By: Taylor of Galveston H.B. No. 1951

A BILL TO BE ENTITLED

AN ACT

relating to the continuation and operation of the Texas Department of Insurance and the operation of certain insurance programs; imposing administrative penalties.

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

ARTICLE 1. GENERAL PROVISIONS

SECTION 1.001. Section 31.002, Insurance Code, is amended to read as follows:

Sec. 31.002. DUTIES OF DEPARTMENT. In addition to the other duties required of the Texas Department of Insurance, the department shall:

(1) regulate the business of insurance in this state;

(2) administer the workers' compensation system of this state as provided by Title 5, Labor Code; [~~and~~]

(3) ensure that this code and other laws regarding insurance and insurance companies are executed;

(4) protect and ensure the fair treatment of consumers; and

(5) ensure fair competition in the insurance industry in order to foster a competitive market.

SECTION 1.002. Section 31.004(a), Insurance Code, is amended to read as follows:

(a) The Texas Department of Insurance is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in

existence as provided by that chapter, the department is abolished September 1, 2023 [~~2011~~].

SECTION 1.003. Subchapter B, Chapter 36, Insurance Code, is amended by adding Section 36.110 to read as follows:

Sec. 36.110. NEGOTIATED RULEMAKING AND ALTERNATIVE DISPUTE RESOLUTION POLICY. (a) The commissioner shall develop and implement a policy to encourage the use of:

(1) negotiated rulemaking procedures under Chapter 2008, Government Code, for the adoption of department rules; and

(2) appropriate alternative dispute resolution procedures under Chapter 2009, Government Code, to assist in the resolution of internal and external disputes under the department's jurisdiction.

(b) The department's procedures relating to alternative dispute resolution must conform, to the extent possible, to any model guidelines issued by the State Office of Administrative Hearings for the use of alternative dispute resolution by state agencies.

(c) The commissioner shall:

(1) coordinate the implementation of the policy adopted under Subsection (a);

(2) provide training as needed to implement the procedures for negotiated rulemaking or alternative dispute resolution; and

(3) collect data concerning the effectiveness of those procedures.

SECTION 1.004. Section 559.003, Insurance Code, is amended

1 to read as follows:
2 Sec. 559.003. INFORMATION PROVIDED TO PUBLIC. The
3 department shall:
4 (1) update insurer profiles maintained on the
5 department's Internet website to provide information to consumers
6 stating whether or not an insurer uses credit scoring; and
7 (2) post on the department's Internet website:
8 (A) the report required under former Section 15,
9 Article 21.49-2U; and
10 (B) information as to how consumers may obtain
11 copies of individual credit reports and claims history reports,
12 including posting the Internet website address for each nationwide
13 credit reporting agency[, on the department's Internet website].
14 SECTION 1.005. Subchapter A, Chapter 2301, Insurance Code,
15 is amended by adding Section 2301.010 to read as follows:
16 Sec. 2301.010. CONTRACTUAL LIMITATIONS PERIOD AND CLAIM
17 FILING PERIOD IN CERTAIN PROPERTY INSURANCE FORMS. (a) A policy
18 form or printed endorsement form for residential or commercial
19 property insurance that is filed by an insurer or adopted by the
20 department under this subchapter may provide for a contractual
21 limitations period for filing suit on a first-party claim under the
22 policy. The contractual limitations period may not end before the
23 earlier of:
24 (1) two years from the date the insurer accepts or
25 rejects the claim; or
26 (2) three years from the date of the loss that is the
27 subject of the claim.

1 (b) A policy or endorsement described by Subsection (a) may
2 contain a provision requiring that a claim be filed with the insurer
3 not later than one year after the date of the loss that is the
4 subject of the claim. A provision under this subsection must
5 include a provision allowing the filing of claims after the first
6 anniversary of the date of the loss for good cause shown by the
7 person filing the claim.
8 (c) A contractual provision contrary to Subsection (a) or
9 (b) is void. This subsection does not affect the validity of other
10 provisions of a contract that may be given effect without the voided
11 provision to the extent those provisions are severable.
12 SECTION 1.006. Section 16.070, Civil Practice and Remedies
13 Code, is amended by amending Subsection (a) and adding Subsection
14 (c) to read as follows:
15 (a) Except as provided by Subsections [~~Subsection~~] (b) and
16 (c), a person may not enter a stipulation, contract, or agreement
17 that purports to limit the time in which to bring suit on the
18 stipulation, contract, or agreement to a period shorter than two
19 years. A stipulation, contract, or agreement that establishes a
20 limitations period that is shorter than two years is void in this
21 state.
22 (c) This section does not apply to provisions related to
23 claims covered by a residential or commercial property insurance
24 policy that complies with Section 2301.010, Insurance Code.
25 SECTION 1.007. (a) The Texas Department of Insurance shall
26 conduct a study concerning the feasibility and effectiveness of the
27 establishment of a mandatory medical reinsurance program in this

1 state through which issuers of group health benefit plans offered
2 by employers with 100 or fewer employees would be required to
3 purchase reinsurance.
4 (b) The study conducted under this section must:
5 (1) include an analysis of data from calendar years
6 2009, 2010, and 2011; and
7 (2) seek to determine what effect, if any, the
8 establishment of a medical reinsurance program described by
9 Subsection (a) of this section would have had on premium rates,
10 renewal rates, and overall costs to employers during calendar years
11 2009, 2010, and 2011, had the program been operational during those
12 years.
13 (c) The department may request information from the
14 Employees Retirement System of Texas, the Teacher Retirement System
15 of Texas, and health benefit plan issuers in this state as necessary
16 to complete the study required under this section.
17 (d) The department shall include the results of the study
18 conducted under this section in the biennial report submitted to
19 the legislature under Section 32.022, Insurance Code, nearest to
20 December 31, 2012.
21 SECTION 1.008. Section 2301.010, Insurance Code, as added
22 by this article, applies only to an insurance policy that is
23 delivered, issued for delivery, or renewed on or after January 1,
24 2012. A policy delivered, issued for delivery, or renewed before
25 January 1, 2012, is governed by the law as it existed immediately
26 before the effective date of this Act, and that law is continued in
27 effect for that purpose.

ARTICLE 2. CERTAIN ADVISORY BOARDS, COMMITTEES, AND COUNCILS AND RELATED TECHNICAL CORRECTIONS

SECTION 2.001. Chapter 32, Insurance Code, is amended by adding Subchapter E to read as follows:

SUBCHAPTER E. RULES REGARDING USE OF ADVISORY COMMITTEES

Sec. 32.151. RULEMAKING AUTHORITY. (a) The commissioner shall adopt rules, in compliance with Section 39.003 of this code and Chapter 2110, Government Code, regarding the purpose, structure, and use of advisory committees by the commissioner, the state fire marshal, or department staff, including rules governing an advisory committee's:

(1) purpose, role, responsibility, and goals;

(2) size and quorum requirements;

(3) qualifications for membership, including experience requirements and geographic representation;

(4) appointment procedures;

(5) terms of service;

(6) training requirements; and

(7) duration.

(b) An advisory committee must be structured and used to advise the commissioner, the state fire marshal, or department staff. An advisory committee may not be responsible for rulemaking or policymaking.

Sec. 32.152. PERIODIC EVALUATION. The commissioner shall by rule establish a process by which the department shall periodically evaluate an advisory committee to ensure its continued necessity. The department may retain or develop committees as

1 appropriate to meet changing needs.

2 Sec. 32.153. COMPLIANCE WITH OPEN MEETINGS ACT. A
3 department advisory committee must comply with Chapter 551,
4 Government Code.

5 SECTION 2.002. Section 843.441, Insurance Code, is
6 transferred to Subchapter L, Chapter 843, Insurance Code,
7 redesignated as Section 843.410, Insurance Code, and amended to
8 read as follows:

9 Sec. 843.410 [843.441]. ASSESSMENTS. (a) To provide
10 funds for the administrative expenses of the commissioner regarding
11 rehabilitation, liquidation, supervision, conservatorship, or
12 seizure [conservation] of a [an impaired] health maintenance
13 organization in this state that is placed under supervision or in
14 conservatorship under Chapter 441 or against which a delinquency
15 proceeding is commenced under Chapter 443 and that is found by the
16 commissioner to have insufficient funds to pay the total amount of
17 health care claims and the administrative[, including] expenses
18 incurred by the commissioner regarding the rehabilitation,
19 liquidation, supervision, conservatorship, or seizure, the
20 commissioner [acting as receiver or by a special deputy receiver,
21 the committee, at the commissioner's direction,] shall assess each
22 health maintenance organization in the proportion that the gross
23 premiums of the health maintenance organization that were written
24 in this state during the preceding calendar year bear to the
25 aggregate gross premiums that were written in this state by all
26 health maintenance organizations, as found [provided to the
27 committee by the commissioner] after review of annual statements

and other reports the commissioner considers necessary.

(b) [~~(c)~~] The commissioner may abate or defer an assessment in whole or in part if, in the opinion of the commissioner, payment of the assessment would endanger the ability of a health maintenance organization to fulfill its contractual obligations. If an assessment is abated or deferred in whole or in part, the amount of the abatement or deferral may be assessed against the remaining health maintenance organizations in a manner consistent with the calculations made by the commissioner under Subsection (a) [~~basis for assessments provided by the approved plan of operation~~].

(c) [~~(d)~~] The total of all assessments on a health maintenance organization may not exceed one-fourth of one percent of the health maintenance organization's gross premiums in any one calendar year.

(d) [~~(e)~~] Notwithstanding any other provision of this subchapter, funds derived from an assessment made under this section may not be used for more than 180 consecutive days for the expenses of administering the affairs of a [~~an impaired~~] health maintenance organization the surplus of which is impaired and that is [~~while~~] in supervision[~~, rehabilitation,~~] or conservatorship [~~conservation for more than 150 days~~]. The commissioner [~~committee~~] may extend the period during which the commissioner [~~it~~] makes assessments for the administrative expenses [~~of an impaired health maintenance organization as it considers appropriate~~].

SECTION 2.003. Section 1660.004, Insurance Code, is amended to read as follows:

Sec. 1660.004. GENERAL RULEMAKING. The commissioner may adopt rules as necessary to implement this chapter[~~, including rules requiring the implementation and provision of the technology recommended by the advisory committee~~].

SECTION 2.004. Section 1660.102(b), Insurance Code, is amended to read as follows:

(b) The commissioner may consider [~~the~~] recommendations [~~of the advisory committee~~] or any <u>other</u> information provided in response to a department-issued request for information relating to electronic data exchange, including identification card programs, before adopting rules regarding:

(1) information to be included on the identification cards;

(2) technology to be used to implement the identification card pilot program; and

(3) confidentiality and accuracy of the information required to be included on the identification cards.

SECTION 2.005. Section 4001.009(a), Insurance Code, is amended to read as follows:

(a) As referenced in Section 4001.003(9), a reference to an agent in the following laws includes a subagent without regard to whether a subagent is specifically mentioned:

(1) Chapters 281, 402, 421-423, 441, 444, 461-463, [~~523,~~] 541-556, 558, 559, [~~702,~~] 703, 705, 821, 823-825, 827, 828, 844, 963, 1108, <u>1205-1208</u> [~~1205-1209~~], <u>1211, 1213, 1214</u> [~~1211-1214~~], 1352, 1353, 1357, 1358, 1360-1363, 1369, 1453-1455, 1503, 1550, 1801, 1803, 2151-2154, 2201-2203, 2205-2213, 3501,

3502, 4007, 4102, and 4201-4203;

(2) Chapter 403, excluding Section 403.002;

(3) Subchapter A, Chapter 491;

(4) Subchapter C, Chapter 521;

(5) Subchapter A, Chapter 557;

(6) Subchapter B, Chapter 805;

(7) Subchapters D, E, and F, Chapter 982;

(8) Subchapter D, Chapter 1103;

(9) Subchapters B, C, D, and E, Chapter 1204, excluding Sections 1204.153 and 1204.154;

(10) Subchapter B, Chapter 1366;

(11) Subchapters B, C, and D, Chapter 1367, excluding Section 1367.053(c);

(12) Subchapters A, C, D, E, F, H, and I, Chapter 1451;

(13) Subchapter B, Chapter 1452;

(14) Sections 551.004, 841.303, 982.001, 982.002, 982.004, 982.052, 982.102, 982.103, 982.104, 982.106, 982.107, 982.108, 982.110, 982.111, 982.112, and 1802.001; and

(15) Chapter 107, Occupations Code.

SECTION 2.006. Section 4102.005, Insurance Code, is amended to read as follows:

Sec. 4102.005. CODE OF ETHICS. The commissioner[~~, with guidance from the public insurance adjusters examination advisory committee,~~] by rule shall adopt:

(1) a code of ethics for public insurance adjusters that fosters the education of public insurance adjusters concerning the ethical, legal, and business principles that should govern

their conduct;

(2) recommendations regarding the solicitation of the adjustment of losses by public insurance adjusters; and

(3) any other principles of conduct or procedures that the commissioner considers necessary and reasonable.

SECTION 2.007. Section 2154.052(a), Occupations Code, is amended to read as follows:

(a) The commissioner:

(1) shall administer this chapter through the state fire marshal; and

(2) may issue rules to administer this chapter [~~in compliance with Section 2154.054~~].

SECTION 2.008. The following laws are repealed:

(1) Article 3.70-3D(d), Insurance Code, as effective on appropriation in accordance with Section 5, Chapter 1457 (H.B. 3021), Acts of the 76th Legislature, Regular Session, 1999;

(2) Chapter 523, Insurance Code;

(3) Section 524.061, Insurance Code;

(4) the heading to Subchapter M, Chapter 843, Insurance Code;

(5) Sections 843.435, 843.436, 843.437, 843.438, 843.439, and 843.440, Insurance Code;

(6) Chapter 1212, Insurance Code;

(7) Section 1660.002(2), Insurance Code;

(8) Subchapter B, Chapter 1660, Insurance Code;

(9) Section 1660.101(c), Insurance Code;

(10) Sections 4002.004, 4004.002, 4101.006, and

4102.059, Insurance Code;

(11) Sections 4201.003(c) and (d), Insurance Code;

(12) Subchapter C, Chapter 6001, Insurance Code;

(13) Subchapter C, Chapter 6002, Insurance Code;

(14) Subchapter C, Chapter 6003, Insurance Code;

(15) Section 2154.054, Occupations Code; and

(16) Section 2154.055(c), Occupations Code.

SECTION 2.009. (a) The following boards, committees, councils, and task forces are abolished on the effective date of this Act:

(1) the consumer assistance program for health maintenance organizations advisory committee;

(2) the executive committee of the market assistance program for residential property insurance;

(3) the TexLink to Health Coverage Program task force;

(4) the health maintenance organization solvency surveillance committee;

(5) the technical advisory committee on claims processing;

(6) the technical advisory committee on electronic data exchange;

(7) the examination of license applicants advisory board;

(8) the advisory council on continuing education for insurance agents;

(9) the insurance adjusters examination advisory board;

1 (10) the public insurance adjusters examination
2 advisory committee;
3 (11) the utilization review agents advisory
4 committee;
5 (12) the fire extinguisher advisory council;
6 (13) the fire detection and alarm devices advisory
7 council;
8 (14) the fire protection advisory council; and
9 (15) the fireworks advisory council.
10 (b) All powers, duties, obligations, rights, contracts,
11 funds, records, and real or personal property of a board,
12 committee, council, or task force listed under Subsection (a) of
13 this section shall be transferred to the Texas Department of
14 Insurance not later than February 28, 2012.
15 SECTION 2.010. The changes in law made by this Act by
16 repealing Sections 523.003 and 843.439, Insurance Code, apply only
17 to a cause of action that accrues on or after the effective date of
18 this Act. A cause of action that accrues before the effective date
19 of this Act is governed by the law in effect immediately before that
20 date, and that law is continued in effect for that purpose.
21 ARTICLE 3. RATE REGULATION
22 SECTION 3.001. Subchapter F, Chapter 843, Insurance Code,
23 is amended by adding Section 843.2071 to read as follows:
24 Sec. 843.2071. NOTICE OF INCREASE IN CHARGE FOR COVERAGE.
25 (a) Not less than 60 days before the date on which an increase in a
26 charge for coverage under this chapter takes effect, a health
27 maintenance organization shall:

1 (1) give to each enrollee under an individual evidence
2 of coverage written notice of the effective date of the increase;
3 and
4 (2) provide the enrollee a table that clearly lists:
5 (A) the actual dollar amount of the charge for
6 coverage on the date of the notice;
7 (B) the actual dollar amount of the charge for
8 coverage after the charge increase; and
9 (C) the percentage change between the amounts
10 described by Paragraphs (A) and (B).
11 (b) The notice required by this section must be based on
12 coverage in effect on the date of the notice.
13 (c) This section may not be construed to prevent a health
14 maintenance organization, at the request of an enrollee, from
15 negotiating a change in benefits or rates after delivery of the
16 notice required by this section.
17 (d) A health maintenance organization may not require an
18 enrollee entitled to notice under this section to respond to the
19 health maintenance organization to renew the coverage or take other
20 action relating to the renewal or extension of the coverage before
21 the 45th day after the date the notice described by Subsection (a)
22 is given.
23 (e) The notice required by this section must include:
24 (1) contact information for the department, including
25 information concerning how to file a complaint with the department;
26 (2) contact information for the Texas Consumer Health
27 Assistance Program, including information concerning how to

1 request from the program consumer protection information or
2 assistance with filing a complaint; and
3 (3) the addresses of Internet websites that provide
4 consumer information related to rate increase justifications,
5 including the websites of the department and the United States
6 Department of Health and Human Services.
7 SECTION 3.002. Subchapter C, Chapter 1201, Insurance Code,
8 is amended by adding Section 1201.109 to read as follows:
9 Sec. 1201.109. NOTICE OF RATE INCREASE. (a) Not less than
10 60 days before the date on which a premium rate increase takes
11 effect on an individual accident and health insurance policy
12 delivered or issued for delivery in this state by an insurer, the
13 insurer shall:
14 (1) give written notice to the insured of the
15 effective date of the increase; and
16 (2) provide the insured a table that clearly lists:
17 (A) the actual dollar amount of the premium on
18 the date of the notice;
19 (B) the actual dollar amount of the premium after
20 the premium rate increase; and
21 (C) the percentage change between the amounts
22 described by Paragraphs (A) and (B).
23 (b) The notice required by this section must be based on
24 coverage in effect on the date of the notice.
25 (c) This section may not be construed to prevent an insurer,
26 at the request of an insured, from negotiating a change in benefits
27 or rates after delivery of the notice required by this section.

