sec. 463.506. COMPUTATION OF NET BALANCE. (a) Not later than the 30th day after the election date, the association and each reinsurer under a reinsurance contract assumed by the association shall compute the net balance due to or from the association under the reinsurance contract, as of the election date, with respect to a policy or annuity covered wholly or partially by the association.

(b) The computation must give full credit to all items paid by the insurer or the insurer's receiver or the reinsurer before the election date. The reinsurer shall pay the receiver any amounts due for losses or events before the date of the order of liquidation, subject to any set-off for premiums unpaid for periods before that date, and the association or reinsurer shall pay any remaining balance due to the other. The payment must be made not later than the fifth day after the date on which the computation is completed.

(c) A dispute regarding the amounts due to the association or the reinsurer shall be resolved by arbitration under the terms of the affected reinsurance contract or, if the contract does not contain an arbitration clause, as otherwise provided by law.

(d) If the receiver has received any amounts due to the association under Section 463.505(a), the receiver shall remit those amounts to the association as promptly as practicable.

Sec. 463.507. PROHIBITED ACTS BY REINSURER. If the

association, or the receiver on the association's behalf, pays, not later than the 60th day after the election date, the unpaid premiums due for periods before and after the election date that relate to policies or annuities covered wholly or partially by the association, the reinsurer may not:

(1) terminate a reinsurance contract for failure to pay premium to the extent that the reinsurance contract relates to a policy or annuity covered wholly or partially by the association; or

(2) set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the association, against amounts due to the association.

Sec. 463.508. RIGHTS AND OBLIGATIONS OF PARTIES. (a) During the period from the date of the order of liquidation until the election date, or, if the election date does not occur, until the 180th day after the date of the order of liquidation:

(1) the association and the reinsurer have no rights or obligations under a reinsurance contract that the association has the right to assume under Section 463.503, whether for periods before or after the date of the order of liquidation; and

(2) the reinsurer, the receiver, and the association shall, to the extent practicable, provide to each other data and records reasonably requested.

(b) After the association has elected to assume a reinsurance contract, the parties' rights and obligations are governed by this subchapter.

(c) If the association does not elect to assume a reinsurance contract by the date described by Section 463.503(a), the association has no rights or obligations with

respect to the reinsurance contract for periods before or after the date of the order of liquidation.

Sec. 463.509. TRANSFERS OF REINSURANCE CONTRACTS TO ASSUMING INSURERS. (a) In the case of a contract assumed under Section 463.503, if a policy or annuity, or a covered obligation with respect to the policy or annuity, is transferred to an assuming insurer, reinsurance on the policy or annuity may also be transferred by the association, subject to the requirements of this section.

(b) Unless the reinsurer and the assuming insurer otherwise agree, the transferred reinsurance contract may not cover any new insurance policy or annuity in addition to those transferred.

(c) The obligations described by this subchapter do not apply with respect to matters arising after the effective date of a transfer under this section.

(d) The transferring party must give notice in writing, return receipt requested, to the affected reinsurer not later than the 30th day before the effective date of the transfer.

Sec. 463.510. EFFECT OF OTHER LAW OR CONTRACT PROVISION. (a) This subchapter supersedes the provisions of any law, or of any affected reinsurance contract, that provides for or requires payment of reinsurance proceeds because of a loss or event that occurs after the date of the order of liquidation, to:

(1) the receiver of the insolvent insurer; or

(2) any other person.

(b) The receiver remains entitled to any amounts payable by the reinsurer under the reinsurance contract with respect to a loss or event that occurs before the date of the order of liquidation, subject to any applicable set-off provisions.

SECTION ___. (a) Except as provided by Subsection (b),

the change in law made by this Act to Chapter 463, Insurance Code applies only to an insurer that first becomes an impaired or insolvent insurer on or after the effective date of this Act. An insurer that becomes an impaired or insolvent insurer before the effective date of this Act is governed by the law as it existed immediately before that date, and that law is continued in effect for that purpose.

(b) The change in law made by this Act to Section 463.153(c), Insurance Code, as amended by this Act, applies to an assessment authorized on or after October 1, 2008, with respect to an insurer that first became impaired or insolvent on or after September 1, 2005.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

May 28, 2009

TO: Honorable Joe Straus, Speaker of the House, House of Representatives

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB2752** by Eiland (Relating to independent audits of insurer financial statements and insurer internal controls.), **As Passed 2nd House**

Estimated Two-year Net Impact to General Revenue Related Funds for HB2752, As Passed 2nd House: a negative impact of ($154,948) through the biennium ending August 31, 2011.

