SENATE AMENDMENTS

2nd Printing

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

to read as follows:

Sec. 559.003. INFORMATION PROVIDED TO PUBLIC. The department shall:

(1) update insurer profiles maintained on the department's Internet website to provide information to consumers stating whether or not an insurer uses credit scoring; and

(2) post on the department's Internet website:

(A) the report required under former Section 15, Article 21.49-2U; and

(B) information as to how consumers may obtain copies of individual credit reports and claims history reports, including posting the Internet website address for each nationwide credit reporting agency[~~, on the department's Internet website~~].

SECTION 1.005. Subchapter A, Chapter 2301, Insurance Code, is amended by adding Section 2301.010 to read as follows:

Sec. 2301.010. CONTRACTUAL LIMITATIONS PERIOD AND CLAIM FILING PERIOD IN CERTAIN PROPERTY INSURANCE FORMS. (a) A policy form or printed endorsement form for residential or commercial property insurance that is filed by an insurer or adopted by the department under this subchapter may provide for a contractual limitations period for filing suit on a first-party claim under the policy. The contractual limitations period may not end before the earlier of:

(1) two years from the date the insurer accepts or rejects the claim; or

(2) three years from the date of the loss that is the subject of the claim.

(b) A policy or endorsement described by Subsection (a) may contain a provision requiring that a claim be filed with the insurer not later than one year after the date of the loss that is the subject of the claim. A provision under this subsection must include a provision allowing the filing of claims after the first anniversary of the date of the loss for good cause shown by the person filing the claim.

(c) A contractual provision contrary to Subsection (a) or (b) is void. This subsection does not affect the validity of other provisions of a contract that may be given effect without the voided provision to the extent those provisions are severable.

SECTION 1.006. Section 16.070, Civil Practice and Remedies Code, is amended by amending Subsection (a) and adding Subsection (c) to read as follows:

(a) Except as provided by Subsections [~~Subsection~~] (b) and (c), a person may not enter a stipulation, contract, or agreement that purports to limit the time in which to bring suit on the stipulation, contract, or agreement to a period shorter than two years. A stipulation, contract, or agreement that establishes a limitations period that is shorter than two years is void in this state.

(c) This section does not apply to provisions related to claims covered by a residential or commercial property insurance policy that complies with Section 2301.010, Insurance Code.

SECTION 1.007. (a) The Texas Department of Insurance shall conduct a study concerning the feasibility and effectiveness of the establishment of a mandatory medical reinsurance program in this

state through which issuers of group health benefit plans offered by employers with 100 or fewer employees would be required to purchase reinsurance.

(b) The study conducted under this section must:

(1) include an analysis of data from calendar years 2009, 2010, and 2011; and

(2) seek to determine what effect, if any, the establishment of a medical reinsurance program described by Subsection (a) of this section would have had on premium rates, renewal rates, and overall costs to employers during calendar years 2009, 2010, and 2011, had the program been operational during those years.

(c) The department may request information from the Employees Retirement System of Texas, the Teacher Retirement System of Texas, and health benefit plan issuers in this state as necessary to complete the study required under this section.

(d) The department shall include the results of the study conducted under this section in the biennial report submitted to the legislature under Section 32.022, Insurance Code, nearest to December 31, 2012.

SECTION 1.008. Section 2301.010, Insurance Code, as added by this article, applies only to an insurance policy that is 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 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

appropriate to meet changing needs.

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

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

Sec. 843.410 [~~843.441~~]. ASSESSMENTS. (a) To provide funds for the administrative expenses of the commissioner regarding rehabilitation, liquidation, supervision, conservatorship, or seizure [~~conservation~~] of a [~~an impaired~~] health maintenance organization in this state that is placed under supervision or in conservatorship under Chapter 441 or against which a delinquency proceeding is commenced under Chapter 443 and that is found by the commissioner to have insufficient funds to pay the total amount of health care claims and the administrative[~~, including~~] expenses incurred by the commissioner regarding the rehabilitation, liquidation, supervision, conservatorship, or seizure, the commissioner [~~acting as receiver or by a special deputy receiver, the committee, at the commissioner's direction,~~] shall assess each health maintenance organization in the proportion that the gross premiums of the health maintenance organization that were written in this state during the preceding calendar year bear to the aggregate gross premiums that were written in this state by all health maintenance organizations, as found [~~provided to the 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 other 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, 1205-1208 [~~1205-1209~~], 1211, 1213, 1214 [~~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;

(10) the public insurance adjusters examination advisory committee;

(11) the utilization review agents advisory committee;

(12) the fire extinguisher advisory council;

(13) the fire detection and alarm devices advisory council;

(14) the fire protection advisory council; and

(15) the fireworks advisory council.

(b) All powers, duties, obligations, rights, contracts, funds, records, and real or personal property of a board, committee, council, or task force listed under Subsection (a) of this section shall be transferred to the Texas Department of Insurance not later than February 28, 2012.

SECTION 2.010. The changes in law made by this Act by repealing Sections 523.003 and 843.439, Insurance Code, apply only to a cause of action that accrues 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 immediately before that date, and that law is continued in effect for that purpose.

ARTICLE 3. RATE REGULATION

SECTION 3.001. Subchapter F, Chapter 843, Insurance Code, is amended by adding Section 843.2071 to read as follows:

Sec. 843.2071. NOTICE OF INCREASE IN CHARGE FOR COVERAGE. (a) Not less than 60 days before the date on which an increase in a charge for coverage under this chapter takes effect, a health maintenance organization shall:

(1) give to each enrollee under an individual evidence of coverage written notice of the effective date of the increase; and

(2) provide the enrollee a table that clearly lists:

(A) the actual dollar amount of the charge for coverage on the date of the notice;

(B) the actual dollar amount of the charge for coverage after the charge increase; and

(C) the percentage change between the amounts described by Paragraphs (A) and (B).

(b) The notice required by this section must be based on coverage in effect on the date of the notice.

(c) This section may not be construed to prevent a health maintenance organization, at the request of an enrollee, from negotiating a change in benefits or rates after delivery of the notice required by this section.

(d) A health maintenance organization may not require an enrollee entitled to notice under this section to respond to the health maintenance organization to renew the coverage or take other action relating to the renewal or extension of the coverage 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 3.002. Subchapter C, Chapter 1201, Insurance Code, is amended by adding Section 1201.109 to read as follows:

Sec. 1201.109. NOTICE OF RATE INCREASE. (a) Not less than 60 days before the date on which a premium rate increase takes effect on an individual accident and health insurance policy delivered or issued for delivery in this state by an insurer, the insurer shall:

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

(2) provide the insured a table that clearly lists:

(A) the actual dollar amount of the premium on the date of the notice;

(B) the actual dollar amount of the premium after the premium rate increase; and

(C) the percentage change between the amounts described by Paragraphs (A) and (B).

(b) The notice required by this section must be based on coverage in effect on the date of the notice.

(c) This section may not be construed to prevent an insurer, at the request of an insured, from negotiating a change in benefits 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

the date of the notice;

(B) the actual dollar amount of the premium after the premium rate increase; and

(C) the percentage change between the amounts described by Paragraphs (A) and (B).

(b) The notice required by this section must be based on coverage in effect on the date of the notice.

(c) This section may not be construed to prevent an insurer, at the request of a small employer, from negotiating a change in benefits or rates after delivery of the notice required by this section.