(d) An insurer may not require an insured entitled to notice under this section to respond to the insurer to renew the policy or take other action relating to the renewal or extension of the policy before the 45th day after the date the notice described by Subsection (a) is given.

(e) The notice required by this section must include:

(1) contact information for the department, including information concerning how to file a complaint with the department;

(2) contact information for the Texas Consumer Health Assistance Program, including information concerning how to request from the program consumer protection information or assistance with filing a complaint; and

(3) the addresses of Internet websites that provide consumer information related to rate increase justifications, including the websites of the department and the United States Department of Health and Human Services.

SECTION 3.003. Subchapter E, Chapter 1501, Insurance Code, is amended by adding Section 1501.216 to read as follows:

Sec. 1501.216. PREMIUM RATES: NOTICE OF INCREASE. (a) Not less than 60 days before the date on which a premium rate increase takes effect on a small employer health benefit plan delivered or issued for delivery in this state by an insurer, the insurer shall:

(1) give written notice to the small employer of the effective date of the increase; and

(2) provide the small employer a table that clearly lists:

(A) the actual dollar amount of the premium on

1 the date of the notice;
2 (B) the actual dollar amount of the premium after
3 the premium rate increase; and
4 (C) the percentage change between the amounts
5 described by Paragraphs (A) and (B).
6 (b) The notice required by this section must be based on
7 coverage in effect on the date of the notice.
8 (c) This section may not be construed to prevent an insurer,
9 at the request of a small employer, from negotiating a change in
10 benefits or rates after delivery of the notice required by this
11 section.
12 (d) An insurer may not require a small employer entitled to
13 notice under this section to respond to the insurer to renew the
14 policy or take other action relating to the renewal or extension of
15 the policy before the 45th day after the date the notice described
16 by Subsection (a) is given.
17 (e) The notice required by this section must include:
18 (1) contact information for the department, including
19 information concerning how to file a complaint with the department;
20 (2) contact information for the Texas Consumer Health
21 Assistance Program, including information concerning how to
22 request from the program consumer protection information or
23 assistance with filing a complaint; and
24 (3) the addresses of Internet websites that provide
25 consumer information related to rate increase justifications,
26 including the websites of the department and the United States
27 Department of Health and Human Services.

SECTION 3.004. Section 2251.002(8), Insurance Code, is amended to read as follows:

(8) "Supporting information" means:

(A) the experience and judgment of the filer and the experience or information of other insurers or advisory organizations on which the filer relied;

(B) the interpretation of any other information on which the filer relied;

(C) a description of methods used in making a rate; and

(D) any other information the department receives from a filer as a response to a request under Section 38.001 [~~requires to be filed~~].

SECTION 3.005. Section 2251.101, Insurance Code, is amended to read as follows:

Sec. 2251.101. RATE FILINGS AND SUPPORTING INFORMATION. (a) Except as provided by Subchapter D, for risks written in this state, each insurer shall file with the commissioner all rates, applicable rating manuals, supplementary rating information, and additional information as required by the commissioner. An insurer may use a rate filed under this subchapter on and after the date the rate is filed.

(b) The commissioner by rule shall:

(1) determine the information required to be included in the filing, including:

(A) [~~(1)~~] categories of supporting information and supplementary rating information;

1 (B) [(2)] statistics or other information to
2 support the rates to be used by the insurer, including information
3 necessary to evidence that the computation of the rate does not
4 include disallowed expenses; and
5 (C) [(3)] information concerning policy fees,
6 service fees, and other fees that are charged or collected by the
7 insurer under Section 550.001 or 4005.003; and
8 (2) prescribe the process through which the department
9 requests supplementary rating information and supporting
10 information under this section, including:
11 (A) the number of times the department may make a
12 request for information; and
13 (B) the types of information the department may
14 request when reviewing a rate filing.
15 SECTION 3.006. Section 2251.103, Insurance Code, is amended
16 to read as follows:
17 Sec. 2251.103. COMMISSIONER ACTION CONCERNING [DISAPPROVAL
18 OF RATE IN] RATE FILING NOT YET IN EFFECT; HEARING AND ANALYSIS.
19 (a) Not later than the earlier of the date the rate takes effect or
20 the 30th day after the date a rate is filed with the department
21 under Section 2251.101, the [The] commissioner shall disapprove the
22 [a] rate if the commissioner determines that the rate [filing made
23 under this chapter] does not comply with the requirements of this
24 chapter [meet the standards established under Subchapter B].
25 (b) Except as provided by Subsection (c), if a rate has not
26 been disapproved by the commissioner before the expiration of the
27 30-day period described by Subsection (a), the rate is not

1 considered disapproved under this section.
2 (c) For good cause, the commissioner may, on the expiration
3 of the 30-day period described by Subsection (a), extend the period
4 for disapproval of a rate for one additional 30-day period. The
5 commissioner and the insurer may not by agreement extend the 30-day
6 period described by Subsection (a) or this subsection.
7 (d) If the commissioner disapproves a rate under this
8 section [filing], the commissioner shall issue an order specifying
9 in what respects the rate [filing] fails to meet the requirements of
10 this chapter.
11 (e) An insurer that files a rate that is disapproved under
12 this section [(c) The filer] is entitled to a hearing on written
13 request made to the commissioner not later than the 30th day after
14 the date the order disapproving the rate [filing] takes effect.
15 (f) The department shall track, compile, and routinely
16 analyze the factors that contribute to the disapproval of rates
17 under this section.
18 SECTION 3.007. Subchapter C, Chapter 2251, Insurance Code,
19 is amended by adding Section 2251.1031 to read as follows:
20 Sec. 2251.1031. REQUESTS FOR ADDITIONAL INFORMATION.
21 (a) If the department determines that the information filed by an
22 insurer under this subchapter or Subchapter D is incomplete or
23 otherwise deficient, the department may request additional
24 information from the insurer.
25 (b) If the department requests additional information from
26 the insurer during the 30-day period described by Section
27 2251.103(a) or 2251.153(a) or under a second 30-day period

described by Section 2251.103(c) or 2251.153(c), as applicable, the time between the date the department submits the request to the insurer and the date the department receives the information requested is not included in the computation of the first 30-day period or the second 30-day period, as applicable.

(c) For purposes of this section, the date of the department's submission of a request for additional information is the earlier of:

(1) the date of the department's electronic mailing or documented telephone call relating to the request for additional information; or

(2) the postmarked date on the department's letter relating to the request for additional information.

(d) The department shall track, compile, and routinely analyze the volume and content of requests for additional information made under this section to ensure that all requests for additional information are fair and reasonable.

SECTION 3.008. The heading to Section 2251.104, Insurance Code, is amended to read as follows:

Sec. 2251.104. COMMISSIONER DISAPPROVAL OF RATE IN EFFECT; HEARING.

SECTION 3.009. Section 2251.107, Insurance Code, is amended to read as follows:

Sec. 2251.107. PUBLIC [~~INSPECTION OF~~] INFORMATION. Each filing made, and any supporting information filed, under this chapter is public information subject to Chapter 552, Government Code, including any applicable exception from required disclosure

1 under that chapter [~~open to public inspection as of the date of the~~
2 ~~filing~~].
3 SECTION 3.010. Section 2251.151, Insurance Code, is amended
4 by adding Subsections (c-1) and (f) and amending Subsection (e) to
5 read as follows:
6 (c-1) If the commissioner requires an insurer to file the
7 insurer's rates under this section, the commissioner shall
8 periodically assess whether the conditions described by Subsection
9 (a) continue to exist. If the commissioner determines that the
10 conditions no longer exist, the commissioner shall issue an order
11 excusing the insurer from filing the insurer's rates under this
12 section.
13 (e) If the commissioner requires an insurer to file the
14 insurer's rates under this section, the commissioner shall issue an
15 order specifying the commissioner's reasons for requiring the rate
16 filing and explaining any steps the insurer must take and any
17 conditions the insurer must meet in order to be excused from filing
18 the insurer's rates under this section. An affected insurer is
19 entitled to a hearing on written request made to the commissioner
20 not later than the 30th day after the date the order is issued.
21 (f) The commissioner by rule shall define:
22 (1) the financial conditions and rating practices that
23 may subject an insurer to this section under Subsection (a)(1); and
24 (2) the process by which the commissioner determines
25 that a statewide insurance emergency exists under Subsection
26 (a)(2).
27 SECTION 3.011. Section 2251.156, Insurance Code, is amended

1 to read as follows:

2 Sec. 2251.156. RATE FILING DISAPPROVAL BY COMMISSIONER;
3 HEARING. (a) If the commissioner disapproves a rate filing under
4 Section 2251.153(a)(2), the commissioner shall issue an order
5 disapproving the filing in accordance with Section 2251.103(d)
6 [2251.103(b)].

7 (b) An insurer whose rate filing is disapproved is entitled
8 to a hearing in accordance with Section 2251.103(e) [2251.103(c)].

9 (c) The department shall track precedents related to
10 disapprovals of rates under this subchapter to ensure uniform
11 application of rate standards by the department.

12 SECTION 3.012. Section 2254.003(a), Insurance Code, is
13 amended to read as follows:

14 (a) This section applies to a rate for personal automobile
15 insurance or residential property insurance filed on or after the
16 effective date of Chapter 206, Acts of the 78th Legislature,
17 Regular Session, 2003.

18 SECTION 3.013. Section 2251.154, Insurance Code, is
19 repealed.

20 SECTION 3.014. Sections 843.2071, 1201.109, and 1501.216,
21 Insurance Code, as added by this Act, apply only to a health
22 maintenance organization individual evidence of coverage, an
23 individual accident and health insurance policy, or a small
24 employer health benefit plan that is delivered, issued for
25 delivery, or renewed on or after the effective date of this Act. An
26 evidence of coverage, policy, or plan delivered, issued for
27 delivery, or renewed before the effective date of this Act is

1 governed by the law as it existed immediately before the effective
2 date of this Act, and that law is continued in effect for that
3 purpose.

4 SECTION 3.015. Sections 2251.002(8) and 2251.107,
5 Insurance Code, as amended by this Act, apply only to a request to
6 inspect information or to obtain public information made to the
7 Texas Department of Insurance on or after the effective date of this
8 Act. A request made before the effective date of this Act is
9 governed by the law in effect immediately before the effective date
10 of this Act, and the former law is continued in effect for that
11 purpose.

12 SECTION 3.016. Section 2251.103, Insurance Code, as amended
13 by this Act, and Section 2251.1031, Insurance Code, as added by this
14 Act, apply only to a rate filing made on or after the effective date
15 of this Act. A rate filing made before the effective date of this
16 Act is governed by the law in effect at the time the filing was made,
17 and that law is continued in effect for that purpose.

18 SECTION 3.017. Section 2251.151(c-1), Insurance Code, as
19 added by this Act, applies to an insurer that is required to file
20 the insurer's rates for approval under Section 2251.151, Insurance
21 Code, on or after the effective date of this Act, regardless of when
22 the order requiring the insurer to file the insurer's rates for
23 approval under that section is first issued.

24 SECTION 3.018. Section 2251.151(e), Insurance Code, as
25 amended by this Act, applies only to an order issued by the
26 commissioner of insurance on or after the effective date of this
27 Act. An order of the commissioner issued before the effective date

1 of this Act is governed by the law in effect on the date the order
2 was issued, and that law is continued in effect for that purpose.

3 ARTICLE 4. STATE FIRE MARSHAL'S OFFICE

4 SECTION 4.001. Section 417.008, Government Code, is amended
5 by adding Subsection (f) to read as follows:
6 (f) The commissioner by rule shall prescribe a reasonable
7 fee for an inspection performed by the state fire marshal that may
8 be charged to a property owner or occupant who requests the
9 inspection, as the commissioner considers appropriate. In
10 prescribing the fee, the commissioner shall consider the overall
11 cost to the state fire marshal to perform the inspections,
12 including the approximate amount of time the staff of the state fire
13 marshal needs to perform an inspection, travel costs, and other
14 expenses.
15 SECTION 4.002. Section 417.0081, Government Code, is
16 amended to read as follows:
17 Sec. 417.0081. INSPECTION OF CERTAIN STATE-OWNED OR
18 STATE-LEASED BUILDINGS. (a) The state fire marshal, at the
19 commissioner's direction, shall periodically inspect public
20 buildings under the charge and control of the Texas Facilities
21 [General Services] Commission and buildings leased for the use of a
22 state agency by the Texas Facilities Commission.
23 (b) For the purpose of determining a schedule for conducting
24 inspections under this section, the commissioner by rule shall
25 adopt guidelines for assigning potential fire safety risk to
26 state-owned and state-leased buildings. Rules adopted under this
27 subsection must provide for the inspection of each state-owned and

state-leased building to which this section applies, regardless of how low the potential fire safety risk of the building may be.

(c) On or before January 1 of each year, the state fire marshal shall report to the governor, lieutenant governor, speaker of the house of representatives, and appropriate standing committees of the legislature regarding the state fire marshal's findings in conducting inspections under this section.

SECTION 4.003. Section 417.0082, Government Code, is amended to read as follows:

Sec. 417.0082. PROTECTION OF CERTAIN STATE-OWNED OR STATE-LEASED BUILDINGS AGAINST FIRE HAZARDS. (a) The state fire marshal, under the direction of the commissioner, shall take any action necessary to protect a public building under the charge and control of the Texas Facilities [Building and Procurement] Commission, and the building's occupants, and the occupants of a building leased for the use of a state agency by the Texas Facilities Commission, against an existing or threatened fire hazard. The state fire marshal and the Texas Facilities [Building and Procurement] Commission shall include the State Office of Risk Management in all communication concerning fire hazards.

(b) The commissioner, the Texas Facilities [Building and Procurement] Commission, and the risk management board shall make and each adopt by rule a memorandum of understanding that coordinates the agency's duties under this section.

SECTION 4.004. Section 417.010, Government Code, is amended to read as follows:

Sec. 417.010. DISCIPLINARY AND ENFORCEMENT ACTIONS;

1 ADMINISTRATIVE PENALTIES [ALTERNATE REMEDIES]. (a) This section
2 applies to each person and firm licensed, registered, or otherwise
3 regulated by the department through the state fire marshal,
4 including:
5 (1) a person regulated under Title 20, Insurance Code;
6 and
7 (2) a person licensed under Chapter 2154, Occupations
8 Code.
9 (b) The commissioner by rule shall delegate to the state
10 fire marshal the authority to take disciplinary and enforcement
11 actions, including the imposition of administrative penalties in
12 accordance with this section on a person regulated under a law
13 listed under Subsection (a) who violates that law or a rule or order
14 adopted under that law. In the rules adopted under this subsection,
15 the commissioner shall:
16 (1) specify which types of disciplinary and
17 enforcement actions are delegated to the state fire marshal; and
18 (2) outline the process through which the state fire
19 marshal may, subject to Subsection (e), impose administrative
20 penalties or take other disciplinary and enforcement actions.
21 (c) The commissioner by rule shall adopt a schedule of
22 administrative penalties for violations subject to a penalty under
23 this section to ensure that the amount of an administrative penalty
24 imposed is appropriate to the violation. The department shall
25 provide the administrative penalty schedule to the public on
26 request. The amount of an administrative penalty imposed under
27 this section must be based on:

1 (1) the seriousness of the violation, including:
2 (A) the nature, circumstances, extent, and
3 gravity of the violation; and
4 (B) the hazard or potential hazard created to the
5 health, safety, or economic welfare of the public;
6 (2) the economic harm to the public interest or public
7 confidence caused by the violation;
8 (3) the history of previous violations;
9 (4) the amount necessary to deter a future violation;
10 (5) efforts to correct the violation;
11 (6) whether the violation was intentional; and
12 (7) any other matter that justice may require.
13 (d) In [The state fire marshal, in] the enforcement of a law
14 that is enforced by or through the state fire marshal, the state
15 fire marshal may, in lieu of cancelling, revoking, or suspending a
16 license or certificate of registration, impose on the holder of the
17 license or certificate of registration an order directing the
18 holder to do one or more of the following:
19 (1) cease and desist from a specified activity;
20 (2) pay an administrative penalty imposed under this
21 section [remit to the commissioner within a specified time a
22 monetary forfeiture not to exceed $10,000 for each violation of an
23 applicable law or rule]; or [and]
24 (3) make restitution to a person harmed by the holder's
25 violation of an applicable law or rule.
26 (e) The state fire marshal shall impose an administrative
27 penalty under this section in the manner prescribed for imposition

1 of an administrative penalty under Subchapter B, Chapter 84,
2 Insurance Code. The state fire marshal may impose an
3 administrative penalty under this section without referring the
4 violation to the department for commissioner action.
5 (f) An affected person may dispute the imposition of the
6 penalty or the amount of the penalty imposed in the manner
7 prescribed by Subchapter C, Chapter 84, Insurance Code. Failure to
8 pay an administrative penalty imposed under this section is subject
9 to enforcement by the department.
10 ARTICLE 5. TITLE INSURANCE
11 SECTION 5.001. Chapter 2501, Insurance Code, is amended by
12 adding Section 2501.009 to read as follows:
13 Sec. 2501.009. GIFTS, GRANTS, AND DONATIONS FOR EDUCATIONAL
14 PURPOSES. (a) The department may accept gifts, grants, and
15 donations to enable employees of the department to participate in
16 educational events, and for other educational purposes, related to
17 title insurance.
18 (b) The commissioner may adopt rules related to the
19 acceptance of gifts, grants, and donations described in Subsection
20 (a).
21 SECTION 5.002. Section 2502.055(a), Insurance Code, is
22 amended to read as follows:
23 (a) The activities described in this section are not
24 rebates. Nothing in this subchapter prohibits a title insurance
25 company or a title insurance agent from:
26 (1) engaging in [~~legal~~] promotional and educational
27 activities that are not conditioned on the referral of title

insurance business and not prohibited by Subchapter B, Chapter 541;

(2) purchasing advertising promoting the title insurance company or the title insurance agent at market rates from any person in any publication, event, or media;

(3) delivering to a party in the transaction or the party's representative legal documents or funds which are directly or indirectly related to a transaction closed by the title insurance company or title insurance agent; [~~or~~]

(4) participating in an association of attorneys, builders, developers, realtors, or other real estate practitioners provided that the level of such participation does not exceed normal participation of a volunteer member of the association and is not activity that would ordinarily be performed by paid staff of an association; or

(5) providing continuing education courses at market rates, regardless of whether participants receive credit hours.