Depending on the number of insurer insolvencies and subsequent premium tax credits, there would be an indeterminate negative fiscal impact to General Revenue.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2010	($78,724)
2011	($76,224)
2012	($76,224)
2013	($76,224)
2014	($76,224)

All Funds, Five-Year Impact:

Fiscal Year	Probable (Cost) from *General Revenue Fund* 1	Probable Revenue Gain from *Insurance Maint Tax Fees* 8042	Probable (Cost) from *Insurance Maint Tax Fees* 8042	Change in Number of State Employees from FY 2009
2010	($78,724)	$251,170	($251,170)	2.5
2011	($76,224)	$241,779	($241,779)	2.5
2012	($76,224)	$241,779	($241,779)	2.5
2013	($76,224)	$241,779	($241,779)	2.5
2014	($76,224)	$241,779	($241,779)	2.5

Fiscal Analysis

The bill would amend the Insurance Code to revise the audit requirements for audited financial reports from insurers and to change the professional requirements of the auditor preparing the report. The bill would not require health maintenance organizations to submit an audited financial report to the Texas Department of Insurance (TDI). The bill would require TDI to revise the exemption process for receiving audited financial reports from insurers.

The bill would require the Office of the Attorney General (OAG) to conduct enforcement activities regarding complaints for health care sharing organizations and adopt rules regarding the implementation of the bill.

The bill would amend the Insurance Code to expand the regulation of certain market conduct activities of certain life, accident, and health insurers and health benefit plan issuers. The bill would change the requirements for the sale of certain annuities and requires TDI adopt rules to implement this section.

The bill would create an independent review process for certain rescission decisions. The bill would require TDI to adopt standards for the independent review organizations and to adopt rules to implement these provisions.

The bill would require preferred provider benefit plan companies to file annually or more often as required by the commissioner, their loss ratio data to TDI and publish the information on TDI's website. The bill would require TDI to adopt rules to implement these provisions.

The bill would create a complaint process for premium rate increases for small employer health benefit plans. The bill would require the Office of Public Insurance Counsel (OPIC) to accept complaints against small employer health benefit plans from small employers, eligible employees or their dependents concerning significant rate increases. The bill would authorize OPIC to determine which complaints are appropriate to refer to TDI and authorize TDI to issue an order assessing penalties if the rate is determined to be excessive. The bill would allow OPIC to request reimbursement from TDI for costs and fees associated with the investigation and resolution of complaint of a rate increase. The bill would not require, but would allow, TDI to reimburse OPIC for these expenses.

The bill would create the Honesty-In-Premium Account as a fund in the General Revenue Fund. The bill would allow TDI to make an assessment against each small employer health benefit plan issuer to cover the costs of investigating and resolving a complaint. The bill would allow the fund to receive revenue from any assessments TDI makes as specified in the bill and from interest earned on the fund.

The bill would increase the number of contractual obligations that the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association would pay in certain cases of insurer insolvency. TDI would need to update certain publications to reflect the changes made by the bill.

The bill would take effect on September 1, 2009.

Methodology

The additional obligations to the Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association would result in indeterminate negative fiscal implications to General Revenue. Members of this association are assessed for the insolvency claim payouts and certain amounts of these assessments result in the members receiving a premium tax credit against General Revenue. The bill may result in a decrease in premium taxes due to increased claim payments. Since the number of insolvencies and number of additional contractual obligations per insurer insolvency is undetermined, the fiscal implication of this section of the bill cannot be estimated.

Based on the analysis by the OAG, the cost to conduct enforcement activities regarding complaints for health care sharing organizations could be absorbed within existing agency resources.

Based on the analysis by TDI, it is anticipated that the loss ratio collection and review process and the complaint process will require an additional 3.5 FTEs in fiscal year 2010 and 2.5 FTEs in fiscal year 2011 and each subsequent fiscal year. The additional FTEs in 2010 are necessary for the development of a new computer application for the annual collection of loss ratio data.

In fiscal year 2010, the 3.5 FTEs would cost $230,700 for salaries and wages with associated benefit costs of $65,911, travel costs of $1,250, and telephone and other operating expenses of $6,690. Additionally, one-time equipment expenditures are anticipated to be $13,999 in fiscal year 2010. In

fiscal year 2011, the 2.5 FTEs would cost $164,998 for salaries and wages with associated benefit costs of $47,140, travel costs of $1,250, and telephone and other operating expenses of $6,690. Additionally, expert witnesses will be required in contested rate cases at a cost of $100,000 each year of 2010-2014. Since insurance maintenance tax is self-leveling, this analysis assumes that the costs to implement this bill would come from fund balances or the maintenance tax would be set to recover a higher level of revenue.