(d) An insurer may not require a small employer 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 3.004. 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;

(B) [~~(2)~~] statistics or other information to support the rates to be used by the insurer, including information necessary to evidence that the computation of the rate does not include disallowed expenses; and

(C) [~~(3)~~] information concerning policy fees, service fees, and other fees that are charged or collected by the insurer under Section 550.001 or 4005.003; and

(2) prescribe the process through which the department requests supplementary rating information and supporting information under this section, including:

(A) the number of times the department may make a request for information; and

(B) the types of information the department may request when reviewing a rate filing.

SECTION 3.006. Section 2251.103, Insurance Code, is amended to read as follows:

Sec. 2251.103. COMMISSIONER ACTION CONCERNING [~~DISAPPROVAL OF RATE IN~~] RATE FILING NOT YET IN EFFECT; HEARING AND ANALYSIS. (a) Not later than the earlier of the date the rate takes effect or the 30th day after the date a rate is filed with the department under Section 2251.101, the [~~The~~] commissioner shall disapprove the [~~a~~] rate if the commissioner determines that the rate [~~filing made under this chapter~~] does not comply with the requirements of this chapter [~~meet the standards established under Subchapter B~~].

(b) Except as provided by Subsection (c), if a rate has not been disapproved by the commissioner before the expiration of the 30-day period described by Subsection (a), the rate is not

considered disapproved under this section.

(c) For good cause, the commissioner may, on the expiration of the 30-day period described by Subsection (a), extend the period for disapproval of a rate for one additional 30-day period. The commissioner and the insurer may not by agreement extend the 30-day period described by Subsection (a) or this subsection.

(d) If the commissioner disapproves a rate under this section [~~filing~~], the commissioner shall issue an order specifying in what respects the rate [~~filing~~] fails to meet the requirements of this chapter.

(e) An insurer that files a rate that is disapproved under this section [~~(c) The filer~~] is entitled to a hearing on written request made to the commissioner not later than the 30th day after the date the order disapproving the rate [~~filing~~] takes effect.

(f) The department shall track, compile, and routinely analyze the factors that contribute to the disapproval of rates under this section.

SECTION 3.007. Subchapter C, Chapter 2251, Insurance Code, is amended by adding Section 2251.1031 to read as follows:

Sec. 2251.1031. REQUESTS FOR ADDITIONAL INFORMATION. (a) If the department determines that the information filed by an insurer under this subchapter or Subchapter D is incomplete or otherwise deficient, the department may request additional information from the insurer.

(b) If the department requests additional information from the insurer during the 30-day period described by Section 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

under that chapter [~~open to public inspection as of the date of the filing~~].

SECTION 3.010. Section 2251.151, Insurance Code, is amended by adding Subsections (c-1) and (f) and amending Subsection (e) to read as follows:

(c-1) If the commissioner requires an insurer to file the insurer's rates under this section, the commissioner shall periodically assess whether the conditions described by Subsection (a) continue to exist. If the commissioner determines that the conditions no longer exist, the commissioner shall issue an order excusing the insurer from filing the insurer's rates under this section.

(e) If the commissioner requires an insurer to file the insurer's rates under this section, the commissioner shall issue an order specifying the commissioner's reasons for requiring the rate filing and explaining any steps the insurer must take and any conditions the insurer must meet in order to be excused from filing the insurer's rates under this section. An affected insurer is entitled to a hearing on written request made to the commissioner not later than the 30th day after the date the order is issued.

(f) The commissioner by rule shall define:

(1) the financial conditions and rating practices that may subject an insurer to this section under Subsection (a)(1); and

(2) the process by which the commissioner determines that a statewide insurance emergency exists under Subsection (a)(2).

SECTION 3.011. Section 2251.156, Insurance Code, is amended

to read as follows:

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

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

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

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

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

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

SECTION 3.014. Sections 843.2071, 1201.109, and 1501.216, Insurance Code, as added by this Act, apply only to a health maintenance organization individual evidence of coverage, an individual accident and health insurance policy, or a small employer health benefit plan that is delivered, issued for delivery, or renewed on or after the effective date of this Act. An evidence of coverage, policy, or plan delivered, issued for delivery, or renewed before the effective date of this Act 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 3.015. Sections 2251.002(8) and 2251.107, Insurance Code, as amended by this Act, apply only to a request to inspect information or to obtain public information made to the Texas Department of Insurance on or after the effective date of this Act. A request made 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.

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

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

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

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

ARTICLE 4. STATE FIRE MARSHAL'S OFFICE

SECTION 4.001. Section 417.008, Government Code, is amended by adding Subsection (f) to read as follows:

(f) The commissioner by rule shall prescribe a reasonable fee for an inspection performed by the state fire marshal that may be charged to a property owner or occupant who requests the inspection, as the commissioner considers appropriate. In prescribing the fee, the commissioner shall consider the overall cost to the state fire marshal to perform the inspections, including the approximate amount of time the staff of the state fire marshal needs to perform an inspection, travel costs, and other expenses.

SECTION 4.002. Section 417.0081, Government Code, is amended to read as follows:

Sec. 417.0081. INSPECTION OF CERTAIN STATE-OWNED OR STATE-LEASED BUILDINGS. (a) The state fire marshal, at the commissioner's direction, shall periodically inspect public buildings under the charge and control of the Texas Facilities [~~General Services~~] Commission and buildings leased for the use of a state agency by the Texas Facilities Commission.

(b) For the purpose of determining a schedule for conducting inspections under this section, the commissioner by rule shall adopt guidelines for assigning potential fire safety risk to state-owned and state-leased buildings. Rules adopted under this 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;

ADMINISTRATIVE PENALTIES [~~ALTERNATE REMEDIES~~]. (a) This section applies to each person and firm licensed, registered, or otherwise regulated by the department through the state fire marshal, including:

(1) a person regulated under Title 20, Insurance Code; and

(2) a person licensed under Chapter 2154, Occupations Code.

(b) The commissioner by rule shall delegate to the state fire marshal the authority to take disciplinary and enforcement actions, including the imposition of administrative penalties in accordance with this section on a person regulated under a law listed under Subsection (a) who violates that law or a rule or order adopted under that law. In the rules adopted under this subsection, the commissioner shall:

(1) specify which types of disciplinary and enforcement actions are delegated to the state fire marshal; and

(2) outline the process through which the state fire marshal may, subject to Subsection (e), impose administrative penalties or take other disciplinary and enforcement actions.

(c) The commissioner by rule shall adopt a schedule of administrative penalties for violations subject to a penalty under this section to ensure that the amount of an administrative penalty imposed is appropriate to the violation. The department shall provide the administrative penalty schedule to the public on request. The amount of an administrative penalty imposed under this section must be based on:

(1) the seriousness of the violation, including:

(A) the nature, circumstances, extent, and gravity of the violation; and

(B) the hazard or potential hazard created to the health, safety, or economic welfare of the public;

(2) the economic harm to the public interest or public confidence caused by the violation;

(3) the history of previous violations;

(4) the amount necessary to deter a future violation;

(5) efforts to correct the violation;

(6) whether the violation was intentional; and

(7) any other matter that justice may require.

(d) In [~~The state fire marshal, in~~] the enforcement of a law that is enforced by or through the state fire marshal, the state fire marshal may, in lieu of cancelling, revoking, or suspending a license or certificate of registration, impose on the holder of the license or certificate of registration an order directing the holder to do one or more of the following:

(1) cease and desist from a specified activity;

(2) pay an administrative penalty imposed under this section [~~remit to the commissioner within a specified time a monetary forfeiture not to exceed $10,000 for each violation of an applicable law or rule~~]; or [~~and~~]

(3) make restitution to a person harmed by the holder's violation of an applicable law or rule.