SECTION 5.003. Section 2551.302, Insurance Code, is amended to read as follows:

Sec. 2551.302. REQUIREMENTS FOR REINSURING POLICIES. A title insurance company may reinsure any of its policies and contracts issued on real property located in this state or on policies and contracts issued in this state under Chapter 2751, if:

(1) the reinsuring title insurance company is authorized to engage in business in this state under this title; or [~~and~~]

(2) the title insurance company acquires reinsurance in accordance with Section 2551.305 [~~the department first approves~~

~~the form of the reinsurance contract~~].

SECTION 5.004. Section 2551.305, Insurance Code, is amended to read as follows:

Sec. 2551.305. CERTAIN REINSURANCE ALLOWED. (a) Notwithstanding any other provision of this subchapter, a title insurance company may acquire reinsurance on an individual policy or facultative basis from a title insurance company not authorized to engage in the business of title insurance in this state if:

(1) the title insurance company from which the reinsurance is acquired:

(A) has a combined capital and surplus of at least $20 million as stated in the company's most recent annual statement preceding the acceptance of reinsurance; and

(B) is domiciled in another state and is authorized to engage in the business of title insurance in one or more states; and

(2) the title insurance company acquiring reinsurance gives written notice to the department at least 30 days before acquiring the reinsurance, and the commissioner does not, before the expiration of the 30-day period and on the ground that the transaction may result in a hazardous financial condition, prohibit the title insurance company from obtaining reinsurance under this section.

(b) The notice required under Subsection (a)(2) must provide sufficient information to enable the commissioner to evaluate the proposed transaction, including a summary of the

1 significant terms of the reinsurance, the financial impact of the
2 transaction on the title insurance company acquiring reinsurance,
3 and the specific identity and state of domicile of each title
4 insurance company from which reinsurance is acquired.
5 (c) Notwithstanding any other provision of this subchapter,
6 the department may, on application and hearing, permit a title
7 insurance company to acquire reinsurance that does not comply with
8 Subsection (a) on an individual policy or facultative basis from a
9 title insurance company domiciled in another state and not
10 authorized to engage in the business of title insurance in this
11 state, if:
12 (1) the company has exhausted the opportunity to
13 acquire reinsurance from all other authorized title insurance
14 companies; and
15 (2) the title insurance company from which the
16 reinsurance is acquired has a combined capital and surplus of at
17 least $2 [~~$1.4~~] million as stated in its annual statement preceding
18 the acceptance of reinsurance.
19 (d) [~~(b)~~] Notwithstanding any other provision of this
20 subchapter, the department may, on application and hearing, permit
21 a title insurance company, including an authorized reinsuring title
22 insurance company, to retain an additional potential liability of
23 not more than 40 percent of the company's capital stock and surplus
24 as stated in the most recent annual statement of the company, if:
25 (1) the company has exhausted the opportunity to
26 acquire reinsurance under Subsection (c) [~~(a)~~]; and
27 (2) the additional potential liability of the company

1 is incurred only if the loss suffered by the insured under the
2 policy exceeds the amount of insurance and reinsurance accepted by
3 the company and its reinsuring title insurance companies under the
4 other provisions of this subchapter.

5 SECTION 5.005. Section 2651.007, Insurance Code, is amended
6 by adding Subsections (d), (e), (f), and (g) to read as follows:

7 (d) Not later than the 20th business day after the date the
8 department receives a renewal application, the department shall
9 notify the applicant in writing of any deficiencies in the
10 application that render the renewal application incomplete.

11 (e) Not later than the fifth business day after the date the
12 renewal application is complete, the department shall notify the
13 applicant in writing of the date that the renewal application is
14 complete.

15 (f) A renewal application is automatically approved on the
16 30th business day after the date the renewal application is
17 complete, unless on or before that date the department notifies the
18 applicant in writing of the factual grounds on which the department
19 proposes to deny the license under Section 2651.301.

20 (g) The department may provide a notice required under this
21 section by e-mail.

22 SECTION 5.006. Section 2651.009, Insurance Code, is amended
23 by amending Subsection (c) and adding Subsections (c-1), (c-2), and
24 (c-3) to read as follows:

25 (c) Not later than the 20th business day after the date the
26 department receives a notice under Subsection (b), the department
27 shall notify the title insurance agent and appointing title

1 insurance company in writing of any deficiencies in the notice that
2 render the notice incomplete. A notice under Subsection (b) is
3 considered complete on the date the department receives the notice,
4 unless the department provides notice of the deficiencies under
5 this section.

6 (c-1) Not later than the fifth business day after the date
7 the notice under Subsection (b) is complete, the department shall
8 notify the title insurance agent and appointing title insurance
9 company in writing of the date that the notice under Subsection (b)
10 is complete.

11 (c-2) The appointment is effective on the eighth business
12 day following the date [the department receives] the [completed]
13 notice of appointment is complete and the department receives the
14 fee, unless the department proposes to reject [rejects] the
15 appointment. If the department proposes to reject [rejects] the
16 appointment, the department shall notify the title insurance agent
17 and the appointing title insurance company [state] in writing of
18 the factual grounds on which the department proposes to reject the
19 appointment [reasons for rejection] not later than the seventh
20 business day after the date on which the [department receives the
21 completed] notice of appointment is complete.

22 (c-3) The department may provide a notice required under
23 this section by e-mail.

24 SECTION 5.007. Subchapter G, Chapter 2651, Insurance Code,
25 is amended by adding Sections 2651.3015 and 2651.303 to read as
26 follows:

27 Sec. 2651.3015. PROHIBITED GROUNDS FOR REJECTION, DELAY, OR

1 DENIAL. (a) Except as provided by Subsection (b) or (c), the
2 department may not reject, delay, or deny a notice of appointment
3 under Section 2651.009 based wholly or partly on a pending
4 department audit or complaint investigation or a pending
5 disciplinary action against a title insurance agent or appointing
6 title insurance company that has not been finally closed or
7 resolved by a final order issued by the commissioner on or before
8 the date on which the notice is received by the department.
9 (b) The department may reject a notice of appointment under
10 Section 2651.009 if the department determines that the appointing
11 title insurance company or the title insurance agent intentionally
12 made a material misstatement in the notice of appointment or
13 attempted to have the appointment approved by fraud or
14 misrepresentation.
15 (c) The department may delay approval of a notice of
16 appointment if:
17 (1) the title insurance agent or the appointing title
18 insurance company is the subject of a criminal investigation or
19 prosecution; or
20 (2) the deputy commissioner of the title division of
21 the department makes a good faith determination that there is a
22 credible suspicion that there are ongoing or continuing acts of
23 fraud by the title insurance agent or appointing title insurance
24 company.
25 (d) Except as provided by Subsection (e) or (f), the
26 department may not delay or deny a renewal application under
27 Section 2651.007 based wholly or partly on a department audit or

complaint investigation of, or disciplinary or enforcement action against, an applicant or license holder that is pending and has not been finally closed or resolved by a final order issued by the commissioner on or before the date on which the application is filed.

(e) The department may deny a renewal application under Section 2651.007 if the department determines that the applicant or license holder intentionally made a material misstatement in the renewal application or attempted to obtain the license renewal by fraud or misrepresentation.

(f) The department may delay a renewal application if:

(1) the applicant or license holder is the subject of a criminal investigation or prosecution; or

(2) the deputy commissioner of the title division of the department makes a good faith determination that there is a credible suspicion that there are ongoing or continuing acts of fraud by the applicant or license holder.

Sec. 2651.303. NOTICE OF DISCIPLINARY OR ENFORCEMENT ACTION; AUTOMATIC DISMISSAL. (a) The department shall notify a license holder in writing of a disciplinary or enforcement action against the license holder not later than the 30th business day after the date the department assigns a file number to the action, except that this subsection does not apply to a file or action:

(1) that is the subject of a pending criminal investigation or prosecution; or

(2) about which the deputy commissioner of the title division of the department makes a good faith determination that

there is a credible suspicion that there are ongoing or continuing acts of fraud by a person who is the subject of the action.

(b) A notice required by Subsection (a) may be provided by e-mail and must provide a license holder fair notice of the alleged facts known by the department on the date of the notice that constitute grounds for the action.

(c) A disciplinary or enforcement action is automatically dismissed with prejudice, unless the department serves a notice of hearing on the license holder not later than the 60th business day after the date the department receives a hearing request from the license holder.

(d) The department may provide information about an enforcement action, including a copy of a notice issued under this section, to each title insurance company with which a title insurance agent has, or proposes to obtain, an appointment.

SECTION 5.008. Subchapter B, Chapter 2652, Insurance Code, is amended by adding Section 2652.059 to read as follows:

Sec. 2652.059. DENIAL OF LICENSE APPLICATION OR LICENSE RENEWAL; APPROVAL. (a) Not later than the 20th business day after the date the department receives a license application or a license renewal under this chapter, the department shall notify the applicant or license holder in writing of any deficiencies in the application that render the application incomplete.

(b) Not later than the fifth business day after the date the application is complete, the department shall notify the applicant or license holder in writing of the date that the license application or license renewal is complete.

(c) An application is automatically approved on the 30th business day after the date the application is complete, unless on or before that date the department notifies the applicant or license holder in writing of the factual grounds on which the department proposes to deny the application.

(d) The department may provide a notice required under this section by e-mail.

SECTION 5.009. Subchapter E, Chapter 2652, Insurance Code, is amended by adding Sections 2652.2015 and 2652.203 to read as follows:

Sec. 2652.2015. PROHIBITED GROUNDS FOR DELAY OR DENIAL. (a) Except as provided by Subsection (b) or (c), the department may not delay or deny a license application or a license renewal based wholly or partly on a department audit or complaint investigation of, or disciplinary or enforcement action against, a license holder or applicant that is pending and has not been closed or finally adjudicated on or before the date on which the initial or renewal application is filed.

(b) The department may delay a license application or license renewal if:

(1) the applicant or license holder is the subject of a criminal investigation or prosecution; or

(2) the deputy commissioner of the title division of the department makes a good faith determination that there is a credible suspicion that there are ongoing or continuing acts of fraud by the applicant or license holder.

(c) The department may deny a license application or license

1 renewal if the department determines that the applicant or license
2 holder intentionally made a material misstatement in the license
3 application or license renewal or the applicant or license holder
4 attempted to obtain the license or renewal by fraud or
5 misrepresentation.
6 Sec. 2652.203. NOTICE OF DISCIPLINARY OR ENFORCEMENT
7 ACTION; AUTOMATIC DISMISSAL. (a) The department shall notify a
8 license holder of a disciplinary action or enforcement action
9 against the license holder not later than the 30th business day
10 after the date the department assigns a file number to the action,
11 except that this subsection does not apply to a file or action:
12 (1) that is the subject of a pending criminal
13 investigation or prosecution; or
14 (2) about which the deputy commissioner of the title
15 division of the department makes a good faith determination that
16 there is a credible suspicion that there are ongoing or continuing
17 acts of fraud by a person who is the subject of the action.
18 (b) A notice required by Subsection (a) must provide a
19 license holder fair notice of the alleged facts known by the
20 department on the date of the notice that constitute grounds for the
21 action.
22 (c) A disciplinary or enforcement action is automatically
23 dismissed with prejudice, unless the department serves a notice of
24 hearing on the license holder not later than the 60th business day
25 after the date the department receives a hearing request from the
26 license holder.
27 (d) The department may provide information about an

1 enforcement action, including a copy of a notice issued under this
2 section, to each title insurance agent or direct operation with
3 which an escrow officer has, or proposes to obtain, employment.
4 SECTION 5.010. Subchapter B, Chapter 2703, Insurance Code,
5 is amended by adding Section 2703.0515 to read as follows:
6 Sec. 2703.0515. CERTAIN REQUIREMENTS PROHIBITED. (a) A
7 title insurance company is not required to offer or provide in
8 connection with a title insurance policy an endorsement insuring a
9 loss from damage resulting from the use of the surface of the land
10 for the extraction or development of coal, lignite, oil, gas, or
11 another mineral if the policy includes a general exception or
12 exclusion from coverage a loss from damage resulting from the use of
13 the surface of the land for the extraction or development of coal,
14 lignite, oil, gas, or another mineral.
15 (b) In this section, "general exception or exclusion" means
16 a provision in a title insurance policy or other title insuring form
17 that provides that title insurance coverage under the policy or
18 form:
19 (1) is subject to, and the title insurer does not
20 insure title to, and excepts from the description of the covered
21 property, coal, lignite, oil, gas, and other minerals in and under
22 and that may be produced from the covered property, together with
23 related rights, privileges, and immunities; or
24 (2) does not cover a lease, grant, exception, or
25 reservation of coal, lignite, oil, gas, or other minerals, or
26 related rights, privileges, and immunities, appearing in the public
27 records.

(c) An additional premium or other amount may not be charged for an endorsement to a loan policy of title insurance if the endorsement:

(1) insures against loss from damage to improvements or permanent buildings located on land that results from the future exercise of any right existing on the date of the loan policy to use the surface of the land for the extraction or development of coal, lignite, oil, gas, or another mineral;

(2) expressly does not insure against loss resulting from subsidence; and

(3) was promulgated by the commissioner in calendar year 2009.

SECTION 5.011. Subchapter B, Chapter 2703, Insurance Code, is amended by adding Sections 2703.055 and 2703.056 to read as follows:

Sec. 2703.055. REQUIREMENT OF CERTAIN PROVISIONS PROHIBITED. The commissioner may not require by rule, or through adoption of a title insurance policy or other insuring form, that a title insurance policy delivered or issued for delivery in this state:

(1) insure against a loss that a person with an interest in real property sustains from damage to the property by reason of severance of minerals from the surface estate; or

(2) provide insurance as to ownership of minerals.

Sec. 2703.056. EXCEPTIONS; MINERAL INTERESTS. (a) Subject to the underwriting standards of the title insurance company, a title insurance company may in a commitment for title insurance or a

1 title insurance policy include a general exception or a special
2 exception to except from coverage a mineral estate or an instrument
3 that purports to reserve or transfer all or part of a mineral
4 estate.
5 (b) The inclusion in a title insurance policy of a general
6 exception or a special exception described by Subsection (a) does
7 not create title insurance coverage as to the condition or
8 ownership of the mineral estate.
9 SECTION 5.012. Section 2703.153, Insurance Code, is amended
10 by amending Subsections (c) and (d) and adding Subsections (h) and
11 (i) to read as follows:
12 (c) Not less frequently than once every five years, the
13 commissioner shall evaluate the information required under this
14 section to determine whether the department needs additional or
15 different information or no longer needs certain information to
16 promulgate rates. If the department requires a title insurance
17 company or title insurance agent to include new or different
18 information in the statistical report, that information may be
19 considered by the commissioner in fixing premium rates if the
20 information collected is reasonably credible for the purposes for
21 which the information is to be used.
22 (d) A title insurance company or a title insurance agent
23 aggrieved by a department requirement concerning the submission of
24 information may bring a suit in a district court in Travis County
25 alleging that the request for information:
26 (1) is unduly burdensome; or
27 (2) is not a request for information material to

1 fixing and promulgating premium rates or another matter that may be
2 the subject of the periodic [~~biennial~~] hearing and is not a request
3 reasonably designed to lead to the discovery of that information.
4 (h) The contents of the statistical report, including any
5 amendments to the statistical report, must be established in a
6 rulemaking hearing under Subchapter B, Chapter 2001, Government
7 Code.
8 (i) An amendment to the contents of the statistical report
9 may not apply retroactively.
10 SECTION 5.013. Section 2703.202, Insurance Code, is amended
11 by amending Subsections (b) and (d) and adding Subsections (g),
12 (h), (i), (j), (k), (l), (m), (n), and (o) to read as follows:
13 (b) The commissioner shall order a public hearing to
14 consider changing a premium rate, including fixing a new premium
15 rate, in response to a written [~~At the~~] request of:
16 (1) a title insurance company;
17 (2) an association composed of at least 50 percent of
18 the number of title insurance agents and title insurance companies
19 licensed or authorized by the department;
20 (3) an association composed of at least 20 percent of
21 the number of title insurance agents licensed or authorized by the
22 department; or
23 (4) the office of public insurance counsel[~~, the~~
24 ~~commissioner shall order a public hearing to consider changing a~~
25 ~~premium rate~~].
26 (d) Notwithstanding Subsection (c), [~~at the request of a~~
27 ~~title insurance company or the public insurance counsel,~~] a public

hearing held under Subsection (a) or under Section 2703.206 must be conducted by the commissioner as a contested case hearing under Subchapters C through H and Subchapter Z, Chapter 2001, Government Code, at the request of:

(1) a title insurance company;

(2) an association composed of at least 50 percent of the number of title insurance agents and title insurance companies licensed or authorized by the department;

(3) an association composed of at least 20 percent of the number of title insurance agents licensed or authorized by the department; or

(4) the office of public insurance counsel.