Since reimbursements to OPIC for the small employer health benefit plan complaint process for premium rate increases are at the discretion of TDI, this analysis assumes that TDI would not make assessments on the small employer health benefit plan issuer and therefore would not reimburse OPIC for costs related to the complaint process.

Based on analysis provided by OPIC, it is anticipated that the complaint process will require an additional 1 FTE to analyze complaints to determine if the rate change is sufficient to warrant OPIC's participation. The 1 FTE would have a salary cost of $59,286 with associated benefits of $16,938 each fiscal year. Additionally, a one-time equipment cost of $2,500 is anticipated in fiscal year 2010. These costs would be funded through General Revenue.

Based on analysis provided by the Employee Retirement System (ERS) regarding the loss ratio collection and review, this bill would have no significant fiscal impact on the agency.

Based on analysis provided by the Teacher Retirement System (TRS) regarding the loss ratio collection and review, this bill would have no fiscal impact on the agency.

Based on analysis provided by TDI, the cost to collect medical loss ratios of preferred provider benefit plan issues and to revise the requirements of audited financial reports can be absorbed within existing resources.

Implementation of the new requirements for the sale of certain annuities will result in a small one-time revenue gain in General Revenue Dedicated Account Fund 36 in fiscal year 2010 from additional form filings. Since General Revenue Dedicated Account Fund 36 is a self-leveling account, this analysis assumes this revenue would go toward fund balances or the maintenance tax would be set to recover a lower level of revenue the following year.

This legislation would do one or more of the following: create or recreate a dedicated account in the General Revenue Fund, create or recreate a special or trust fund either with or outside of the Treasury, or create a dedicated revenue source. Legislative policy, implemented as Government Code 403.094, consolidated special funds (except those affected by constitutional, federal, or other restrictions) into the General Revenue Fund as of August 31, 1993, and eliminated all applicable statutory revenue dedications as of August 31, 1995. Each subsequent Legislature has reviewed bills that affect funds consolidation. The fund, account, or revenue dedication included in this bill would be subject to funds consolidation review by the current Legislature.

Technology

The bill is anticipated to have a technology impact of $5,388 in fiscal year 2010.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 302 Office of the Attorney General, 359 Office of Public Insurance Counsel, 454 Department of Insurance

LBB Staff: JOB, JRO, MW, CH

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

May 18, 2009

TO: Honorable Troy Fraser, Chair, Senate Committee on Business & Commerce

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB2752** by Eiland (Relating to independent audits of insurer financial statements and insurer internal controls.), **Committee Report 2nd House, Substituted**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code to revise the audit requirements for audited financial reports from insurers and to change the professional requirements of the auditor preparing the report. The bill would not require health maintenance organizations to submit an audited financial report to the Texas Department of Insurance (TDI). The bill would require TDI to revise the exemption process for receiving audited financial reports from insurers. Based on the analysis by TDI, it is assumed any costs associated with implementing this bill could be absorbed within current agency resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 454 Department of Insurance
LBB Staff: JOB, JRO, KJG, MW, CH

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

April 28, 2009

TO: Honorable Troy Fraser, Chair, Senate Committee on Business & Commerce

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB2752** by Eiland (Relating to independent audits of insurer financial statements and insurer internal controls.), **As Engrossed**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code to revise the audit requirements for audited financial reports from insurers and to change the professional requirements of the auditor preparing the report. The bill would not require health maintenance organizations to submit an audited financial report to the Texas Department of Insurance (TDI). The bill would require TDI to revise the exemption process for receiving audited financial reports from insurers. Based on the analysis by TDI, it is assumed any costs associated with implementing this bill could be absorbed within current agency resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 454 Department of Insurance
LBB Staff: JOB, JRO, KJG, MW, CH

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

March 23, 2009

TO: Honorable John T. Smithee, Chair, House Committee on Insurance

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB2752** by Eiland (Relating to independent audits of insurer financial statements and insurer internal controls.), **As Introduced**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code to revise the audit requirements for audited financial reports from insurers and to change the professional requirements of the auditor preparing the report. The bill would not require health maintenance organizations to submit an audited financial report to the Texas Department of Insurance (TDI). The bill would require TDI to revise the exemption process for receiving audited financial reports from insurers. Based on the analysis by TDI, it is assumed any costs associated with implementing this bill could be absorbed within current agency resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 454 Department of Insurance
LBB Staff: JOB, KJG, MW, CH