(e) The state fire marshal shall impose an administrative penalty under this section in the manner prescribed for imposition

of an administrative penalty under Subchapter B, Chapter 84, Insurance Code. The state fire marshal may impose an administrative penalty under this section without referring the violation to the department for commissioner action.

(f) An affected person may dispute the imposition of the penalty or the amount of the penalty imposed in the manner prescribed by Subchapter C, Chapter 84, Insurance Code. Failure to pay an administrative penalty imposed under this section is subject to enforcement by the department.

ARTICLE 5. TITLE INSURANCE

SECTION 5.001. Chapter 2501, Insurance Code, is amended by adding Section 2501.009 to read as follows:

Sec. 2501.009. GIFTS, GRANTS, AND DONATIONS FOR EDUCATIONAL PURPOSES. (a) The department may accept gifts, grants, and donations to enable employees of the department to participate in educational events, and for other educational purposes, related to title insurance.

(b) The commissioner may adopt rules related to the acceptance of gifts, grants, and donations described in Subsection (a).

SECTION 5.002. Section 2502.055(a), Insurance Code, is amended to read as follows:

(a) The activities described in this section are not rebates. Nothing in this subchapter prohibits a title insurance company or a title insurance agent from:

(1) engaging in [~~legal~~] promotional and educational 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

significant terms of the reinsurance, the financial impact of the transaction on the title insurance company acquiring reinsurance, and the specific identity and state of domicile of each title insurance company from which reinsurance is acquired.

(c) Notwithstanding any other provision of this subchapter, the department may, on application and hearing, permit a title insurance company to acquire reinsurance that does not comply with Subsection (a) on an individual policy or facultative basis from a title insurance company domiciled in another state and not authorized to engage in the business of title insurance in this state, if:

(1) the company has exhausted the opportunity to acquire reinsurance from all other authorized title insurance companies; and

(2) the title insurance company from which the reinsurance is acquired has a combined capital and surplus of at least $2 [~~$1.4~~] million as stated in its annual statement preceding the acceptance of reinsurance.

(d) [~~(b)~~] Notwithstanding any other provision of this subchapter, the department may, on application and hearing, permit a title insurance company, including an authorized reinsuring title insurance company, to retain an additional potential liability of not more than 40 percent of the company's capital stock and surplus as stated in the most recent annual statement of the company, if:

(1) the company has exhausted the opportunity to acquire reinsurance under Subsection (c) [~~(a)~~]; and

(2) the additional potential liability of the company

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DENIAL. (a) Except as provided by Subsection (b) or (c), the department may not reject, delay, or deny a notice of appointment under Section 2651.009 based wholly or partly on a pending department audit or complaint investigation or a pending disciplinary action against a title insurance agent or appointing title insurance company that has not been finally closed or resolved by a final order issued by the commissioner on or before the date on which the notice is received by the department.

(b) The department may reject a notice of appointment under Section 2651.009 if the department determines that the appointing title insurance company or the title insurance agent intentionally made a material misstatement in the notice of appointment or attempted to have the appointment approved by fraud or misrepresentation.

(c) The department may delay approval of a notice of appointment if:

(1) the title insurance agent or the appointing title insurance company 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 title insurance agent or appointing title insurance company.

(d) Except as provided by Subsection (e) or (f), the department may not delay or deny a renewal application under 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

renewal if the department determines that the applicant or license holder intentionally made a material misstatement in the license application or license renewal or the applicant or license holder attempted to obtain the license or renewal by fraud or misrepresentation.

Sec. 2652.203. NOTICE OF DISCIPLINARY OR ENFORCEMENT ACTION; AUTOMATIC DISMISSAL. (a) The department shall notify a license holder of a disciplinary action 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) 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 agent or direct operation with which an escrow officer has, or proposes to obtain, employment.

SECTION 5.010. Subchapter B, Chapter 2703, Insurance Code, is amended by adding Section 2703.0515 to read as follows:

Sec. 2703.0515. CERTAIN REQUIREMENTS PROHIBITED. (a) A title insurance company is not required to offer or provide in connection with a title insurance policy an endorsement insuring a loss from damage resulting from the use of the surface of the land for the extraction or development of coal, lignite, oil, gas, or another mineral if the policy includes a general exception or exclusion from coverage a loss from damage resulting from the use of the surface of the land for the extraction or development of coal, lignite, oil, gas, or another mineral.

(b) In this section, "general exception or exclusion" means a provision in a title insurance policy or other title insuring form that provides that title insurance coverage under the policy or form:

(1) is subject to, and the title insurer does not insure title to, and excepts from the description of the covered property, coal, lignite, oil, gas, and other minerals in and under and that may be produced from the covered property, together with related rights, privileges, and immunities; or

(2) does not cover a lease, grant, exception, or reservation of coal, lignite, oil, gas, or other minerals, or related rights, privileges, and immunities, appearing in the public 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

title insurance policy include a general exception or a special exception to except from coverage a mineral estate or an instrument that purports to reserve or transfer all or part of a mineral estate.

(b) The inclusion in a title insurance policy of a general exception or a special exception described by Subsection (a) does not create title insurance coverage as to the condition or ownership of the mineral estate.

SECTION 5.012. Section 2703.153, Insurance Code, is amended by amending Subsections (c) and (d) and adding Subsections (h) and (i) to read as follows:

(c) Not less frequently than once every five years, the commissioner shall evaluate the information required under this section to determine whether the department needs additional or different information or no longer needs certain information to promulgate rates. If the department requires a title insurance company or title insurance agent to include new or different information in the statistical report, that information may be considered by the commissioner in fixing premium rates if the information collected is reasonably credible for the purposes for which the information is to be used.

(d) A title insurance company or a title insurance agent aggrieved by a department requirement concerning the submission of information may bring a suit in a district court in Travis County alleging that the request for information:

(1) is unduly burdensome; or

(2) is not a request for information material to

fixing and promulgating premium rates or another matter that may be the subject of the periodic [~~biennial~~] hearing and is not a request reasonably designed to lead to the discovery of that information.

(h) The contents of the statistical report, including any amendments to the statistical report, must be established in a rulemaking hearing under Subchapter B, Chapter 2001, Government Code.

(i) An amendment to the contents of the statistical report may not apply retroactively.

SECTION 5.013. Section 2703.202, Insurance Code, is amended by amending Subsections (b) and (d) and adding Subsections (g), (h), (i), (j), (k), (l), (m), (n), and (o) to read as follows:

(b) The commissioner shall order a public hearing to consider changing a premium rate, including fixing a new premium rate, in response to a written [~~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[~~, the commissioner shall order a public hearing to consider changing a premium rate~~].

(d) Notwithstanding Subsection (c), [~~at the request of a 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

hearing requested under Subsection (d) not later than the 30th day after the date responses to the notice of call are required under Subdivision (2);

(4) the commissioner shall commence the public hearing not earlier than the 120th day after the date the commissioner issues a notice of hearing under Subdivision (3);

(5) the commissioner shall close the public hearing not later than the 150th day after the date the commissioner issues the notice of hearing under Subdivision (3); and

(6) the commissioner shall render a decision and issue a final order not later than the 60th day after the record made in the public hearing is closed under Subdivision (5).