(g) If a hearing held under Subsection (a) is not conducted as a contested case hearing, the commissioner shall render a decision and issue a final order not later than the 120th day after the date the commissioner receives a written request under Subsection (b).

(h) If a hearing held under Subsection (a) is conducted as a contested case hearing:

(1) not later than the 30th day after the date the commissioner receives a request for a public hearing under Subsection (b), the commissioner shall issue a notice of call for items to be considered at the hearing;

(2) the commissioner may not require responses to the notice of call before the 60th day after the date the commissioner issues the notice of call;

(3) the commissioner shall issue a notice of public

1 hearing requested under Subsection (d) not later than the 30th day
2 after the date responses to the notice of call are required under
3 Subdivision (2);
4 (4) the commissioner shall commence the public hearing
5 not earlier than the 120th day after the date the commissioner
6 issues a notice of hearing under Subdivision (3);
7 (5) the commissioner shall close the public hearing
8 not later than the 150th day after the date the commissioner issues
9 the notice of hearing under Subdivision (3); and
10 (6) the commissioner shall render a decision and issue
11 a final order not later than the 60th day after the record made in
12 the public hearing is closed under Subdivision (5).
13 (i) A party's presentation of relevant, admissible oral
14 testimony in a hearing under this section may not be limited.
15 (j) The commissioner shall consider each matter presented
16 in a hearing under this section and announce in a public hearing all
17 decisions on all matters considered.
18 (k) A party described by Subsection (b) may petition a
19 district court in Travis County to enter an order requiring the
20 commissioner to comply with the deadlines described by this section
21 if the commissioner fails to meet a requirement in Subsection (g) or
22 (h).
23 (l) Subject to Subsection (m), if the commissioner fails to
24 comply with the requirements under Subsection (g) or (h)(6), a
25 combination of at least three associations, persons, or entities
26 listed in Subsection (b) may jointly petition a district court of
27 Travis County to adopt a rate based on the record made in the

hearing before the commissioner under this section.

(m) If the record made in the hearing before the commissioner is not complete before the request for the court to adopt a premium rate under Subsection (l), the court shall hold an evidentiary hearing to establish a record before adopting the premium rate.

(n) After a petition has been filed under Subsection (l), the commissioner may not issue findings or an order related to the subject matter of the petition until after the date the court enters a final judgment.

(o) A district court may appoint a magistrate to adopt a rate under this section.

SECTION 5.014. Section 2703.203, Insurance Code, is amended to read as follows:

Sec. 2703.203. PERIODIC [~~BIENNIAL~~] HEARING. The commissioner shall hold a [~~biennial~~] public hearing not earlier than July 1 after the fifth anniversary of the closing of a hearing held under this chapter [~~of each even-numbered year~~] to consider adoption of premium rates and other matters relating to regulating the business of title insurance that an association, title insurance company, title insurance agent, or member of the public admitted as a party under Section 2703.204 requests to be considered or that the commissioner determines necessary to consider.

SECTION 5.015. Section 2703.204, Insurance Code, is amended to read as follows:

Sec. 2703.204. ADMISSION AS PARTY TO PERIODIC [~~BIENNIAL~~]

1 HEARING. (a) Subject to this section, a trade association whose
2 membership is composed of at least 20 percent of the members of an
3 industry or group represented by the trade association, an
4 association, a person or entity described by Section 2703.202(b),
5 or department staff [an individual or association or other entity
6 recommending adoption of a premium rate or another matter relating
7 to regulating the business of title insurance] shall be admitted as
8 a party to the periodic [biennial] hearing under Section 2703.203.
9 (b) A party to any portion of the periodic [the ratemaking
10 phase of the biennial] hearing relating to ratemaking may request
11 that the commissioner remove any other party to that portion of [the
12 ratemaking phase of] the hearing on the grounds that the other party
13 does not have a substantial interest in title insurance. A decision
14 of the commission to deny or grant the request is final and subject
15 to appeal in accordance with Section 36.202.
16 SECTION 5.016. Section 2703.207, Insurance Code, is amended
17 to read as follows:
18 Sec. 2703.207. NOTICE OF CERTAIN HEARINGS. Not later than
19 the 60th day before the date of a hearing under Section 2703.202,
20 2703.203, or 2703.206, notice of the hearing and of each item to be
21 considered at the hearing shall be:
22 (1) sent directly to all parties to the previous
23 hearing conducted under Section 2703.202, 2703.203, or 2703.206, if
24 the hearing was conducted as a contested case hearing [title
25 insurance companies and title insurance agents]; and
26 (2) published in the Texas Register and on the
27 department's Internet website [provided to the public in a manner

~~that gives fair notice concerning the hearing~~].

SECTION 5.017. Section 2551.303, Insurance Code, is repealed.

SECTION 5.018. Section 2703.205, Insurance Code, is repealed.

SECTION 5.019. Section 2703.0515, Insurance Code, as added by this article, applies only to a title insurance policy that is delivered or issued for delivery on or after January 1, 2012. A policy delivered or issued for delivery before January 1, 2012, 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 5.020. Sections 2703.055 and 2703.056, Insurance Code, as added by this article, apply only to a title insurance policy that is delivered or issued for delivery on or after January 1, 2012. A policy delivered or issued for delivery before January 1, 2012, 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 5.021. Sections 2551.302 and 2551.305, Insurance Code, as amended by this article, and the repeal of Section 2551.303, Insurance Code, by this article, apply only to a reinsurance contract entered into by a title insurance company on or after the effective date of this Act. A reinsurance contract entered into by a title insurance company before the effective date of this Act is governed by the law in effect immediately before the effective date of this Act, and the former law is continued in

effect for that purpose.

ARTICLE 6. ELECTRONIC TRANSACTIONS

SECTION 6.001. Subtitle A, Title 2, Insurance Code, is amended by adding Chapter 35 to read as follows:

CHAPTER 35. ELECTRONIC TRANSACTIONS

Sec. 35.001. DEFINITIONS. In this chapter:

(1) "Conduct business" includes engaging in or transacting any business in which a regulated entity is authorized to engage or is authorized to transact under the law of this state.

(2) "Regulated entity" means each insurer or other organization regulated by the department, including:

(A) a domestic or foreign, stock or mutual, life, health, or accident insurance company;

(B) a domestic or foreign, stock or mutual, fire or casualty insurance company;

(C) a Mexican casualty company;

(D) a domestic or foreign Lloyd's plan;

(E) a domestic or foreign reciprocal or interinsurance exchange;

(F) a domestic or foreign fraternal benefit society;

(G) a domestic or foreign title insurance company;

(H) an attorney's title insurance company;

(I) a stipulated premium company;

(J) a nonprofit legal service corporation;

(K) a health maintenance organization;

1 (L) a statewide mutual assessment company;
2 (M) a local mutual aid association;
3 (N) a local mutual burial association;
4 (O) an association exempt under Section 887.102;
5 (P) a nonprofit hospital, medical, or dental
6 service corporation, including a company subject to Chapter 842;
7 (Q) a county mutual insurance company; and
8 (R) a farm mutual insurance company.
9 Sec. 35.002. CONSTRUCTION WITH OTHER LAW.
10 (a) Notwithstanding any other provision of this code, a regulated
11 entity may conduct business electronically in accordance with this
12 chapter and the rules adopted under Section 35.004.
13 (b) To the extent of any conflict between another provision
14 of this code and a provision of this chapter, the provision of this
15 chapter controls.
16 Sec. 35.003. ELECTRONIC TRANSACTIONS AUTHORIZED. A
17 regulated entity may conduct business electronically to the same
18 extent that the entity is authorized to conduct business otherwise
19 if before the conduct of business each party to the business agrees
20 to conduct the business electronically.
21 Sec. 35.004. RULES. (a) The commissioner shall adopt
22 rules necessary to implement and enforce this chapter.
23 (b) The rules adopted by the commissioner under this section
24 must include rules that establish minimum standards with which a
25 regulated entity must comply in the entity's electronic conduct of
26 business with other regulated entities and consumers.
27 SECTION 6.002. Chapter 35, Insurance Code, as added by this

1 Act, applies only to business conducted on or after the effective
2 date of this Act. Business conducted before the effective date of
3 this Act is governed by the law in effect on the date the business
4 was conducted, and that law is continued in effect for that purpose.
5 ARTICLE 7. DATA COLLECTION
6 SECTION 7.001. Chapter 38, Insurance Code, is amended by
7 adding Subchapter I to read as follows:
8 SUBCHAPTER I. DATA COLLECTION RELATING TO
9 CERTAIN PERSONAL LINES OF INSURANCE
10 Sec. 38.401. APPLICABILITY OF SUBCHAPTER. This subchapter
11 applies only to an insurer who writes personal automobile insurance
12 or residential property insurance in this state.
13 Sec. 38.402. FILING OF CERTAIN CLAIMS INFORMATION.
14 (a) The commissioner shall require each insurer described by
15 Section 38.401 to file with the commissioner aggregate personal
16 automobile insurance and residential property insurance claims
17 information for the period covered by the filing, including the
18 number of claims:
19 (1) filed during the reporting period;
20 (2) pending on the last day of the reporting period,
21 including pending litigation;
22 (3) closed with payment during the reporting period;
23 (4) closed without payment during the reporting
24 period; and
25 (5) carrying over from the reporting period
26 immediately preceding the current reporting period.
27 (b) An insurer described by Section 38.401 must file the

1 information described by Subsection (a) on an annual basis. The
2 information filed must be broken down by quarter.
3 Sec. 38.403. PUBLIC INFORMATION. (a) The department shall
4 post the data contained in claims information filings under Section
5 38.402 on the department's Internet website. The commissioner by
6 rule may establish a procedure for posting data under this
7 subsection that includes a description of the data that must be
8 posted and the manner in which the data must be posted.
9 (b) Information provided under this section must be
10 aggregate data by line of insurance for each insurer and may not
11 reveal proprietary or trade secret information of any insurer.
12 Sec. 38.404. RULES. The commissioner may adopt rules
13 necessary to implement this subchapter.
14 ARTICLE 7A. HEALTH BENEFIT PLAN INNOVATIONS PROGRAM
15 SECTION 7A.001. Subtitle B, Title 5, Insurance Code, is
16 amended by adding Chapter 525 to read as follows:
17 CHAPTER 525. HEALTH BENEFIT PLAN INNOVATIONS PROGRAM
18 Sec. 525.001. PROGRAM ESTABLISHED. (a) The department
19 shall develop and implement a health benefit plan innovations
20 program to study the number of uninsured individuals in this state,
21 the reasons those individuals are uninsured, and possible solutions
22 that would expand access to affordable health benefit plan coverage
23 in this state.
24 (b) The department shall use department employees already
25 employed in the consumer protection division of the department to
26 implement the program. The department may not hire full-time
27 employees whose primary job functions would solely be

1 implementation of the program.
2 Sec. 525.002. PROGRAM COMPONENTS. (a) Except as provided
3 by Subsection (b), the program implemented under this chapter must:
4 (1) collect and analyze data concerning the number,
5 age, and demographic characteristics of uninsured individuals in
6 this state;
7 (2) identify the reasons why individuals in this state
8 are uninsured;
9 (3) examine and evaluate the effectiveness of programs
10 implemented in other states to reduce the number of uninsured
11 residents in those states;
12 (4) monitor and evaluate the health benefit market in
13 this state and determine whether residents of this state have
14 sufficient access to a variety of health benefit plan products to
15 ensure adequate health benefit plan coverage; and
16 (5) make recommendations to the department and to the
17 legislature concerning programs or initiatives to be implemented in
18 this state to reduce the number of uninsured residents in this
19 state.
20 (b) The program must supplement and may not duplicate a
21 service or function of another existing program or state agency and
22 shall refer consumers to other programs and agencies where
23 appropriate.
24 (c) The program may:
25 (1) operate a statewide clearinghouse for objective
26 consumer information about health care coverage, including options
27 for obtaining health care coverage;

1 (2) collect, track, and quantify problems and
2 inquiries encountered by consumers;
3 (3) educate consumers on their rights and
4 responsibilities with respect to group health plans and health
5 insurance coverages;
6 (4) provide existing health-related information to
7 the general public and health care providers to improve the quality
8 of and access to health care; and
9 (5) establish an advisory committee composed of state
10 agencies to increase collaboration and coordination of
11 health-related programs and benefits.
12 (d) The department shall coordinate program components that
13 involve market and cost research or data collection and analysis
14 with health benefit plan issuers and the Health and Human Services
15 Commission to ensure the collection and analysis of complete and
16 accurate information.
17 Sec. 525.003. REPORT. The department shall include in its
18 biennial report to the legislature under Section 32.022 the
19 program's findings concerning the information and recommendations
20 described by Section 525.002.
21 Sec. 525.004. FUNDING. The department shall make a
22 reasonable effort to obtain funding in the form of gifts and grants
23 from the federal government or an organization or other private
24 party that does not have a potential conflict of interest with the
25 department or the goals of this chapter to assist with funding the
26 program. The department shall adopt rules governing acceptance of
27 gifts and grants that are consistent with the provisions for

acceptance of gifts under Chapter 575, Government Code. Before adopting rules under this section, the department shall:

(1) submit the proposed rules to the Texas Ethics Commission for review; and

(2) consider that commission's recommendations regarding the proposed rules.

Sec. 525.005. RULES. The commissioner may adopt rules as necessary to implement this chapter.

ARTICLE 8. STUDY ON RATE FILING AND APPROVAL REQUIREMENTS FOR CERTAIN INSURERS WRITING IN UNDERSERVED AREAS; UNDERSERVED AREA DESIGNATION

SECTION 8.001. Section 2004.002, Insurance Code, is amended by amending Subsection (b) and adding Subsections (c) and (d) to read as follows:

(b) In determining which areas to designate as underserved, the commissioner shall consider:

(1) whether residential property insurance is not reasonably available to a substantial number of owners of insurable property in the area; [~~and~~]

(2) whether access to the full range of coverages and policy forms for residential property insurance does not reasonably exist; and

(3) any other relevant factor as determined by the commissioner.

(c) The commissioner shall determine which areas to designate as underserved under this section not less than once every six years.

(d) The commissioner shall conduct a study concerning the accuracy of current designations of underserved areas under this section for the purpose of increasing and improving access to insurance in those areas not less than once every six years.

SECTION 8.002. Subchapter F, Chapter 2251, Insurance Code, is amended by adding Section 2251.253 to read as follows:

Sec. 2251.253. REPORT. (a) The commissioner shall conduct a study concerning the impact of increasing the percentage of the total amount of premiums collected by insurers for residential property insurance under Section 2251.252.

(b) The commissioner shall report the results of the study in the biennial report required under Section 32.022.

(c) This section expires September 1, 2013.

ARTICLE 9. TEXAS WINDSTORM INSURANCE ASSOCIATION

SECTION 9.001. Section 83.002, Insurance Code, is amended by adding Subsection (c) to read as follows:

(c) This chapter also applies to:

(1) a person appointed as a qualified inspector under Section 2210.254 or 2210.255; and

(2) a person acting as a qualified inspector under Section 2210.254 or 2210.255 without being appointed as a qualified inspector under either of those sections.

SECTION 9.002. Section 2210.105, Insurance Code, is amended by amending Subsection (b) and adding Subsections (b-1), (e), and (f) to read as follows:

(b) Except for a closed meeting authorized by Subchapter D, Chapter 551, Government Code, a meeting of the board of directors or

of the members of the association is open to[~~:~~

[~~(1) the commissioner or the commissioner's designated representative; and~~

[~~(2)~~] the public.

(b-1) A meeting of the board of directors or the members of the association, including a closed meeting authorized by Subchapter D, Chapter 551, Government Code, is open to the commissioner or the commissioner's designated representative.

(e) The association shall:

(1) broadcast live on the association's Internet website all meetings of the board of directors, other than closed meetings; and

(2) maintain on the association's Internet website an archive of meetings of the board of directors.

(f) A recording of a meeting must be maintained in the archive required under Subsection (e) through and including the fifth anniversary of the meeting. A recording of a meeting may be maintained for a period longer than the period required by this subsection.

SECTION 9.003. Subchapter C, Chapter 2210, Insurance Code, is amended by adding Section 2210.108 to read as follows:

Sec. 2210.108. OPEN MEETINGS AND OPEN RECORDS. Except as specifically provided by this chapter or another law, the association is subject to Chapters 551 and 552, Government Code.