(i) A party's presentation of relevant, admissible oral testimony in a hearing under this section may not be limited.

(j) The commissioner shall consider each matter presented in a hearing under this section and announce in a public hearing all decisions on all matters considered.

(k) A party described by Subsection (b) may petition a district court in Travis County to enter an order requiring the commissioner to comply with the deadlines described by this section if the commissioner fails to meet a requirement in Subsection (g) or (h).

(l) Subject to Subsection (m), if the commissioner fails to comply with the requirements under Subsection (g) or (h)(6), a combination of at least three associations, persons, or entities listed in Subsection (b) may jointly petition a district court of 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~~]

HEARING. (a) Subject to this section, a trade association whose membership is composed of at least 20 percent of the members of an industry or group represented by the trade association, an association, a person or entity described by Section 2703.202(b), or department staff [~~an individual or association or other entity recommending adoption of a premium rate or another matter relating to regulating the business of title insurance~~] shall be admitted as a party to the periodic [~~biennial~~] hearing under Section 2703.203.

(b) A party to any portion of the periodic [~~the ratemaking phase of the biennial~~] hearing relating to ratemaking may request that the commissioner remove any other party to that portion of [~~the ratemaking phase of~~] the hearing on the grounds that the other party does not have a substantial interest in title insurance. A decision of the commission to deny or grant the request is final and subject to appeal in accordance with Section 36.202.

SECTION 5.016. Section 2703.207, Insurance Code, is amended to read as follows:

Sec. 2703.207. NOTICE OF CERTAIN HEARINGS. Not later than the 60th day before the date of a hearing under Section 2703.202, 2703.203, or 2703.206, notice of the hearing and of each item to be considered at the hearing shall be:

(1) sent directly to all parties to the previous hearing conducted under Section 2703.202, 2703.203, or 2703.206, if the hearing was conducted as a contested case hearing [~~title insurance companies and title insurance agents~~]; and

(2) published in the Texas Register and on the 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;

(L) a statewide mutual assessment company;

(M) a local mutual aid association;

(N) a local mutual burial association;

(O) an association exempt under Section 887.102;

(P) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 842;

(Q) a county mutual insurance company; and

(R) a farm mutual insurance company.

Sec. 35.002. CONSTRUCTION WITH OTHER LAW. (a) Notwithstanding any other provision of this code, a regulated entity may conduct business electronically in accordance with this chapter and the rules adopted under Section 35.004.

(b) To the extent of any conflict between another provision of this code and a provision of this chapter, the provision of this chapter controls.

Sec. 35.003. ELECTRONIC TRANSACTIONS AUTHORIZED. A regulated entity may conduct business electronically to the same extent that the entity is authorized to conduct business otherwise if before the conduct of business each party to the business agrees to conduct the business electronically.

Sec. 35.004. RULES. (a) The commissioner shall adopt rules necessary to implement and enforce this chapter.

(b) The rules adopted by the commissioner under this section must include rules that establish minimum standards with which a regulated entity must comply in the entity's electronic conduct of business with other regulated entities and consumers.

SECTION 6.002. Chapter 35, Insurance Code, as added by this

Act, applies only to business conducted on or after the effective date of this Act. Business conducted before the effective date of this Act is governed by the law in effect on the date the business was conducted, and that law is continued in effect for that purpose.

ARTICLE 7. DATA COLLECTION

SECTION 7.001. Chapter 38, Insurance Code, is amended by adding Subchapter I to read as follows:

SUBCHAPTER I. DATA COLLECTION RELATING TO CERTAIN PERSONAL LINES OF INSURANCE

Sec. 38.401. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to an insurer who writes personal automobile insurance or residential property insurance in this state.

Sec. 38.402. FILING OF CERTAIN CLAIMS INFORMATION. (a) The commissioner shall require each insurer described by Section 38.401 to file with the commissioner aggregate personal automobile insurance and residential property insurance claims information for the period covered by the filing, including the number of claims:

(1) filed during the reporting period;

(2) pending on the last day of the reporting period, including pending litigation;

(3) closed with payment during the reporting period;

(4) closed without payment during the reporting period; and

(5) carrying over from the reporting period immediately preceding the current reporting period.

(b) An insurer described by Section 38.401 must file the

information described by Subsection (a) on an annual basis. The information filed must be broken down by quarter.

Sec. 38.403. PUBLIC INFORMATION. (a) The department shall post the data contained in claims information filings under Section 38.402 on the department's Internet website. The commissioner by rule may establish a procedure for posting data under this subsection that includes a description of the data that must be posted and the manner in which the data must be posted.

(b) Information provided under this section must be aggregate data by line of insurance for each insurer and may not reveal proprietary or trade secret information of any insurer.

Sec. 38.404. RULES. The commissioner may adopt rules necessary to implement this subchapter.

ARTICLE 7A. HEALTH BENEFIT PLAN INNOVATIONS PROGRAM

SECTION 7A.001. Subtitle B, Title 5, Insurance Code, is amended by adding Chapter 525 to read as follows:

CHAPTER 525. HEALTH BENEFIT PLAN INNOVATIONS PROGRAM

Sec. 525.001. PROGRAM ESTABLISHED. (a) The department shall develop and implement a health benefit plan innovations program to study the number of uninsured individuals in this state, the reasons those individuals are uninsured, and possible solutions that would expand access to affordable health benefit plan coverage in this state.

(b) The department shall use department employees already employed in the consumer protection division of the department to implement the program. The department may not hire full-time employees whose primary job functions would solely be

implementation of the program.

Sec. 525.002. PROGRAM COMPONENTS. (a) Except as provided by Subsection (b), the program implemented under this chapter must:

(1) collect and analyze data concerning the number, age, and demographic characteristics of uninsured individuals in this state;

(2) identify the reasons why individuals in this state are uninsured;

(3) examine and evaluate the effectiveness of programs implemented in other states to reduce the number of uninsured residents in those states;

(4) monitor and evaluate the health benefit market in this state and determine whether residents of this state have sufficient access to a variety of health benefit plan products to ensure adequate health benefit plan coverage; and

(5) make recommendations to the department and to the legislature concerning programs or initiatives to be implemented in this state to reduce the number of uninsured residents in this state.

(b) The program must supplement and may not duplicate a service or function of another existing program or state agency and shall refer consumers to other programs and agencies where appropriate.

(c) The program may:

(1) operate a statewide clearinghouse for objective consumer information about health care coverage, including options for obtaining health care coverage;

(2) collect, track, and quantify problems and inquiries encountered by consumers;

(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverages;

(4) provide existing health-related information to the general public and health care providers to improve the quality of and access to health care; and

(5) establish an advisory committee composed of state agencies to increase collaboration and coordination of health-related programs and benefits.

(d) The department shall coordinate program components that involve market and cost research or data collection and analysis with health benefit plan issuers and the Health and Human Services Commission to ensure the collection and analysis of complete and accurate information.

Sec. 525.003. REPORT. The department shall include in its biennial report to the legislature under Section 32.022 the program's findings concerning the information and recommendations described by Section 525.002.

Sec. 525.004. FUNDING. The department shall make a reasonable effort to obtain funding in the form of gifts and grants from the federal government or an organization or other private party that does not have a potential conflict of interest with the department or the goals of this chapter to assist with funding the program. The department shall adopt rules governing acceptance of 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

for initial [~~the~~] insurance coverage on behalf of the applicant on forms prescribed by the association. The association shall develop a simplified renewal process that allows for the acceptance of an application for renewal coverage, and payment of premiums, from a property and casualty agent or a person insured under this chapter. An [~~The~~] application for initial or renewal coverage must contain:

(1) a statement as to whether the applicant has submitted or will submit the premium in full from personal funds or, if not, to whom a balance is or will be due; and

(2) [~~. Each application for initial or renewal coverage must also contain~~] a statement that the agent acting on behalf of the applicant possesses proof of the declination described by Subsection (a) and proof of flood insurance coverage or unavailability of that coverage as described by Section 2210.203(a-1).

SECTION 9.005. Sections 2210.203(a) and (c), Insurance Code, are amended to read as follows:

(a) If the association determines that the property for which an application for initial insurance coverage is made is insurable property, the association, on payment of the premium, shall direct the issuance of an insurance policy as provided by the plan of operation.

(c) A policy may be renewed annually on application for renewal as long as the property continues to be insurable property. If the association determines that the property for which an application for renewal insurance coverage is made is insurable 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

for persons appointed as qualified inspectors.

SECTION 9.008. Subchapter F, Chapter 2210, Insurance Code, is amended by adding Section 2210.2551 to read as follows:

Sec. 2210.2551. EXCLUSIVE ENFORCEMENT AUTHORITY; RULES. (a) The department has exclusive authority over all matters relating to the appointment and oversight of qualified inspectors for purposes of this chapter.

(b) The commissioner by rule shall establish criteria to ensure that a person seeking appointment as a qualified inspector under this subchapter, including an engineer seeking appointment under Section 2210.255, possesses the knowledge, understanding, and professional competence to perform windstorm inspections under this chapter and to comply with other requirements of this chapter.

(c) Subsection (b) applies only to a determination concerning the appointment of a qualified inspector under this chapter. The exclusive jurisdiction of the department under this section does not apply to the practice of engineering as defined by Section 1001.003, Occupations Code, or to a license issued, qualification required, determination made, order issued, judgment rendered, or other action of a board operating under Chapter 1001, Occupations Code. In the event of conflict, the authority of that board prevails with regard to the practice of engineering.

SECTION 9.009. The heading to Section 2210.256, Insurance Code, is amended to read as follows:

Sec. 2210.256. DISCIPLINARY PROCEEDINGS REGARDING APPOINTED INSPECTORS AND CERTAIN OTHER PERSONS.

SECTION 9.010. Section 2210.256, Insurance Code, is amended

by adding Subsection (a-2) to read as follows:

(a-2) In addition to any other action authorized under this section, the commissioner ex parte may enter an emergency cease and desist order under Chapter 83 against a qualified inspector, or a person acting as a qualified inspector, if:

(1) the commissioner believes that:

(A) the qualified inspector has:

(i) through submitting or failing to submit to the department sealed plans, designs, calculations, or other substantiating information, failed to demonstrate that a structure or a portion of a structure subject to inspection meets the requirements of this chapter and department rules; or

(ii) refused to comply with requirements imposed under this chapter or department rules; or

(B) the person acting as a qualified inspector is acting without appointment as a qualified inspector under Section 2210.254 or 2210.255; and

(2) the commissioner determines that the conduct described by Subdivision (1) is fraudulent or hazardous or creates an immediate danger to the public.

SECTION 9.011. Section 2210.258(b), Insurance Code, is amended to read as follows:

(b) The association may not insure a structure described by Subsection (a) until:

(1) the structure has been inspected for compliance with the plan of operation in accordance with Section 2210.251(a); 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

department;

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

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

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

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

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

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

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

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

ARTICLE 11. TEXLINK TO HEALTH COVERAGE PROGRAM

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

Sec. 524.004. INFORMATION SHARING AGREEMENTS. The division

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

Code, a regional or local health care program operating under Chapter 75, Health and Safety Code, that seeks to obtain certification from the division that a plan offered by the program is a qualified health plan is subject to regulation by the department under this code, including provisions of this code designated by the commissioner by rule as necessary for the protection of the public, in the same manner as an insurer.

SECTION 11.003. Section 524.053, Insurance Code, as added by Chapter 721 (S.B. 78), Acts of the 81st Legislature, Regular Session, 2009, is amended by adding Subsection (d) to read as follows:

(d) The division may provide on an Internet website comparative information on health plans offered for sale in the state that are certified by the division using a standardized format for presenting health benefit plan options.

SECTION 11.004. Chapter 524, Insurance Code, as amended by Chapter 721 (S.B. 78), Acts of the 81st Legislature, Regular Session, 2009, is amended by adding Section 524.0545 to read as follows:

Sec. 524.0545. INFORMATION REGARDING ELIGIBILITY REQUIREMENTS. (a) The division may make available information regarding eligibility requirements for enrollment in medical assistance programs offered by the state.

(b) The division, in coordination with the Health and Human Services Commission, may assist in the facilitation of enrollment of individuals identified as eligible for programs described under Subsection (a).

ARTICLE 12. ALTERNATIVE DISPUTE RESOLUTION PROCEDURES FOR CERTAIN DISPUTES

SECTION 12.001. Chapter 541, Insurance Code, is amended by adding Subchapter D-1 to read as follows:

SUBCHAPTER D-1. DISPUTES SUBJECT TO ALTERNATIVE DISPUTE RESOLUTION PROCEDURES

Sec. 541.181. PRIVATE ACTION SUBJECT TO ALTERNATIVE DISPUTE RESOLUTION PROCEDURE. (a) In this subchapter:

(1) "Alternative dispute resolution procedure" means a procedure included in an insurance policy to resolve disputes arising under the policy, including arbitration, mediation, and appraisal procedures.

(2) "Residential property insurance" has the meaning assigned by Section 544.352.

(b) Before filing a private action for damages under this chapter, an insured who disputes the amount of a loss of or damage to property covered by a residential property insurance policy that includes an alternative dispute resolution procedure must:

(1) send the insurer written notice of the dispute; and

(2) comply with all applicable policy terms and conditions with respect to the dispute.

(c) The insurer shall initiate the alternative dispute resolution procedure included in the residential property insurance policy with respect to the dispute not later than:

(1) the 45th day after the date the insurer receives the notice required by Subsection (b); or

(2) an earlier date provided by the policy.

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

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

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

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

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

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

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

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

Subsection (a)(2).

(d) An insurer may not recover court costs and attorney's fees awarded under Subsection (a)(2) out of money awarded to a person who prevails in an alternative dispute resolution procedure.

Sec. 541.183. NOTICE OF ALTERNATIVE DISPUTE RESOLUTION REQUIRED. On receipt of written notice from the insured of a dispute arising under the policy, an insurer shall provide an insured under a residential property insurance policy that includes an alternative dispute resolution procedure with all necessary information relating to the prerequisites for bringing a private action for damages in compliance with the policy and this subchapter.

SECTION 12.002. Section 542.058(b), Insurance Code, is amended to read as follows:

(b) Subsection (a) does not apply in a case in which it is found as a result of arbitration or litigation that a claim received by an insurer is invalid and should not be paid by the insurer or in a case in which an insurer and a claimant participate in an alternative dispute resolution procedure included in the relevant insurance policy.

SECTION 12.003. Subchapter D-1, Chapter 541, Insurance Code, as added by this Act, and Section 542.058(b), Insurance Code, as amended by this Act, apply only to a residential property insurance policy delivered, issued for delivery, or renewed on or after January 1, 2012. A residential property insurance policy delivered, issued for delivery, or renewed before January 1, 2012, 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

to estimate audit results or findings for a larger batch or group of claims not reviewed by the health maintenance organization or pharmacy benefit manager.