SECTION 9.004. Section 2210.202(b), Insurance Code, is amended to read as follows:

(b) A property and casualty agent must submit an application

1 for initial [the] insurance coverage on behalf of the applicant on
2 forms prescribed by the association. The association shall develop
3 a simplified renewal process that allows for the acceptance of an
4 application for renewal coverage, and payment of premiums, from a
5 property and casualty agent or a person insured under this chapter.
6 An [The] application for initial or renewal coverage must contain:
7 (1) a statement as to whether the applicant has
8 submitted or will submit the premium in full from personal funds or,
9 if not, to whom a balance is or will be due; and
10 (2) [. Each application for initial or renewal
11 coverage must also contain] a statement that the agent acting on
12 behalf of the applicant possesses proof of the declination
13 described by Subsection (a) and proof of flood insurance coverage
14 or unavailability of that coverage as described by Section
15 2210.203(a-1).
16 SECTION 9.005. Sections 2210.203(a) and (c), Insurance
17 Code, are amended to read as follows:
18 (a) If the association determines that the property for
19 which an application for initial insurance coverage is made is
20 insurable property, the association, on payment of the premium,
21 shall direct the issuance of an insurance policy as provided by the
22 plan of operation.
23 (c) A policy may be renewed annually on application for
24 renewal as long as the property continues to be insurable property.
25 If the association determines that the property for which an
26 application for renewal insurance coverage is made is insurable
27 property, the association shall direct the issuance of a renewal

insurance policy as provided by the plan of operation and may collect the premium for the policy directly from the applicant for renewal insurance coverage.

SECTION 9.006. Sections 2210.204(d) and (e), Insurance Code, are amended to read as follows:

(d) If an insured requests cancellation of the insurance coverage, the association shall refund the unearned premium, less any minimum retained premium set forth in the plan of operation, payable to the insured and the holder of an unpaid balance. The property and casualty agent who received a commission as the result of the issuance of an association policy providing the canceled coverage [~~submitted the application~~] shall refund the agent's commission on any unearned premium in the same manner.

(e) For cancellation of insurance coverage under this section, the minimum retained premium in the plan of operation must be for a period of not less than 90 [~~180~~] days, except for events specified in the plan of operation that reflect a significant change in the exposure or the policyholder concerning the insured property, including:

(1) the purchase of similar coverage in the voluntary market;

(2) sale of the property to an unrelated party;

(3) death of the policyholder; or

(4) total loss of the property.

SECTION 9.007. Section 2210.254, Insurance Code, is amended by adding Subsection (e) to read as follows:

(e) The department may establish an annual renewal period

1 for persons appointed as qualified inspectors.
2 SECTION 9.008. Subchapter F, Chapter 2210, Insurance Code,
3 is amended by adding Section 2210.2551 to read as follows:
4 Sec. 2210.2551. EXCLUSIVE ENFORCEMENT AUTHORITY; RULES.
5 (a) The department has exclusive authority over all matters
6 relating to the appointment and oversight of qualified inspectors
7 for purposes of this chapter.
8 (b) The commissioner by rule shall establish criteria to
9 ensure that a person seeking appointment as a qualified inspector
10 under this subchapter, including an engineer seeking appointment
11 under Section 2210.255, possesses the knowledge, understanding,
12 and professional competence to perform windstorm inspections under
13 this chapter and to comply with other requirements of this chapter.
14 (c) Subsection (b) applies only to a determination
15 concerning the appointment of a qualified inspector under this
16 chapter. The exclusive jurisdiction of the department under this
17 section does not apply to the practice of engineering as defined by
18 Section 1001.003, Occupations Code, or to a license issued,
19 qualification required, determination made, order issued, judgment
20 rendered, or other action of a board operating under Chapter 1001,
21 Occupations Code. In the event of conflict, the authority of that
22 board prevails with regard to the practice of engineering.
23 SECTION 9.009. The heading to Section 2210.256, Insurance
24 Code, is amended to read as follows:
25 Sec. 2210.256. DISCIPLINARY PROCEEDINGS REGARDING
26 APPOINTED INSPECTORS AND CERTAIN OTHER PERSONS.
27 SECTION 9.010. Section 2210.256, Insurance Code, is amended

1 by adding Subsection (a-2) to read as follows:
2 (a-2) In addition to any other action authorized under this
3 section, the commissioner ex parte may enter an emergency cease and
4 desist order under Chapter 83 against a qualified inspector, or a
5 person acting as a qualified inspector, if:
6 (1) the commissioner believes that:
7 (A) the qualified inspector has:
8 (i) through submitting or failing to submit
9 to the department sealed plans, designs, calculations, or other
10 substantiating information, failed to demonstrate that a structure
11 or a portion of a structure subject to inspection meets the
12 requirements of this chapter and department rules; or
13 (ii) refused to comply with requirements
14 imposed under this chapter or department rules; or
15 (B) the person acting as a qualified inspector is
16 acting without appointment as a qualified inspector under Section
17 2210.254 or 2210.255; and
18 (2) the commissioner determines that the conduct
19 described by Subdivision (1) is fraudulent or hazardous or creates
20 an immediate danger to the public.
21 SECTION 9.011. Section 2210.258(b), Insurance Code, is
22 amended to read as follows:
23 (b) The association may not insure a structure described by
24 Subsection (a) until:
25 (1) the structure has been inspected for compliance
26 with the plan of operation in accordance with Section 2210.251(a);
27 and

(2) except as provided by Section 2210.260, a certificate of compliance has been issued for the structure in accordance with Section 2210.251(g).

SECTION 9.012. Subchapter F, Chapter 2210, Insurance Code, is amended by adding Section 2210.260 to read as follows:

Sec. 2210.260. ALTERNATIVE ELIGIBILITY FOR COVERAGE. (a) On and after January 1, 2012, a person who has an insurable interest in a residential structure may obtain insurance coverage through the association for that structure without obtaining a certificate of compliance under Section 2210.251(g) in accordance with this section and rules adopted by the commissioner.

(b) The department may issue an alternative certification for a residential structure if the person who has an insurable interest in the structure demonstrates that at least one qualifying structural building component of the structure has been:

(1) inspected by a department inspector or by a qualified inspector; and

(2) determined to be in compliance with applicable building code standards, as set forth in the plan of operation.

(c) The commissioner shall adopt reasonable and necessary rules to implement this section. The rules adopted under this section must establish which structural building components are considered qualifying structural building components for the purposes of Subsection (b), taking into consideration those items that are most probable to generate losses for the association's policyholders and the cost to upgrade those items.

(d) Except as provided in Section 2210.251(f), a person who

has an insurable interest in a residential structure that is insured by the association as of January 1, 2012, but for which the person has not obtained a certificate of compliance under Section 2210.251(g), must obtain an alternative certification under this section before the association, on or after January 1, 2013, may renew coverage for the structure.

(e) Each residential structure for which a person obtains an alternative certification under this section must comply with:

(1) the requirements of this chapter, including Section 2210.258; and

(2) the association's underwriting requirements, including maintaining the structure in an insurable condition and paying premiums in the manner required by the association.

(f) The association shall develop and implement an actuarially sound rate, credit, or surcharge that reflects the risks presented by structures with reference to which alternative certifications have been obtained under this section. A rate, credit, or surcharge under this subsection may vary based on the number of qualifying structural building components included in a structure with reference to which an alternative certification is obtained under this section.

SECTION 9.013. This article applies only to a Texas windstorm and hail insurance policy delivered, issued for delivery, or renewed by the Texas Windstorm Insurance Association on or after the 30th day after the effective date of this Act. A Texas windstorm and hail insurance policy delivered, issued for delivery, or renewed by the Texas Windstorm Insurance Association before the

30th day after the effective date of this Act is governed by the law in effect immediately before the effective date of this Act, and the former law is continued in effect for that purpose.

SECTION 9.014. The Texas Windstorm Insurance Association shall, not later than January 1, 2012, amend the association's plan of operation as necessary to conform to the changes in law made by this article.

ARTICLE 10. ADJUSTER ADVISORY BOARD

SECTION 10.001. (a) The adjuster advisory board established under this section is composed of the following nine members appointed by the commissioner:

(1) two public insurance adjusters;

(2) two members who represent the general public;

(3) two independent adjusters;

(4) one adjuster who represents a domestic insurer authorized to engage in business in this state;

(5) one adjuster who represents a foreign insurer authorized to engage in business in this state; and

(6) one representative of the Independent Insurance Agents of Texas.

(b) A member who represents the general public may not be:

(1) an officer, director, or employee of:

(A) an adjuster or adjusting company;

(B) an insurance agent or agency;

(C) an insurance broker;

(D) an insurer; or

(E) any other business entity regulated by the

1 department;

2 (2) a person required to register as a lobbyist under
3 Chapter 305, Government Code; or

4 (3) a person related within the second degree of
5 affinity or consanguinity to a person described by Subdivision (1)
6 or (2).

7 (c) The advisory board shall make recommendations to the
8 commissioner regarding:

9 (1) matters related to the licensing, testing, and
10 continuing education of licensed adjusters;

11 (2) matters related to claims handling, catastrophic
12 loss preparedness, ethical guidelines, and other professionally
13 relevant issues; and

14 (3) any other matter the commissioner submits to the
15 advisory board for a recommendation.

16 (d) A member of the advisory board serves without
17 compensation. If authorized by the commissioner, a member is
18 entitled to reimbursement for reasonable expenses incurred in
19 attending meetings of the advisory board.

20 (e) The advisory board is subject to Chapter 2110,
21 Government Code.

22 ARTICLE 11. TEXLINK TO HEALTH COVERAGE PROGRAM

23 SECTION 11.001. Chapter 524, Insurance Code, as amended by
24 Chapter 721 (S.B. 78), Acts of the 81st Legislature, Regular
25 Session, 2009, is amended by adding Section 524.004 to read as
26 follows:

27 <u>Sec. 524.004. INFORMATION SHARING AGREEMENTS. The division</u>

may enter into information sharing agreements with federal and state agencies to carry out the division's responsibilities under this chapter. An agreement entered into under this section must include adequate protection with respect to the confidentiality of any information shared and comply with all applicable state and federal law.

SECTION 11.002. Section 524.051, Insurance Code, as added by Chapter 721 (S.B. 78), Acts of the 81st Legislature, Regular Session, 2009, is amended to read as follows:

Sec. 524.051. INFORMATION ABOUT SPECIFIC HEALTH BENEFIT PLAN ISSUERS. (a) In materials produced for the program, the division may include information about specific health benefit plan issuers but may not favor or endorse one particular issuer over another.

(b) The division may:

(1) establish a procedure by which issuers of health benefit plans, including plans offered by regional or local health care programs under Chapter 75, Health and Safety Code, may submit health plans for certification by the division as qualified health plans;

(2) establish a multi-tiered rating system and assign ratings for certified health plans based upon the actuarial level of coverage offered through the plan; and

(3) provide information regarding the availability of and the cost of coverage after the application of any applicable credits.

(c) Notwithstanding Section 75.104(d), Health and Safety

1 Code, a regional or local health care program operating under
2 Chapter 75, Health and Safety Code, that seeks to obtain
3 certification from the division that a plan offered by the program
4 is a qualified health plan is subject to regulation by the
5 department under this code, including provisions of this code
6 designated by the commissioner by rule as necessary for the
7 protection of the public, in the same manner as an insurer.
8 SECTION 11.003. Section 524.053, Insurance Code, as added
9 by Chapter 721 (S.B. 78), Acts of the 81st Legislature, Regular
10 Session, 2009, is amended by adding Subsection (d) to read as
11 follows:
12 (d) The division may provide on an Internet website
13 comparative information on health plans offered for sale in the
14 state that are certified by the division using a standardized
15 format for presenting health benefit plan options.
16 SECTION 11.004. Chapter 524, Insurance Code, as amended by
17 Chapter 721 (S.B. 78), Acts of the 81st Legislature, Regular
18 Session, 2009, is amended by adding Section 524.0545 to read as
19 follows:
20 Sec. 524.0545. INFORMATION REGARDING ELIGIBILITY
21 REQUIREMENTS. (a) The division may make available information
22 regarding eligibility requirements for enrollment in medical
23 assistance programs offered by the state.
24 (b) The division, in coordination with the Health and Human
25 Services Commission, may assist in the facilitation of enrollment
26 of individuals identified as eligible for programs described under
27 Subsection (a).

1 ARTICLE 12. ALTERNATIVE DISPUTE RESOLUTION PROCEDURES FOR CERTAIN
2 DISPUTES
3 SECTION 12.001. Chapter 541, Insurance Code, is amended by
4 adding Subchapter D-1 to read as follows:
5 SUBCHAPTER D-1. DISPUTES SUBJECT TO ALTERNATIVE DISPUTE RESOLUTION
6 PROCEDURES
7 Sec. 541.181. PRIVATE ACTION SUBJECT TO ALTERNATIVE DISPUTE
8 RESOLUTION PROCEDURE. (a) In this subchapter:
9 (1) "Alternative dispute resolution procedure" means
10 a procedure included in an insurance policy to resolve disputes
11 arising under the policy, including arbitration, mediation, and
12 appraisal procedures.
13 (2) "Residential property insurance" has the meaning
14 assigned by Section 544.352.
15 (b) Before filing a private action for damages under this
16 chapter, an insured who disputes the amount of a loss of or damage
17 to property covered by a residential property insurance policy that
18 includes an alternative dispute resolution procedure must:
19 (1) send the insurer written notice of the dispute;
20 and
21 (2) comply with all applicable policy terms and
22 conditions with respect to the dispute.
23 (c) The insurer shall initiate the alternative dispute
24 resolution procedure included in the residential property
25 insurance policy with respect to the dispute not later than:
26 (1) the 45th day after the date the insurer receives
27 the notice required by Subsection (b); or

1 (2) an earlier date provided by the policy.

2 (d) If the insurer does not timely initiate an alternative
3 dispute resolution procedure as required by Subsection (c), the
4 insured may, to the extent otherwise authorized by this chapter,
5 initiate a private action for damages under this chapter.

6 Sec. 541.182. ENFORCEMENT AND REMEDIES. (a) If a court
7 determines that a party has initiated a private action for damages
8 in violation of Section 541.181, the court shall:

9 (1) abate the action and order the parties to
10 participate in the alternative dispute resolution procedure to the
11 extent required by this section; and

12 (2) subject to this section, award to the insurer the
13 insurer's court costs and reasonable and necessary attorney's fees
14 for which the party who initiated the action and each attorney
15 representing that party in the action are jointly and severally
16 liable.

17 (b) An insurer may not execute, collect, or enforce an award
18 under Subsection (a)(2) before initiating the alternative dispute
19 resolution procedure.

20 (c) If an insurer does not comply with a court order under
21 this section by initiating the alternative dispute resolution
22 procedure before the 45th day after the date the order is entered:

23 (1) the insured is not required to participate in the
24 alternative dispute resolution procedure and the action may proceed
25 in court; and

26 (2) the insured and the insured's attorney are not
27 required to pay court costs and attorney's fees awarded under

1 Subsection (a)(2).
2 (d) An insurer may not recover court costs and attorney's
3 fees awarded under Subsection (a)(2) out of money awarded to a
4 person who prevails in an alternative dispute resolution procedure.
5 Sec. 541.183. NOTICE OF ALTERNATIVE DISPUTE RESOLUTION
6 REQUIRED. On receipt of written notice from the insured of a
7 dispute arising under the policy, an insurer shall provide an
8 insured under a residential property insurance policy that includes
9 an alternative dispute resolution procedure with all necessary
10 information relating to the prerequisites for bringing a private
11 action for damages in compliance with the policy and this
12 subchapter.
13 SECTION 12.002. Section 542.058(b), Insurance Code, is
14 amended to read as follows:
15 (b) Subsection (a) does not apply in a case in which it is
16 found as a result of arbitration or litigation that a claim received
17 by an insurer is invalid and should not be paid by the insurer or in
18 a case in which an insurer and a claimant participate in an
19 alternative dispute resolution procedure included in the relevant
20 insurance policy.
21 SECTION 12.003. Subchapter D-1, Chapter 541, Insurance
22 Code, as added by this Act, and Section 542.058(b), Insurance Code,
23 as amended by this Act, apply only to a residential property
24 insurance policy delivered, issued for delivery, or renewed on or
25 after January 1, 2012. A residential property insurance policy
26 delivered, issued for delivery, or renewed before January 1, 2012,
27 is governed by the law in effect immediately before the effective

date of this Act, and that law is continued in effect for that purpose.

ARTICLE 13. CLAIMS REPORTING BY INSURERS

SECTION 13.001. Subtitle C, Title 5, Insurance Code, is amended by adding Chapter 563 to read as follows:

CHAPTER 563. PRACTICES RELATING TO CLAIMS REPORTING

Sec. 563.001. DEFINITIONS. In this chapter:

(1) "Claims database" means a database used by insurers to share, among insurers, insureds' claims histories or damage reports concerning covered properties.

(2) "Insurer," "personal automobile insurance," and "residential property insurance" have the meanings assigned by Section 2254.001.

Sec. 563.002. REPORTING TO CLAIMS DATABASE. An insurer or an insurer's agent may not report to a claims database information regarding an inquiry by an insured regarding coverage provided under a personal automobile insurance policy or a residential property insurance policy unless and until the insured files a claim under the policy.