(9-b) "Freestanding emergency medical care facility" means a facility licensed under Chapter 254, Health and Safety Code.

SECTION 14.002. Section 843.338, Insurance Code, is amended to read as follows:

Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except as provided by Sections [~~Section~~] 843.3385 and 843.339, not later than the 45th day after the date on which a health maintenance organization receives a clean claim from a participating physician or provider in a nonelectronic format or the 30th day after the date the health maintenance organization receives a clean claim from a participating physician or provider that is electronically submitted, the health maintenance organization shall make a determination of whether the claim is payable and:

(1) if the health maintenance organization determines the entire claim is payable, pay the total amount of the claim in accordance with the contract between the physician or provider and the health maintenance organization;

(2) if the health maintenance organization determines a portion of the claim is payable, pay the portion of the claim that is not in dispute and notify the physician or provider in writing why the remaining portion of the claim will not be paid; or

(3) if the health maintenance organization determines that the claim is not payable, notify the physician or provider in

writing why the claim will not be paid.

SECTION 14.003. Section 843.339, Insurance Code, is amended to read as follows:

Sec. 843.339. DEADLINE FOR ACTION ON [~~CERTAIN~~] PRESCRIPTION CLAIMS; PAYMENT. (a) A [~~Not later than the 21st day after the date a~~] health maintenance organization, or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization, that affirmatively adjudicates a pharmacy claim that is electronically submitted[~~, the health maintenance organization~~] shall pay the total amount of the claim through electronic funds transfer not later than the 18th day after the date on which the claim was affirmatively adjudicated.

(b) A health maintenance organization, or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization, that affirmatively adjudicates a pharmacy claim that is not electronically submitted shall pay the total amount of the claim not later than the 21st day after the date on which the claim was affirmatively adjudicated.

SECTION 14.004. Subchapter J, Chapter 843, Insurance Code, is amended by adding Section 843.3401 to read as follows:

Sec. 843.3401. AUDIT OF PHARMACIST OR PHARMACY. (a) A health maintenance organization or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization may not use extrapolation to complete the audit of a provider who is a pharmacist or pharmacy. A health maintenance organization may not require extrapolation audits as a condition of 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

law.

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

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

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

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

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

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

(2) if the insurer determines a portion of the claim is payable, pay the portion of the claim that is not in dispute and notify the preferred provider in writing why the remaining portion of the claim will not be paid; or

(3) if the insurer determines that the claim is not payable, notify the preferred provider in writing why the claim will not be paid.

SECTION 14.009. Section 1301.104, Insurance Code, is amended to read as follows:

Sec. 1301.104. DEADLINE FOR ACTION ON [~~CERTAIN~~] PHARMACY CLAIMS; PAYMENT. (a) An [~~Not later than the 21st day after the date an~~] insurer, or a pharmacy benefit manager that administers pharmacy claims for the insurer under a preferred provider benefit plan, that affirmatively adjudicates a pharmacy claim that is electronically submitted[~~, the insurer~~] shall pay the total amount of the claim through electronic funds transfer not later than the 18th day after the date on which the claim was affirmatively adjudicated.

(b) An insurer, or a pharmacy benefit manager that administers pharmacy claims for the insurer under a preferred provider benefit plan, that affirmatively adjudicates a pharmacy claim that is not electronically submitted shall pay the total amount of the claim not later than the 21st day after the date on which the claim was affirmatively adjudicated.

SECTION 14.010. Subchapter C, Chapter 1301, Insurance Code, is amended by adding Section 1301.1041 to read as follows:

Sec. 1301.1041. AUDIT OF PHARMACIST OR PHARMACY. (a) An

insurer or a pharmacy benefit manager that administers pharmacy claims for the insurer may not use extrapolation to complete the audit of a preferred provider that is a pharmacist or pharmacy. An insurer may not require extrapolation audits as a condition of participation in the insurer's contract, network, or program for a preferred provider that is a pharmacist or pharmacy.

(b) An insurer or a pharmacy benefit manager that administers pharmacy claims for the insurer that performs an on-site audit of a preferred 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 preferred provider not later than the 15th day before the date on which the on-site audit is scheduled to occur.

SECTION 14.011. Section 1301.109, Insurance Code, is amended to read as follows:

Sec. 1301.109. APPLICABILITY TO ENTITIES CONTRACTING WITH INSURER. This subchapter applies to a person, including a pharmacy benefit manager, with whom an insurer contracts to:

(1) process or pay claims;

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

(3) issue verifications or preauthorizations.

SECTION 14.012. Subchapter C-1, Chapter 1301, Insurance Code, is amended by adding Section 1301.139 to read as follows:

Sec. 1301.139. LEGISLATIVE DECLARATION. It is the intent

of the legislature that the requirements contained in this subchapter regarding payment of claims to preferred providers who are pharmacists or pharmacies apply to all insurers and pharmacy benefit managers unless otherwise prohibited by federal law.

SECTION 14.013. (a) With respect to pharmacy benefits provided under a contract, the changes in law made by this article apply only to a contract entered into or renewed on or after the effective date of this Act and payment for pharmacy benefits provided under the contract. A contract entered into before the effective date of this Act and not renewed or that was last renewed before the effective date of this Act, and payment for pharmacy benefits provided under the contract, are governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(b) With respect to payment for pharmacy benefits not provided under a contract to which Subsection (a) of this section applies, the changes in law made by this article apply only to payment for benefits provided on or after the effective date of this Act. Payment for benefits not subject to Subsection (a) of this section and provided 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.

(c) Sections 843.3401 and 1301.1041, Insurance Code, as added by this article, apply to an audit of a pharmacist or pharmacy performed on or after the effective date of this Act unless the audit is performed under a contract that is entered into before the effective date of this Act and that, at the time of the audit, has

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

ARTICLE 15. PAYMENT OF BENEFITS

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

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

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1102.001. DEFINITIONS. In this chapter:

(1) "Insurance policy" means a policy, certificate, or contract of:

(A) life, term, or endowment insurance, including an annuity or pure endowment contract;

(B) group life or term insurance, including a group annuity contract;

(C) industrial life insurance;

(D) accident or health insurance;

(E) group accident or health insurance;

(F) hospitalization insurance;

(G) group hospitalization insurance;

(H) medical or surgical insurance;

(I) group medical or surgical insurance; or

(J) fraternal benefit insurance.

(2) "Insurer" means any insurer, including a:

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

(B) mutual life insurance company;

(C) mutual insurance company other than a life

insurance company;

(D) mutual or natural premium life insurance company;

(E) general casualty company;

(F) Lloyd's plan or a reciprocal or interinsurance exchange;

(G) fraternal benefit society; or

(H) group hospital service corporation.

(3) "Life insurance policy" means a policy, certificate, or contract of:

(A) life, term, or endowment insurance, including an annuity or pure endowment contract;

(B) group life or term insurance, including a group annuity contract;

(C) industrial life insurance; or

(D) fraternal benefit insurance, other than insurance for:

(i) benefits for hospital, medical, or nursing expenses resulting from sickness, bodily infirmity, or accident; or

(ii) other accident or health insurance.

(4) "Retained asset account" means any mechanism whereby the settlement of proceeds payable under a life insurance policy, including but not limited to the payment of cash surrender value, is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account, where those proceeds are retained by the insurer, pursuant to a supplementary

contract not involving annuity benefits.

Sec. 1102.002. 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 B. PAYMENT OF BENEFITS IN CURRENCY

Sec. 1102.051 [~~1102.002~~]. BENEFITS PAYABLE IN CURRENCY. Each benefit payable under an insurance policy delivered, issued, or used in this state by an insurer shall be payable in currency.

Sec. 1102.052 [~~1102.003~~]. STATEMENT REGARDING VALUE OF FOREIGN CURRENCY. (a) An insurance policy described by Section 1102.051 [~~1102.002~~] providing that benefits are payable in foreign currency must include a conspicuous statement that the value of the currency denominated in the policy can fluctuate as compared to the value of United States currency.

(b) The statement must be:

(1) included as part of the policy; or

(2) attached to the insurance policy at the time it is issued.

Sec. 1102.053 [~~1102.004~~]. PREVIOUSLY APPROVED INSURANCE POLICY FORM PAYABLE IN FOREIGN CURRENCY. (a) The commissioner may 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

account.

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

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

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

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

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

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

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

(4) any coverage of the retained asset account guaranteed by the Federal Deposit Insurance Corporation and the amount of the coverage;

(5) any limitations on withdrawal of funds from the retained asset account, including any minimum or maximum benefit payment amounts;

(6) the anticipated duration of any delays that the retained asset account holder might encounter in completing an authorized transaction;

(7) any fees for services provided, including a list of the fees and the method of the fee calculation;

(8) the nature and frequency with which statements concerning the retained asset account are issued, which must be not less than once annually;

(9) that some or all of the benefit may be paid through check, draft, or other instrument;

(10) that the entire proceeds are available to the retained asset account holder by the use of a single check, draft, or other instrument;

(11) whether the insurer or a related party may earn income from the retained asset account, in addition to any fees charged on the account, from the total gains received on the investment of the balance of funds in the account;

(12) the telephone number, address, and other contact information, including website address, to obtain additional information regarding the retained asset account;

(13) a description of the insurer's policy regarding

retained asset accounts that may become inactive; and

(14) any other information prescribed by the commissioner by rule.

SECTION 15.002. Chapter 1102, Insurance Code, as amended by this article, applies only to a claim made under a life insurance policy on or after September 1, 2011. A claim made before September 1, 2011, 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 16. PROHIBITION OF COERCION OF PRACTITIONERS BY MANAGED CARE PLANS

SECTION 16.001. Section 1451.153, Insurance Code, is amended by amending Subsection (a) and adding Subsection (c) to read as follows:

(a) A managed care plan may not:

(1) discriminate against a health care practitioner because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist;

(2) restrict or discourage a plan participant from obtaining covered vision or medical eye care services or procedures from a participating optometrist, therapeutic optometrist, or ophthalmologist solely because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist;

(3) exclude an optometrist, therapeutic optometrist, or ophthalmologist as a participating practitioner in the plan because the optometrist, therapeutic optometrist, or ophthalmologist does not have medical staff privileges at a

hospital or at a particular hospital; [~~or~~]

(4) exclude an optometrist, therapeutic optometrist, or ophthalmologist as a participating practitioner in the plan because the services or procedures provided by the optometrist, therapeutic optometrist, or ophthalmologist may be provided by another type of health care practitioner; or

(5) as a condition for a therapeutic optometrist or ophthalmologist to be included in one or more of the plan's medical panels, require the therapeutic optometrist or ophthalmologist to be included in, or to accept the terms of payment under or for, a particular vision panel in which the therapeutic optometrist or ophthalmologist does not otherwise wish to be included.

(c) For the purposes of Subsection (a)(5), "medical panel" and "vision panel" have the meanings assigned by Section 1451.154(a).

SECTION 16.002. The change in law made by Section 16.001 of this Act applies only to a contract entered into or renewed by a therapeutic optometrist or ophthalmologist and an issuer of a managed care plan on or after January 1, 2012. A contract entered into or renewed before January 1, 2012, 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 17. PROVIDER NETWORK CONTRACT ARRANGEMENTS

SECTION 17.001. Subtitle F, Title 8, Insurance Code, is amended by adding Chapter 1458 to read as follows:

CHAPTER 1458. PROVIDER NETWORK CONTRACT ARRANGEMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1458.001. GENERAL DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(2) "Contracting entity" means a person that:

(A) enters into a direct contract with a provider for the delivery of health care services to covered individuals; and

(B) in the ordinary course of business establishes a provider network for access by another party.

(3) "Covered individual" means an individual who is covered under a health benefit plan.

(4) "Direct notification" means a written or electronic communication from a contracting entity to a physician or other health care provider documenting third party access to a provider network.

(5) "Health care services" means services provided for the diagnosis, prevention, treatment, or cure of a health condition, illness, injury, or disease.

(6) "Person" has the meaning assigned by Section 823.002.

(7) "Provider" means a physician, a professional association composed solely of physicians, a single legal entity authorized to practice medicine owned by two or more physicians, a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code, a partnership composed solely of physicians, a physician-hospital organization that acts

exclusively as an administrator for a provider to facilitate the provider's participation in health care contracts, or an institution licensed under Chapter 241, Health and Safety Code. The term does not include a physician-hospital organization that leases or rents the physician-hospital organization's network to a third party.

(8) "Provider network contract" means a contract between a contracting entity and a provider for the delivery of, and payment for, health care services to a covered individual.

(9) "Third party" means a person that contracts with a contracting entity or another party to gain access to a provider network contract.

Sec. 1458.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) In this chapter, "health benefit plan" means:

(1) a hospital and medical expense incurred policy;

(2) a nonprofit health care service plan contract;

(3) a health maintenance organization subscriber contract; or

(4) any other health care plan or arrangement that pays for or furnishes medical or health care services.

(b) "Health benefit plan" does not include one or more or any combination of the following:

(1) coverage only for accident or disability income insurance or any combination of those coverages;

(2) credit-only insurance;

(3) coverage issued as a supplement to liability insurance;

(4) liability insurance, including general liability insurance and automobile liability insurance;

(5) workers' compensation or similar insurance;

(6) a discount health care program, as defined by Section 7001.001;

(7) coverage for on-site medical clinics;

(8) automobile medical payment insurance; or

(9) other similar insurance coverage, as specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), under which benefits for medical care are secondary or incidental to other insurance benefits.

(c) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the coverage:

(1) dental or vision benefits;

(2) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these benefits;

(3) other similar, limited benefits, including benefits specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191); or

(4) a Medicare supplement benefit plan described by Section 1652.002.

(d) "Health benefit plan" does not include coverage limited

to a specified disease or illness or hospital indemnity coverage or other fixed indemnity insurance coverage if:

(1) the coverage is provided under a separate policy, certificate, or contract of insurance;

(2) there is no coordination between the provision of the coverage and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor; and

(3) the coverage is paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health benefit plan maintained by the same plan sponsor.

Sec. 1458.003. EXEMPTIONS. This chapter does not apply:

(1) to a provider network contract for services provided to a beneficiary under the Medicaid program, the Medicare program, or the state child health plan established under Chapter 62, Health and Safety Code, or the comparable plan under Chapter 63, Health and Safety Code;

(2) under circumstances in which access to the provider network is granted to an entity that operates under the same brand licensee program as the contracting entity; or

(3) to a contract between a contracting entity and a discount health care program operator, as defined by Section 7001.001.