ARTICLE 14. PAYMENT OF CLAIMS TO PHARMACIES AND PHARMACISTS

SECTION 14.001. Section 843.002, Insurance Code, is amended by amending Subdivision (9-a) and adding Subdivision (9-b) to read as follows:

(9-a) "Extrapolation" means a mathematical process or technique used by a health maintenance organization or pharmacy benefit manager that administers pharmacy claims for a health maintenance organization in the audit of a pharmacy or pharmacist

1 to estimate audit results or findings for a larger batch or group of
2 claims not reviewed by the health maintenance organization or
3 pharmacy benefit manager.
4 (9-b) "Freestanding emergency medical care facility"
5 means a facility licensed under Chapter 254, Health and Safety
6 Code.
7 SECTION 14.002. Section 843.338, Insurance Code, is amended
8 to read as follows:
9 Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except
10 as provided by Sections [~~Section~~] 843.3385 and 843.339, not later
11 than the 45th day after the date on which a health maintenance
12 organization receives a clean claim from a participating physician
13 or provider in a nonelectronic format or the 30th day after the date
14 the health maintenance organization receives a clean claim from a
15 participating physician or provider that is electronically
16 submitted, the health maintenance organization shall make a
17 determination of whether the claim is payable and:
18 (1) if the health maintenance organization determines
19 the entire claim is payable, pay the total amount of the claim in
20 accordance with the contract between the physician or provider and
21 the health maintenance organization;
22 (2) if the health maintenance organization determines
23 a portion of the claim is payable, pay the portion of the claim that
24 is not in dispute and notify the physician or provider in writing
25 why the remaining portion of the claim will not be paid; or
26 (3) if the health maintenance organization determines
27 that the claim is not payable, notify the physician or provider in

1 writing why the claim will not be paid.
2 SECTION 14.003. Section 843.339, Insurance Code, is amended
3 to read as follows:
4 Sec. 843.339. DEADLINE FOR ACTION ON [CERTAIN] PRESCRIPTION
5 CLAIMS; PAYMENT. (a) A [Not later than the 21st day after the date
6 a] health maintenance organization, or a pharmacy benefit manager
7 that administers pharmacy claims for the health maintenance
8 organization, that affirmatively adjudicates a pharmacy claim that
9 is electronically submitted[, the health maintenance organization]
10 shall pay the total amount of the claim through electronic funds
11 transfer not later than the 18th day after the date on which the
12 claim was affirmatively adjudicated.
13 (b) A health maintenance organization, or a pharmacy
14 benefit manager that administers pharmacy claims for the health
15 maintenance organization, that affirmatively adjudicates a
16 pharmacy claim that is not electronically submitted shall pay the
17 total amount of the claim not later than the 21st day after the date
18 on which the claim was affirmatively adjudicated.
19 SECTION 14.004. Subchapter J, Chapter 843, Insurance Code,
20 is amended by adding Section 843.3401 to read as follows:
21 Sec. 843.3401. AUDIT OF PHARMACIST OR PHARMACY. (a) A
22 health maintenance organization or a pharmacy benefit manager that
23 administers pharmacy claims for the health maintenance
24 organization may not use extrapolation to complete the audit of a
25 provider who is a pharmacist or pharmacy. A health maintenance
26 organization may not require extrapolation audits as a condition of
27 participation in the health maintenance organization's contract,

network, or program for a provider who is a pharmacist or pharmacy.

(b) A health maintenance organization or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization that performs an on-site audit under this chapter of a provider who is a pharmacist or pharmacy shall provide the provider reasonable notice of the audit and accommodate the provider's schedule to the greatest extent possible. The notice required under this subsection must be in writing and must be sent by certified mail to the provider not later than the 15th day before the date on which the on-site audit is scheduled to occur.

SECTION 14.005. Section 843.344, Insurance Code, is amended to read as follows:

Sec. 843.344. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. This subchapter applies to a person, including a pharmacy benefit manager, with whom a health maintenance organization contracts to:

(1) process or pay claims;

(2) obtain the services of physicians and providers to provide health care services to enrollees; or

(3) issue verifications or preauthorizations.

SECTION 14.006. Subchapter J, Chapter 843, Insurance Code, is amended by adding Section 843.354 to read as follows:

Sec. 843.354. LEGISLATIVE DECLARATION. It is the intent of the legislature that the requirements contained in this subchapter regarding payment of claims to providers who are pharmacists or pharmacies apply to all health maintenance organizations and pharmacy benefit managers unless otherwise prohibited by federal

1 law.

2 SECTION 14.007. Section 1301.001, Insurance Code, is
3 amended by amending Subdivision (1) and adding Subdivision (1-a) to
4 read as follows:

5 (1) "Extrapolation" means a mathematical process or
6 technique used by an insurer or pharmacy benefit manager that
7 administers pharmacy claims for an insurer in the audit of a
8 pharmacy or pharmacist to estimate audit results or findings for a
9 larger batch or group of claims not reviewed by the insurer or
10 pharmacy benefit manager.

11 (1-a) "Health care provider" means a practitioner,
12 institutional provider, or other person or organization that
13 furnishes health care services and that is licensed or otherwise
14 authorized to practice in this state. The term includes a
15 pharmacist and a pharmacy. The term does not include a physician.

16 SECTION 14.008. Section 1301.103, Insurance Code, is
17 amended to read as follows:

18 Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except
19 as provided by Sections 1301.104 and [~~Section~~] 1301.1054, not later
20 than the 45th day after the date an insurer receives a clean claim
21 from a preferred provider in a nonelectronic format or the 30th day
22 after the date an insurer receives a clean claim from a preferred
23 provider that is electronically submitted, the insurer shall make a
24 determination of whether the claim is payable and:

25 (1) if the insurer determines the entire claim is
26 payable, pay the total amount of the claim in accordance with the
27 contract between the preferred provider and the insurer;

1 (2) if the insurer determines a portion of the claim is
2 payable, pay the portion of the claim that is not in dispute and
3 notify the preferred provider in writing why the remaining portion
4 of the claim will not be paid; or
5 (3) if the insurer determines that the claim is not
6 payable, notify the preferred provider in writing why the claim
7 will not be paid.
8 SECTION 14.009. Section 1301.104, Insurance Code, is
9 amended to read as follows:
10 Sec. 1301.104. DEADLINE FOR ACTION ON [~~CERTAIN~~] PHARMACY
11 CLAIMS; PAYMENT. (a) An [~~Not later than the 21st day after the date~~
12 ~~an~~] insurer, or a pharmacy benefit manager that administers
13 pharmacy claims for the insurer under a preferred provider benefit
14 plan, that affirmatively adjudicates a pharmacy claim that is
15 electronically submitted[~~, the insurer~~] shall pay the total amount
16 of the claim through electronic funds transfer not later than the
17 18th day after the date on which the claim was affirmatively
18 adjudicated.
19 (b) An insurer, or a pharmacy benefit manager that
20 administers pharmacy claims for the insurer under a preferred
21 provider benefit plan, that affirmatively adjudicates a pharmacy
22 claim that is not electronically submitted shall pay the total
23 amount of the claim not later than the 21st day after the date on
24 which the claim was affirmatively adjudicated.
25 SECTION 14.010. Subchapter C, Chapter 1301, Insurance Code,
26 is amended by adding Section 1301.1041 to read as follows:
27 Sec. 1301.1041. AUDIT OF PHARMACIST OR PHARMACY. (a) An

1 insurer or a pharmacy benefit manager that administers pharmacy
2 claims for the insurer may not use extrapolation to complete the
3 audit of a preferred provider that is a pharmacist or pharmacy. An
4 insurer may not require extrapolation audits as a condition of
5 participation in the insurer's contract, network, or program for a
6 preferred provider that is a pharmacist or pharmacy.
7 (b) An insurer or a pharmacy benefit manager that
8 administers pharmacy claims for the insurer that performs an
9 on-site audit of a preferred provider who is a pharmacist or
10 pharmacy shall provide the provider reasonable notice of the audit
11 and accommodate the provider's schedule to the greatest extent
12 possible. The notice required under this subsection must be in
13 writing and must be sent by certified mail to the preferred provider
14 not later than the 15th day before the date on which the on-site
15 audit is scheduled to occur.
16 SECTION 14.011. Section 1301.109, Insurance Code, is
17 amended to read as follows:
18 Sec. 1301.109. APPLICABILITY TO ENTITIES CONTRACTING WITH
19 INSURER. This subchapter applies to a person, including a pharmacy
20 benefit manager, with whom an insurer contracts to:
21 (1) process or pay claims;
22 (2) obtain the services of physicians and health care
23 providers to provide health care services to insureds; or
24 (3) issue verifications or preauthorizations.
25 SECTION 14.012. Subchapter C-1, Chapter 1301, Insurance
26 Code, is amended by adding Section 1301.139 to read as follows:
27 Sec. 1301.139. LEGISLATIVE DECLARATION. It is the intent

1 of the legislature that the requirements contained in this
2 subchapter regarding payment of claims to preferred providers who
3 are pharmacists or pharmacies apply to all insurers and pharmacy
4 benefit managers unless otherwise prohibited by federal law.
5 SECTION 14.013. (a) With respect to pharmacy benefits
6 provided under a contract, the changes in law made by this article
7 apply only to a contract entered into or renewed on or after the
8 effective date of this Act and payment for pharmacy benefits
9 provided under the contract. A contract entered into before the
10 effective date of this Act and not renewed or that was last renewed
11 before the effective date of this Act, and payment for pharmacy
12 benefits provided under the contract, are governed by the law in
13 effect immediately before the effective date of this Act, and that
14 law is continued in effect for that purpose.
15 (b) With respect to payment for pharmacy benefits not
16 provided under a contract to which Subsection (a) of this section
17 applies, the changes in law made by this article apply only to
18 payment for benefits provided on or after the effective date of this
19 Act. Payment for benefits not subject to Subsection (a) of this
20 section and provided before the effective date of this Act is
21 governed by the law in effect immediately before the effective date
22 of this Act, and that law is continued in effect for that purpose.
23 (c) Sections 843.3401 and 1301.1041, Insurance Code, as
24 added by this article, apply to an audit of a pharmacist or pharmacy
25 performed on or after the effective date of this Act unless the
26 audit is performed under a contract that is entered into before the
27 effective date of this Act and that, at the time of the audit, has

1 not been renewed or was last renewed before the effective date of
2 this Act.

3 ARTICLE 15. PAYMENT OF BENEFITS

4 SECTION 15.001. Chapter 1102, Insurance Code, is amended to
5 read as follows:

6 CHAPTER 1102. PAYMENT OF INSURANCE BENEFITS [~~IN CURRENCY~~]

7 SUBCHAPTER A. GENERAL PROVISIONS

8 Sec. 1102.001. DEFINITIONS. In this chapter:
9 (1) "Insurance policy" means a policy, certificate, or
10 contract of:
11 (A) life, term, or endowment insurance,
12 including an annuity or pure endowment contract;
13 (B) group life or term insurance, including a
14 group annuity contract;
15 (C) industrial life insurance;
16 (D) accident or health insurance;
17 (E) group accident or health insurance;
18 (F) hospitalization insurance;
19 (G) group hospitalization insurance;
20 (H) medical or surgical insurance;
21 (I) group medical or surgical insurance; or
22 (J) fraternal benefit insurance.
23 (2) "Insurer" means any insurer, including a:
24 (A) life, accident, health, or casualty
25 insurance company;
26 (B) mutual life insurance company;
27 (C) mutual insurance company other than a life

1 insurance company;
2 (D) mutual or natural premium life insurance
3 company;
4 (E) general casualty company;
5 (F) Lloyd's plan or a reciprocal or
6 interinsurance exchange;
7 (G) fraternal benefit society; or
8 (H) group hospital service corporation.
9 (3) "Life insurance policy" means a policy,
10 certificate, or contract of:
11 (A) life, term, or endowment insurance,
12 including an annuity or pure endowment contract;
13 (B) group life or term insurance, including a
14 group annuity contract;
15 (C) industrial life insurance; or
16 (D) fraternal benefit insurance, other than
17 insurance for:
18 (i) benefits for hospital, medical, or
19 nursing expenses resulting from sickness, bodily infirmity, or
20 accident; or
21 (ii) other accident or health insurance.
22 (4) "Retained asset account" means any mechanism
23 whereby the settlement of proceeds payable under a life insurance
24 policy, including but not limited to the payment of cash surrender
25 value, is accomplished by the insurer or an entity acting on behalf
26 of the insurer depositing the proceeds into an account, where those
27 proceeds are retained by the insurer, pursuant to a supplementary

1 contract not involving annuity benefits.
2 Sec. 1102.002. RULES. The commissioner may adopt
3 reasonable rules to accomplish the purposes of this chapter,
4 including rules requiring:
5 (1) appropriate reserves for insurance policies
6 subject to this chapter; or
7 (2) prudent investment of premiums collected from
8 insurance policies subject to this chapter regardless of any other
9 provision of this code related to the investment of money by an
10 insurance company.
11 SUBCHAPTER B. PAYMENT OF BENEFITS IN CURRENCY
12 Sec. 1102.051 [~~1102.002~~]. BENEFITS PAYABLE IN CURRENCY.
13 Each benefit payable under an insurance policy delivered, issued,
14 or used in this state by an insurer shall be payable in currency.
15 Sec. 1102.052 [~~1102.003~~]. STATEMENT REGARDING VALUE OF
16 FOREIGN CURRENCY. (a) An insurance policy described by Section
17 1102.051 [~~1102.002~~] providing that benefits are payable in foreign
18 currency must include a conspicuous statement that the value of the
19 currency denominated in the policy can fluctuate as compared to the
20 value of United States currency.
21 (b) The statement must be:
22 (1) included as part of the policy; or
23 (2) attached to the insurance policy at the time it is
24 issued.
25 Sec. 1102.053 [~~1102.004~~]. PREVIOUSLY APPROVED INSURANCE
26 POLICY FORM PAYABLE IN FOREIGN CURRENCY. (a) The commissioner may
27 disapprove or withdraw approval of a previously approved insurance

policy form that provides benefits payable in foreign currency if the commissioner determines that the foreign currency has been less stable than United States currency in the previous 20-year period.

(b) This section does not require the resubmission for approval of any previously approved insurance policy form unless:

(1) withdrawal of approval is authorized under this section or Chapter 1701; or

(2) after notice and hearing, the commissioner determines that approval was obtained by improper means, including by misrepresentation, fraud, or a misleading statement or document[~~.~~

[~~Sec. 1102.005. RULES. The commissioner may adopt reasonable rules to accomplish the purposes of this chapter, including rules requiring:~~

[~~(1) appropriate reserves for insurance policies subject to this chapter; or~~

[~~(2) prudent investment of premiums collected from insurance policies subject to this chapter regardless of any other provision of this code related to the investment of money by an insurance company~~].

SUBCHAPTER C. RETAINED ASSET ACCOUNTS

Sec. 1102.101. RETAINED ASSET ACCOUNT ELECTION. (a) An insurer may not transfer proceeds payable under a life insurance policy to a retained asset account unless the insurer discloses such option to the beneficiary or the beneficiary's legal representative, or in the case of a group contract, the contract holder or policy owner before transferring the proceeds to the

1 account.

2 (b) A beneficiary shall be informed of the beneficiary's
3 rights to receive a lump-sum payment of life insurance proceeds in
4 the form of a bank check or other form of immediate full payment of
5 benefits.

6 (c) When an insurer offers multiple modes of settlement to a
7 beneficiary, the insurer may not use a retained asset account as the
8 default mode of settlement unless the insurer conspicuously
9 discloses that fact.

10 Sec. 1102.102. DISCLOSURE REQUIREMENTS. (a) The claim
11 form for payment of proceeds under a life insurance policy must
12 include a statement, written in plain language, disclosing benefit
13 payment options available under the policy, including payment
14 through the use of a retained asset account or by check directly to
15 the claimant.

16 (b) An insurer may not transfer proceeds payable under a
17 life insurance policy to a retained asset account unless the
18 insurer, before transferring the proceeds and in a written
19 document, discloses to the claimant, or advises the claimant
20 concerning, the following information:

21 (1) a recommendation to consult a tax, investment, or
22 other financial advisor about tax liability and investment options;

23 (2) when and how interest rates may change, and any
24 dividends and other gains that may be paid or distributed to the
25 account holder;

26 (3) the name and address of the custodian of the
27 retained asset account;

1 (4) any coverage of the retained asset account
2 guaranteed by the Federal Deposit Insurance Corporation and the
3 amount of the coverage;
4 (5) any limitations on withdrawal of funds from the
5 retained asset account, including any minimum or maximum benefit
6 payment amounts;
7 (6) the anticipated duration of any delays that the
8 retained asset account holder might encounter in completing an
9 authorized transaction;
10 (7) any fees for services provided, including a list
11 of the fees and the method of the fee calculation;
12 (8) the nature and frequency with which statements
13 concerning the retained asset account are issued, which must be not
14 less than once annually;
15 (9) that some or all of the benefit may be paid through
16 check, draft, or other instrument;
17 (10) that the entire proceeds are available to the
18 retained asset account holder by the use of a single check, draft,
19 or other instrument;
20 (11) whether the insurer or a related party may earn
21 income from the retained asset account, in addition to any fees
22 charged on the account, from the total gains received on the
23 investment of the balance of funds in the account;
24 (12) the telephone number, address, and other contact
25 information, including website address, to obtain additional
26 information regarding the retained asset account;
27 (13) a description of the insurer's policy regarding

1 retained asset accounts that may become inactive; and
2 (14) any other information prescribed by the
3 commissioner by rule.
4 SECTION 15.002. Chapter 1102, Insurance Code, as amended by
5 this article, applies only to a claim made under a life insurance
6 policy on or after September 1, 2011. A claim made before September
7 1, 2011, is governed by the law as it existed immediately before the
8 effective date of this Act, and that law is continued in effect for
9 that purpose.
10 ARTICLE 16. PROHIBITION OF COERCION OF PRACTITIONERS BY MANAGED
11 CARE PLANS
12 SECTION 16.001. Section 1451.153, Insurance Code, is
13 amended by amending Subsection (a) and adding Subsection (c) to
14 read as follows:
15 (a) A managed care plan may not:
16 (1) discriminate against a health care practitioner
17 because the practitioner is an optometrist, therapeutic
18 optometrist, or ophthalmologist;
19 (2) restrict or discourage a plan participant from
20 obtaining covered vision or medical eye care services or procedures
21 from a participating optometrist, therapeutic optometrist, or
22 ophthalmologist solely because the practitioner is an optometrist,
23 therapeutic optometrist, or ophthalmologist;
24 (3) exclude an optometrist, therapeutic optometrist,
25 or ophthalmologist as a participating practitioner in the plan
26 because the optometrist, therapeutic optometrist, or
27 ophthalmologist does not have medical staff privileges at a

1 hospital or at a particular hospital; [or]
2 (4) exclude an optometrist, therapeutic optometrist,
3 or ophthalmologist as a participating practitioner in the plan
4 because the services or procedures provided by the optometrist,
5 therapeutic optometrist, or ophthalmologist may be provided by
6 another type of health care practitioner; or
7 (5) as a condition for a therapeutic optometrist or
8 ophthalmologist to be included in one or more of the plan's medical
9 panels, require the therapeutic optometrist or ophthalmologist to
10 be included in, or to accept the terms of payment under or for, a
11 particular vision panel in which the therapeutic optometrist or
12 ophthalmologist does not otherwise wish to be included.
13 (c) For the purposes of Subsection (a)(5), "medical panel"
14 and "vision panel" have the meanings assigned by Section
15 1451.154(a).
16 SECTION 16.002. The change in law made by Section 16.001 of
17 this Act applies only to a contract entered into or renewed by a
18 therapeutic optometrist or ophthalmologist and an issuer of a
19 managed care plan on or after January 1, 2012. A contract entered
20 into or renewed before January 1, 2012, is governed by the law in
21 effect immediately before the effective date of this Act, and that
22 law is continued in effect for that purpose.
23 ARTICLE 17. PROVIDER NETWORK CONTRACT ARRANGEMENTS
24 SECTION 17.001. Subtitle F, Title 8, Insurance Code, is
25 amended by adding Chapter 1458 to read as follows:
26 CHAPTER 1458. PROVIDER NETWORK CONTRACT ARRANGEMENTS
27 SUBCHAPTER A. GENERAL PROVISIONS

1 Sec. 1458.001. GENERAL DEFINITIONS. In this chapter:
2 (1) "Affiliate" means a person who, directly or
3 indirectly through one or more intermediaries, controls, is
4 controlled by, or is under common control with another person.
5 (2) "Contracting entity" means a person that:
6 (A) enters into a direct contract with a provider
7 for the delivery of health care services to covered individuals;
8 and
9 (B) in the ordinary course of business
10 establishes a provider network for access by another party.
11 (3) "Covered individual" means an individual who is
12 covered under a health benefit plan.
13 (4) "Direct notification" means a written or
14 electronic communication from a contracting entity to a physician
15 or other health care provider documenting third party access to a
16 provider network.
17 (5) "Health care services" means services provided for
18 the diagnosis, prevention, treatment, or cure of a health
19 condition, illness, injury, or disease.
20 (6) "Person" has the meaning assigned by Section
21 823.002.
22 (7) "Provider" means a physician, a professional
23 association composed solely of physicians, a single legal entity
24 authorized to practice medicine owned by two or more physicians, a
25 nonprofit health corporation certified by the Texas Medical Board
26 under Chapter 162, Occupations Code, a partnership composed solely
27 of physicians, a physician-hospital organization that acts

1 exclusively as an administrator for a provider to facilitate the
2 provider's participation in health care contracts, or an
3 institution licensed under Chapter 241, Health and Safety Code.
4 The term does not include a physician-hospital organization that
5 leases or rents the physician-hospital organization's network to a
6 third party.
7 (8) "Provider network contract" means a contract
8 between a contracting entity and a provider for the delivery of, and
9 payment for, health care services to a covered individual.
10 (9) "Third party" means a person that contracts with a
11 contracting entity or another party to gain access to a provider
12 network contract.
13 Sec. 1458.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) In
14 this chapter, "health benefit plan" means:
15 (1) a hospital and medical expense incurred policy;
16 (2) a nonprofit health care service plan contract;
17 (3) a health maintenance organization subscriber
18 contract; or
19 (4) any other health care plan or arrangement that
20 pays for or furnishes medical or health care services.
21 (b) "Health benefit plan" does not include one or more or
22 any combination of the following:
23 (1) coverage only for accident or disability income
24 insurance or any combination of those coverages;
25 (2) credit-only insurance;
26 (3) coverage issued as a supplement to liability
27 insurance;

1 (4) liability insurance, including general liability
2 insurance and automobile liability insurance;
3 (5) workers' compensation or similar insurance;
4 (6) a discount health care program, as defined by
5 Section 7001.001;
6 (7) coverage for on-site medical clinics;
7 (8) automobile medical payment insurance; or
8 (9) other similar insurance coverage, as specified by
9 federal regulations issued under the Health Insurance Portability
10 and Accountability Act of 1996 (Pub. L. No. 104-191), under which
11 benefits for medical care are secondary or incidental to other
12 insurance benefits.
13 (c) "Health benefit plan" does not include the following
14 benefits if they are provided under a separate policy, certificate,
15 or contract of insurance, or are otherwise not an integral part of
16 the coverage:
17 (1) dental or vision benefits;
18 (2) benefits for long-term care, nursing home care,
19 home health care, community-based care, or any combination of these
20 benefits;
21 (3) other similar, limited benefits, including
22 benefits specified by federal regulations issued under the Health
23 Insurance Portability and Accountability Act of 1996 (Pub. L. No.
24 104-191); or
25 (4) a Medicare supplement benefit plan described by
26 Section 1652.002.
27 (d) "Health benefit plan" does not include coverage limited

1 to a specified disease or illness or hospital indemnity coverage or
2 other fixed indemnity insurance coverage if:
3 (1) the coverage is provided under a separate policy,
4 certificate, or contract of insurance;
5 (2) there is no coordination between the provision of
6 the coverage and any exclusion of benefits under any group health
7 benefit plan maintained by the same plan sponsor; and
8 (3) the coverage is paid with respect to an event
9 without regard to whether benefits are provided with respect to
10 such an event under any group health benefit plan maintained by the
11 same plan sponsor.
12 Sec. 1458.003. EXEMPTIONS. This chapter does not apply:
13 (1) to a provider network contract for services
14 provided to a beneficiary under the Medicaid program, the Medicare
15 program, or the state child health plan established under Chapter
16 62, Health and Safety Code, or the comparable plan under Chapter 63,
17 Health and Safety Code;
18 (2) under circumstances in which access to the
19 provider network is granted to an entity that operates under the
20 same brand licensee program as the contracting entity; or
21 (3) to a contract between a contracting entity and a
22 discount health care program operator, as defined by Section
23 7001.001.
24 [Sections 1458.004-1458.050 reserved for expansion]
25 SUBCHAPTER B. REGISTRATION REQUIREMENTS
26 Sec. 1458.051. REGISTRATION REQUIRED. (a) Unless the
27 person holds a certificate of authority issued by the department to

1 engage in the business of insurance in this state or operate a
2 health maintenance organization under Chapter 843, a person must
3 register with the department not later than the 30th day after the
4 date on which the person begins acting as a contracting entity in
5 this state.

6 (b) Notwithstanding Subsection (a), under Section 1458.055
7 a contracting entity that holds a certificate of authority issued
8 by the department to engage in the business of insurance in this
9 state or is a health maintenance organization shall file with the
10 commissioner an application for exemption from registration under
11 which the affiliates may access the contracting entity's network.

12 (c) An application for an exemption filed under Subsection
13 (b) must be accompanied by a list of the contracting entity's
14 affiliates. The contracting entity shall update the list with the
15 commissioner on an annual basis.

16 (d) A list of affiliates filed with the commissioner under
17 Subsection (c) is public information and is not exempt from
18 disclosure under Chapter 552, Government Code.

19 Sec. 1458.052. DISCLOSURE OF INFORMATION. (a) A person
20 required to register under Section 1458.051 must disclose:

21 (1) all names used by the contracting entity,
22 including any name under which the contracting entity intends to
23 engage or has engaged in business in this state;

24 (2) the mailing address and main telephone number of
25 the contracting entity's headquarters;

26 (3) the name and telephone number of the contracting
27 entity's primary contact for the department; and

1 (4) any other information required by the commissioner
2 by rule.
3 (b) The disclosure made under Subsection (a) must include a
4 description or a copy of the applicant's basic organizational
5 structure documents and a copy of organizational charts and lists
6 that show:
7 (1) the relationships between the contracting entity
8 and any affiliates of the contracting entity, including subsidiary
9 networks or other networks; and
10 (2) the internal organizational structure of the
11 contracting entity's management.
12 Sec. 1458.053. SUBMISSION OF INFORMATION. Information
13 required under this subchapter must be submitted in a written or
14 electronic format adopted by the commissioner by rule.
15 Sec. 1458.054. FEES. The department may collect a
16 reasonable fee set by the commissioner as necessary to administer
17 the registration process. Fees collected under this chapter shall
18 be deposited in the Texas Department of Insurance operating fund.
19 Sec. 1458.055. EXEMPTION FOR AFFILIATES. (a) The
20 commissioner shall grant an exemption for affiliates of a
21 contracting entity if the contracting entity holds a certificate of
22 authority issued by the department to engage in the business of
23 insurance in this state or is a health maintenance organization if
24 the commissioner determines that:
25 (1) the affiliate is not subject to a disclaimer of
26 affiliation under Chapter 823; and
27 (2) the relationships between the person who holds a

1 certificate of authority and all affiliates of the person,
2 including subsidiary networks or other networks, are disclosed and
3 clearly defined.
4 (b) An exemption granted under this section applies only to
5 registration. An entity granted an exemption is otherwise subject
6 to this chapter.
7 (c) The commissioner shall establish a reasonable fee as
8 necessary to administer the exemption process.
9 [Sections 1458.056-1458.100 reserved for expansion]
10 SUBCHAPTER C. RIGHTS AND RESPONSIBILITIES OF A CONTRACTING ENTITY
11 Sec. 1458.101. CONTRACT REQUIREMENTS. A contracting entity
12 may not provide a person access to health care services or
13 contractual discounts under a provider network contract unless the
14 provider network contract specifically states that:
15 (1) the contracting entity may contract with a third
16 party to provide access to the contracting entity's rights and
17 responsibilities under a provider network contract; and
18 (2) the third party must comply with all applicable
19 terms, limitations, and conditions of the provider network
20 contract.
21 Sec. 1458.102. DUTIES OF CONTRACTING ENTITY. (a) A
22 contracting entity that has granted access to health care services
23 and contractual discounts under a provider network contract shall:
24 (1) notify each provider of the identity of, and
25 contact information for, each third party that has or may obtain
26 access to the provider's health care services and contractual
27 discounts;

(2) provide each third party with sufficient information regarding the provider network contract to enable the third party to comply with all relevant terms, limitations, and conditions of the provider network contract;

(3) require each third party to disclose the identity of the contracting entity and the existence of a provider network contract on each remittance advice or explanation of payment form; and

(4) notify each third party of the termination of the provider network contract not later than the 30th day after the effective date of the contract termination.

(b) If a contracting entity knows that a third party is making claims under a terminated contract, the contracting entity must take reasonable steps to cause the third party to cease making claims under the provider network contract. If the steps taken by the contracting entity are unsuccessful and the third party continues to make claims under the terminated provider network contract, the contracting entity must:

(1) terminate the contracting entity's contract with the third party; or

(2) notify the commissioner, if termination of the contract is not feasible.

(c) Any notice provided by a contracting entity to a third party under Subsection (b) must include a statement regarding the third party's potential liability under this chapter for using a provider's contractual discount for services provided after the termination date of the provider network contract.

1 (d) The notice required under Subsection (a)(1):
2 (1) must be provided by:
3 (A) providing for a subscription to receive the
4 notice by e-mail; or
5 (B) posting the information on an Internet
6 website at least once each calendar quarter; and
7 (2) must include a separate prominent section that
8 lists:
9 (A) each third party that the contracting entity
10 knows will have access to a discounted fee of the provider in the
11 succeeding calendar quarter; and
12 (B) the effective date and termination or renewal
13 dates, if any, of the third party's contract to access the network.
14 (e) The e-mail notice described by Subsection (d) may
15 contain a link to an Internet web page that contains a list of third
16 parties that complies with this section.
17 (f) The notice described by Subsection (a)(1) is not
18 required to include information regarding payors who are insurers
19 or health maintenance organizations.
20 Sec. 1458.103. EFFECT OF CONTRACT TERMINATION. Subject to
21 continuity of care requirements, agreements, or contractual
22 provisions:
23 (1) a third party may not access health care services
24 and contractual discounts after the date the provider network
25 contract terminates;
26 (2) claims for health care services performed after
27 the termination date may not be processed or paid under the provider

1 network contract after the termination; and
2 (3) claims for health care services performed before
3 the termination date and processed after the termination date may
4 be processed and paid under the provider network contract after the
5 date of termination.
6 Sec. 1458.104. AVAILABILITY OF CODING GUIDELINES. (a) A
7 contract between a contracting entity and a provider must provide
8 that:
9 (1) the provider may request a description and copy of
10 the coding guidelines, including any underlying bundling,
11 recoding, or other payment process and fee schedules applicable to
12 specific procedures that the provider will receive under the
13 contract;
14 (2) the contracting entity or the contracting entity's
15 agent will provide the coding guidelines and fee schedules not
16 later than the 30th day after the date the contracting entity
17 receives the request;
18 (3) the contracting entity or the contracting entity's
19 agent will provide notice of changes to the coding guidelines and
20 fee schedules that will result in a change of payment to the
21 provider not later than the 90th day before the date the changes
22 take effect and will not make retroactive revisions to the coding
23 guidelines and fee schedules; and
24 (4) if the requested information indicates a reduction
25 in payment to the provider from the amounts agreed to on the
26 effective date of the contract, the contract may be terminated by
27 the provider on written notice to the contracting entity on or

1 before the 30th day after the date the provider receives
2 information requested under this subsection without penalty or
3 discrimination in participation in other health care products or
4 plans.
5 (b) A provider who receives information under Subsection
6 (a) may only:
7 (1) use or disclose the information for the purpose of
8 practice management, billing activities, and other business
9 operations; and
10 (2) disclose the information to a governmental agency
11 involved in the regulation of health care or insurance.
12 (c) The contracting entity shall, on request of the
13 provider, provide the name, edition, and model version of the
14 software that the contracting entity uses to determine bundling and
15 unbundling of claims.
16 (d) The provisions of this section may not be waived,
17 voided, or nullified by contract.
18 (e) If a contracting entity is unable to provide the
19 information described by Subsection (a)(1), (a)(3), or (c), the
20 contracting entity shall by telephone provide a readily available
21 medium in which providers may obtain the information, which may
22 include an Internet website.
23 [Sections 1458.105-1458.150 reserved for expansion]
24 SUBCHAPTER D. RIGHTS AND RESPONSIBILITIES OF THIRD PARTY
25 Sec. 1458.151. THIRD-PARTY RIGHTS AND RESPONSIBILITIES. A
26 third party that leases, sells, aggregates, assigns, or otherwise
27 conveys a provider's contractual discount to another party who is

1 not a covered individual must comply with the responsibilities of a
2 contracting entity under Subchapters C and E.
3 Sec. 1458.152. DISCLOSURE BY THIRD PARTY. (a) A third
4 party shall disclose, to the contracting entity and providers under
5 the provider network contract, the identity of a person other than a
6 covered individual to whom the third party leases, sells,
7 aggregates, assigns, or otherwise conveys a provider's contractual
8 discounts through an electronic notification that complies with
9 Section 1458.102 and includes a link to the Internet website
10 described by Section 1458.102(d).
11 (b) A third party that uses an Internet website under this
12 section must update the website on a quarterly basis. On request, a
13 contracting entity shall disclose the information by telephone or
14 through direct notification.
15 [Sections 1458.153-1458.200 reserved for expansion]
16 SUBCHAPTER E. UNAUTHORIZED ACCESS TO PROVIDER NETWORK CONTRACTS
17 Sec. 1458.201. UNAUTHORIZED ACCESS TO OR USE OF DISCOUNT.
18 (a) A person who knowingly accesses or uses a provider's
19 contractual discount under a provider network contract without a
20 contractual relationship established under this chapter commits an
21 unfair or deceptive act in the business of insurance that violates
22 Subchapter B, Chapter 541. The remedies available for a violation
23 of Subchapter B, Chapter 541, under this subsection do not include a
24 private cause of action under Subchapter D, Chapter 541, or a class
25 action under Subchapter F, Chapter 541.
26 (b) A contracting entity or third party must comply with the
27 disclosure requirements under Sections 1458.102 and 1458.152

1 concerning the services listed on a remittance advice or
2 explanation of payment. A provider may refuse a discount taken
3 without a contract under this chapter or in violation of those
4 sections.
5 (c) Notwithstanding Subsection (b), an error in the
6 remittance advice or explanation of payment may be corrected by a
7 contracting entity or third party not later than the 30th day after
8 the date the provider notifies in writing the contracting entity or
9 third party of the error.
10 Sec. 1458.202. ACCESS TO THIRD PARTY. A contracting entity
11 may not provide a third party access to a provider network contract
12 unless the third party is:
13 (1) a payor or person who administers or processes
14 claims on behalf of the payor;
15 (2) a preferred provider benefit plan issuer or
16 preferred provider network, including a physician-hospital
17 organization; or
18 (3) a person who transports claims electronically
19 between the contracting entity and the payor and does not provide
20 access to the provider's services and discounts to any other third
21 party.
22 [Sections 1458.203-1458.250 reserved for expansion]
23 SUBCHAPTER F. ENFORCEMENT
24 Sec. 1458.251. UNFAIR CLAIM SETTLEMENT PRACTICE. (a) A
25 contracting entity that violates this chapter commits an unfair
26 claim settlement practice under Subchapter A, Chapter 542, and is
27 subject to sanctions under that subchapter as if the contracting

1 entity were an insurer.

2 (b) A provider who is adversely affected by a violation of
3 this chapter may make a complaint under Subchapter A, Chapter 542.

4 Sec. 1458.252. REMEDIES NOT EXCLUSIVE. The remedies
5 provided by this subchapter are in addition to any other defense,
6 remedy, or procedure provided by law, including common law.

7 SECTION 17.002. The change in law made by this article
8 applies only to a provider network contract entered into or renewed
9 on or after January 1, 2012. A provider network contract entered
10 into or renewed before January 1, 2012, is governed by the law as it
11 existed immediately before the effective date of this Act, and that
12 law is continued in effect for that purpose.

13 ARTICLE 18. FAIR PLAN ASSOCIATION

14 SECTION 18.001. Subchapter A, Chapter 2211, Insurance Code,
15 is amended by adding Section 2211.004 to read as follows:

16 Sec. 2211.004. APPLICABILITY OF CERTAIN OTHER LAW;
17 LIMITATION ON DAMAGES. (a) The association may not be held liable
18 for any amount on a claim filed under an insurance policy issued by
19 the association other than:

20 (1) as applicable, amounts payable under the terms of
21 the policy for loss to an insured structure, loss to contents of an
22 insured structure, and additional living expenses; and

23 (2) court costs and reasonable attorney's fees.

24 (b) An insured may not recover consequential, punitive, or
25 exemplary damages in a cause of action against the association,
26 including damages under Section 541.152(b) of this code or Section
27 17.50, Business & Commerce Code, or interest in the amount

described by Section 542.060 of this code.

SECTION 18.002. Section 2211.004, Insurance Code, as added by this article, applies only to a cause of action that accrues against the FAIR Plan Association on or after the effective date of this Act. A cause of action that accrues before the effective date of this Act is governed by the law in effect on the date the cause of action accrued, and the former law is continued in effect for that purpose.

ARTICLE 19. STANDARD FORMS

SECTION 19.001. Section 2301.008, Insurance Code, is amended to read as follows:

Sec. 2301.008. ADOPTION AND USE OF STANDARD FORMS. The commissioner shall [~~may~~] adopt standard insurance policy forms, printed endorsement forms, and related forms other than insurance policy forms and printed endorsement forms, that an insurer shall [~~may~~] use in addition to [~~instead of~~] the insurer's own forms in writing insurance subject to this subchapter.

SECTION 19.002. Section 2301.052(b), Insurance Code, is amended to read as follows:

(b) Subject to Section 2301.0525, an [~~An~~] insurer may continue to use an insurance policy form or endorsement promulgated, approved, or adopted under Article 5.06 or 5.35 before June 11, 2003, on written notification to the commissioner that the insurer will continue to use the form or endorsement.

SECTION 19.003. Subchapter B, Chapter 2301, Insurance Code, is amended by adding Section 2301.0525 to read as follows:

Sec. 2301.0525. USE OF MINIMUM STANDARD INSURANCE POLICY

FORMS REQUIRED. (a) Each insurer that writes residential property insurance in this state shall use the standard insurance policy forms adopted by the commissioner under Section 2301.008 for residential property insurance and, subject to Subsection (b), may also use alternative policy forms approved by the commissioner under Section 2301.006.

(b) An insurer may not deliver or issue for delivery in this state a residential property insurance policy unless the insurer informs each applicant for that insurance coverage, in the manner prescribed by commissioner rule, that an applicant otherwise qualified for that insurance coverage under this code may elect to obtain residential property insurance coverage under a standard insurance policy adopted by the commissioner under Section 2301.008.

(c) An insurer that offers coverage under the standard policy forms shall disclose to the applicant or insured, at the time of the initial application and each renewal, each policy limit and type of coverage available to the insured and the respective costs for each coverage. The form of the disclosure shall be specified by the commissioner, subject to Section 2301.053(c).

(d) An insurer that offers coverage under approved forms other than the standard policy forms shall disclose to the applicant or insured, at the time of the initial application and each renewal, in comparison to the standard policy forms each additional coverage that is provided and the additional cost, each reduction in coverage or exclusion of coverage and the reduced cost, and each policy limit and type of coverage available to the

insured and the respective costs for each coverage. The form of the disclosure shall be specified by the commissioner, subject to Section 2301.053(c). At a minimum, the disclosure must refer the applicant or insured to the Internet website described by Section 32.102 and state that the applicant may compare the rates of insurers at that site.

SECTION 19.004. The change in law made by this article applies only to an insurance policy delivered, issued for delivery, or renewed on or after January 1, 2012. A policy delivered, issued for delivery, or renewed before January 1, 2012, 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.

ARTICLE 20. SURETY BONDS AND RELATED INSTRUMENTS

SECTION 20.001. Section 3503.005(a), Insurance Code, is amended to read as follows:

(a) A bond that is made, given, tendered, or filed under Chapter 53, Property Code, or Chapter 2253, Government Code, may be executed only by a surety company that is authorized to write surety bonds in this state. If the amount of the bond exceeds $100,000, the surety company must also:

(1) hold a certificate of authority from the United States secretary of the treasury to qualify as a surety on obligations permitted or required under federal law; or

(2) have obtained reinsurance for any liability in excess of $1 million [~~$100,000~~] from a reinsurer that:

(A) is an authorized reinsurer in this state; or [~~and~~]

1 (B) holds a certificate of authority from the
2 United States secretary of the treasury to qualify as a surety or
3 reinsurer on obligations permitted or required under federal law.
4 SECTION 20.002. Section 3503.004(b), Insurance Code, is
5 repealed.
6 ARTICLE 21. APPRAISALS UNDER PROPERTY INSURANCE POLICIES
7 SECTION 21.001. Subchapter B, Chapter 542, Insurance Code,
8 is amended by adding Section 542.063 to read as follows:
9 Sec. 542.063. APPRAISALS. (a) A request for appraisal with
10 respect to a claim under a property insurance policy shall not stay
11 court proceedings during the appraisal process.
12 (b) A decision resulting from the appraisal process under a
13 property insurance policy is binding only as to the amount of loss.
14 An appraisal may not be used to determine liability issues such as
15 coverage, causation, or conditions or limits imposed by the policy.
16 The appraisal decision does not affect any other remedy available
17 at law.
18 SECTION 21.002. The heading to Subchapter B, Chapter 542,
19 Insurance Code, is amended to read as follows:
20 SUBCHAPTER B. PROMPT PAYMENT OF CLAIMS; APPRAISALS
21 SECTION 21.003. Section 542.063, Insurance Code, as added
22 by this article, applies only to a dispute that arises on or after
23 the effective date of this Act. A dispute that arises before the
24 effective date of this Act is governed by the law in effect
25 immediately before the effective date of this Act, and that law is
26 continued in effect for that purpose.

1 ARTICLE 22. EMPLOYER CONTRIBUTIONS TO INDIVIDUAL HEALTH INSURANCE
2 POLICIES
3 SECTION 22.001. Subtitle A, Title 8, Insurance Code, is
4 amended by adding Chapter 1221 to read as follows:
5 CHAPTER 1221. EMPLOYER CONTRIBUTIONS TO INDIVIDUAL HEALTH
6 INSURANCE POLICIES
7 Sec. 1221.001. RULES; EMPLOYER CONTRIBUTIONS. The
8 commissioner by rule, unless it would violate state or federal law,
9 may develop procedures to allow an employer to make financial
10 contributions to or premium payments for an employee or retiree's
11 individual consumer directed health insurance policy in a manner
12 that eliminates or minimizes the state or federal tax consequences,
13 or provides positive state or federal tax consequences, to the
14 employer.
15 ARTICLE 23. REQUIRED OFFER TO EXCLUDE NAMED DRIVERS FROM PERSONAL
16 AUTOMOBILE INSURANCE POLICIES
17 SECTION 23.001. Subchapter B, Chapter 1952, Insurance Code,
18 is amended by adding Section 1952.059 to read as follows:
19 Sec. 1952.059. REQUIRED OFFER: EXCLUSION OF NAMED DRIVERS.
20 (a) In addition to applying to the insurers subject to this chapter
21 under Section 1952.001, this section applies to a county mutual
22 insurance company.
23 (b) An insurer that delivers or issues for delivery in this
24 state a personal automobile insurance policy, including a policy
25 provided through the Texas Automobile Insurance Plan Association
26 under Chapter 2151, that covers liability arising out of the
27 ownership, maintenance, or use of a motor vehicle and that would

1 otherwise cover all residents in the named insured's household must
2 offer the insured a provision that would exclude from coverage
3 under the policy any resident of the named insured's household who
4 is specifically named as being excluded.
5 (c) An exclusion under this section must be in writing and
6 must:
7 (1) include the name of the person excluded from
8 coverage;
9 (2) be signed by the named insured; and
10 (3) be attached to the policy and stated on the
11 liability insurance card or any other form of proof of liability
12 insurance verification.
13 ARTICLE 24. RESIDENTIAL FIRE ALARM TECHNICIANS
14 SECTION 24.001. Section 6002.158(e), Insurance Code, is
15 amended to read as follows:
16 (e) The curriculum for a residential fire alarm technician
17 course must consist of at least seven [~~eight~~] hours of instruction
18 on installing, servicing, and maintaining single-family and
19 two-family residential fire alarm systems as defined by National
20 Fire Protection Standard No. 72 and an examination on National Fire
21 Protection Standard No. 72 for which at least one hour is allocated
22 for completion. The examination must consist of at least 25
23 questions, and an applicant must accurately answer at least 80
24 percent of the questions to pass the examination.
25 SECTION 24.002. The changes in law made by this Act to
26 Section 6002.158, Insurance Code, apply only to an application for
27 approval or renewal of approval of a training school submitted to

the state fire marshal on or after the effective date of this Act. An application submitted before the effective date of this Act is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

ARTICLE 25. EXTRA HAZARDOUS COVERAGES

SECTION 25.001. Subchapter A, Chapter 2502, Insurance Code, is amended by adding Section 2502.006 to read as follows:

Sec. 2502.006. CERTAIN EXTRA HAZARDOUS COVERAGES PROHIBITED. (a) A title insurance company may not insure against loss or damage sustained by reason of any claim that under federal bankruptcy, state insolvency, or similar creditor's rights laws the transaction vesting title in the insured as shown in the policy or creating the lien of the insured mortgage is:

(1) a preference or preferential transfer under 11 U.S.C. Section 547;

(2) a fraudulent transfer under 11 U.S.C. Section 548;

(3) a transfer that is fraudulent as to present and future creditors under Section 24.005, Business & Commerce Code, or a similar law of another state; or

(4) a transfer that is fraudulent as to present creditors under Section 24.006, Business & Commerce Code, or a similar law of another state.

(b) The commissioner may by rule designate coverages that violate this section. It is not a defense against a claim that a title insurance company has violated this section that the commissioner has not adopted a rule under this subsection.

(c) Title insurance issued in or on a form prescribed by the

1 commissioner shall be considered to comply with this section.
2 (d) Nothing in this section prohibits title insurance with
3 respect to liens, encumbrances, or other defects to title to land
4 that:
5 (1) appear in the public records before the date on
6 which the contract of title insurance is made;
7 (2) occur or result from transactions before the
8 transaction vesting title in the insured or creating the lien of the
9 insured mortgage; or
10 (3) result from failure to timely perfect or record
11 any instrument before the date on which the contract of title
12 insurance is made.
13 (e) A title insurance company may not engage in the business
14 of title insurance in this state if the title insurance company
15 provides insurance of the type prohibited by Subsection (a)
16 anywhere in the United States, except to the extent that the laws of
17 another state require the title insurance company to provide that
18 type of insurance.
19 SECTION 25.002. Section 2502.006, Insurance Code, as added
20 by this Act, applies only to an insurance policy that is delivered,
21 issued for delivery, or renewed on or after January 1, 2012. A
22 policy delivered, issued for delivery, or renewed before January 1,
23 2012, is governed by the law as it existed immediately before the
24 effective date of this Act, and that law is continued in effect for
25 that purpose.
26 ARTICLE 26. RESCISSION OF HEALTH BENEFIT PLAN
27 SECTION 26.001. Chapter 1202, Insurance Code, is amended by

1 adding Subchapter C to read as follows:

2 SUBCHAPTER C. RESCISSION OF HEALTH BENEFIT PLAN

3 Sec. 1202.101. DEFINITION. In this subchapter,
4 "rescission" means the termination of an insurance agreement,
5 contract, evidence of coverage, insurance policy, or other similar
6 coverage document in which the health benefit plan issuer, as
7 applicable, refunds premium payments or demands the recoupment of
8 any benefit already paid under the plan.

9 Sec. 1202.102. APPLICABILITY. (a) This subchapter applies
10 only to a health benefit plan, including a small or large employer
11 health benefit plan written under Chapter 1501, that provides
12 benefits for medical or surgical expenses incurred as a result of a
13 health condition, accident, or sickness, including an individual,
14 group, blanket, or franchise insurance policy or insurance
15 agreement, a group hospital service contract, or an individual or
16 group evidence of coverage or similar coverage document that is
17 offered by:

18 (1) an insurance company;

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

21 (3) a fraternal benefit society operating under
22 Chapter 885;

23 (4) a stipulated premium company operating under
24 Chapter 884;

25 (5) a reciprocal exchange operating under Chapter 942;

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

27 (7) a health maintenance organization operating under

1 Chapter 843;
2 (8) a multiple employer welfare arrangement that holds
3 a certificate of authority under Chapter 846; or
4 (9) an approved nonprofit health corporation that
5 holds a certificate of authority under Chapter 844.
6 (b) This subchapter does not apply to:
7 (1) a health benefit plan that provides coverage:
8 (A) only for a specified disease or for another
9 limited benefit other than an accident policy;
10 (B) only for accidental death or dismemberment;
11 (C) for wages or payments in lieu of wages for a
12 period during which an employee is absent from work because of
13 sickness or injury;
14 (D) as a supplement to a liability insurance
15 policy;
16 (E) for credit insurance;
17 (F) only for dental or vision care;
18 (G) only for hospital expenses; or
19 (H) only for indemnity for hospital confinement;
20 (2) a Medicare supplemental policy as defined by
21 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
22 as amended;
23 (3) a workers' compensation insurance policy;
24 (4) medical payment insurance coverage provided under
25 a motor vehicle insurance policy;
26 (5) a long-term care insurance policy, including a
27 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 PROHIBITED; EXCEPTION. (a) Notwithstanding any other law, except as provided by Subsection (b), a health benefit plan issuer may not rescind coverage under a health benefit plan with respect to an enrollee in the plan.

(b) A health benefit plan issuer may rescind coverage under a health benefit plan with respect to an enrollee if the enrollee engages in conduct that constitutes fraud or makes an intentional misrepresentation of a material fact.

Sec. 1202.104. NOTICE OF INTENT TO RESCIND. (a) A health benefit plan issuer may not rescind a health benefit plan without first notifying the affected enrollee in writing at least 30 days in advance of the issuer's intent to rescind the health benefit plan.

(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 date on which the rescission is effective and the prior date to which the rescission retroactively reaches;

(3) an itemized list of any pending or paid claims the health benefit plan issuer intends to recoup following the rescission;

(4) an explanation of how the enrollee may obtain any documentation used by the health benefit plan issuer to justify the rescission;

(5) a statement that the enrollee is entitled to appeal a rescission decision to an independent review organization and that the health benefit plan issuer bears the burden of proof on appeal;

(6) an explanation of any time limit with which the enrollee must comply to appeal the rescission decision to an independent review organization, and a description of the consequences of failure to appeal within that time limit; and

(7) a statement that there is no cost to the individual to appeal the rescission decision to an independent review organization.

Sec. 1202.105. INDEPENDENT REVIEW PROCESS; PAYMENT OF CLAIMS. (a) An enrollee may appeal a health benefit plan issuer's rescission decision to an independent review organization in the manner prescribed by the commissioner by rule.

(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

1 decision to rescind.
2 (c) A health benefit plan issuer shall pay all otherwise
3 valid medical claims under an individual's plan until the later of:
4 (1) the date on which an independent review
5 organization determines that the decision to rescind is
6 appropriate; or
7 (2) the time to appeal to an independent review
8 organization has expired without an affected individual initiating
9 an appeal.
10 (d) The commissioner shall adopt rules necessary to
11 implement and enforce this section, including rules establishing
12 certification standards for independent review organizations for
13 purposes of this chapter.
14 Sec. 1202.106. BURDEN OF PROOF. In an appeal to an
15 independent review organization under Section 1202.105 or an
16 enforcement action or cause of action based on a violation of this
17 subchapter by a health benefit plan issuer, the health benefit plan
18 issuer must prove that the issuer did not violate this subchapter.
19 SECTION 26.002. The change in law made by this article
20 applies only to a health benefit plan that is delivered, issued for
21 delivery, or renewed on or after January 1, 2012. A health benefit
22 plan that is delivered, issued for delivery, or renewed before
23 January 1, 2012, is governed by the law as it existed immediately
24 before the effective date of this Act, and that law is continued in
25 effect for that purpose.
26 ARTICLE 27. TRANSITION; EFFECTIVE DATE
27 SECTION 27.001. Except as otherwise provided by this Act,

1 this Act applies only to an insurance policy, contract, or evidence
2 of coverage that is delivered, issued for delivery, or renewed on or
3 after January 1, 2012. A policy, contract, or evidence of coverage
4 delivered, issued for delivery, or renewed before January 1, 2012,
5 is governed by the law as it existed immediately before the
6 effective date of this Act, and that law is continued in effect for
7 that purpose.
8 SECTION 27.002. This Act takes effect September 1, 2011.