[Sections 1458.004-1458.050 reserved for expansion]

SUBCHAPTER B. REGISTRATION REQUIREMENTS

Sec. 1458.051. REGISTRATION REQUIRED. (a) Unless the person holds a certificate of authority issued by the department to

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

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

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

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

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

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

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

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

(4) any other information required by the commissioner by rule.

(b) The disclosure made under Subsection (a) must include a description or a copy of the applicant's basic organizational structure documents and a copy of organizational charts and lists that show:

(1) the relationships between the contracting entity and any affiliates of the contracting entity, including subsidiary networks or other networks; and

(2) the internal organizational structure of the contracting entity's management.

Sec. 1458.053. SUBMISSION OF INFORMATION. Information required under this subchapter must be submitted in a written or electronic format adopted by the commissioner by rule.

Sec. 1458.054. FEES. The department may collect a reasonable fee set by the commissioner as necessary to administer the registration process. Fees collected under this chapter shall be deposited in the Texas Department of Insurance operating fund.

Sec. 1458.055. EXEMPTION FOR AFFILIATES. (a) The commissioner shall grant an exemption for affiliates of a contracting entity if the contracting entity holds a certificate of authority issued by the department to engage in the business of insurance in this state or is a health maintenance organization if the commissioner determines that:

(1) the affiliate is not subject to a disclaimer of affiliation under Chapter 823; and

(2) the relationships between the person who holds a

certificate of authority and all affiliates of the person, including subsidiary networks or other networks, are disclosed and clearly defined.

(b) An exemption granted under this section applies only to registration. An entity granted an exemption is otherwise subject to this chapter.

(c) The commissioner shall establish a reasonable fee as necessary to administer the exemption process.

[Sections 1458.056-1458.100 reserved for expansion]

SUBCHAPTER C. RIGHTS AND RESPONSIBILITIES OF A CONTRACTING ENTITY

Sec. 1458.101. CONTRACT REQUIREMENTS. A contracting entity may not provide a person access to health care services or contractual discounts under a provider network contract unless the provider network contract specifically states that:

(1) the contracting entity may contract with a third party to provide access to the contracting entity's rights and responsibilities under a provider network contract; and

(2) the third party must comply with all applicable terms, limitations, and conditions of the provider network contract.

Sec. 1458.102. DUTIES OF CONTRACTING ENTITY. (a) A contracting entity that has granted access to health care services and contractual discounts under a provider network contract shall:

(1) notify each provider of the identity of, and contact information for, each third party that has or may obtain access to the provider's health care services and contractual 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.

(d) The notice required under Subsection (a)(1):

(1) must be provided by:

(A) providing for a subscription to receive the notice by e-mail; or

(B) posting the information on an Internet website at least once each calendar quarter; and

(2) must include a separate prominent section that lists:

(A) each third party that the contracting entity knows will have access to a discounted fee of the provider in the succeeding calendar quarter; and

(B) the effective date and termination or renewal dates, if any, of the third party's contract to access the network.

(e) The e-mail notice described by Subsection (d) may contain a link to an Internet web page that contains a list of third parties that complies with this section.

(f) The notice described by Subsection (a)(1) is not required to include information regarding payors who are insurers or health maintenance organizations.

Sec. 1458.103. EFFECT OF CONTRACT TERMINATION. Subject to continuity of care requirements, agreements, or contractual provisions:

(1) a third party may not access health care services and contractual discounts after the date the provider network contract terminates;

(2) claims for health care services performed after the termination date may not be processed or paid under the provider

network contract after the termination; and

(3) claims for health care services performed before the termination date and processed after the termination date may be processed and paid under the provider network contract after the date of termination.

Sec. 1458.104. AVAILABILITY OF CODING GUIDELINES. (a) A contract between a contracting entity and a provider must provide that:

(1) the provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the provider will receive under the contract;

(2) the contracting entity or the contracting entity's agent will provide the coding guidelines and fee schedules not later than the 30th day after the date the contracting entity receives the request;

(3) the contracting entity or the contracting entity's agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the provider not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and

(4) if the requested information indicates a reduction in payment to the provider from the amounts agreed to on the effective date of the contract, the contract may be terminated by the provider on written notice to the contracting entity on or

before the 30th day after the date the provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

(b) A provider who receives information under Subsection (a) may only:

(1) use or disclose the information for the purpose of practice management, billing activities, and other business operations; and

(2) disclose the information to a governmental agency involved in the regulation of health care or insurance.

(c) The contracting entity shall, on request of the provider, provide the name, edition, and model version of the software that the contracting entity uses to determine bundling and unbundling of claims.

(d) The provisions of this section may not be waived, voided, or nullified by contract.

(e) If a contracting entity is unable to provide the information described by Subsection (a)(1), (a)(3), or (c), the contracting entity shall by telephone provide a readily available medium in which providers may obtain the information, which may include an Internet website.

[Sections 1458.105-1458.150 reserved for expansion]

SUBCHAPTER D. RIGHTS AND RESPONSIBILITIES OF THIRD PARTY

Sec. 1458.151. THIRD-PARTY RIGHTS AND RESPONSIBILITIES. A third party that leases, sells, aggregates, assigns, or otherwise conveys a provider's contractual discount to another party who is

not a covered individual must comply with the responsibilities of a contracting entity under Subchapters C and E.

Sec. 1458.152. DISCLOSURE BY THIRD PARTY. (a) A third party shall disclose, to the contracting entity and providers under the provider network contract, the identity of a person other than a covered individual to whom the third party leases, sells, aggregates, assigns, or otherwise conveys a provider's contractual discounts through an electronic notification that complies with Section 1458.102 and includes a link to the Internet website described by Section 1458.102(d).

(b) A third party that uses an Internet website under this section must update the website on a quarterly basis. On request, a contracting entity shall disclose the information by telephone or through direct notification.

[Sections 1458.153-1458.200 reserved for expansion]

SUBCHAPTER E. UNAUTHORIZED ACCESS TO PROVIDER NETWORK CONTRACTS

Sec. 1458.201. UNAUTHORIZED ACCESS TO OR USE OF DISCOUNT. (a) A person who knowingly accesses or uses a provider's contractual discount under a provider network contract without a contractual relationship established under this chapter commits an unfair or deceptive act in the business of insurance that violates Subchapter B, Chapter 541. The remedies available for a violation of Subchapter B, Chapter 541, under this subsection do not include a private cause of action under Subchapter D, Chapter 541, or a class action under Subchapter F, Chapter 541.

(b) A contracting entity or third party must comply with the disclosure requirements under Sections 1458.102 and 1458.152

concerning the services listed on a remittance advice or explanation of payment. A provider may refuse a discount taken without a contract under this chapter or in violation of those sections.

(c) Notwithstanding Subsection (b), an error in the remittance advice or explanation of payment may be corrected by a contracting entity or third party not later than the 30th day after the date the provider notifies in writing the contracting entity or third party of the error.

Sec. 1458.202. ACCESS TO THIRD PARTY. A contracting entity may not provide a third party access to a provider network contract unless the third party is:

(1) a payor or person who administers or processes claims on behalf of the payor;

(2) a preferred provider benefit plan issuer or preferred provider network, including a physician-hospital organization; or

(3) a person who transports claims electronically between the contracting entity and the payor and does not provide access to the provider's services and discounts to any other third party.

[Sections 1458.203-1458.250 reserved for expansion]

SUBCHAPTER F. ENFORCEMENT

Sec. 1458.251. UNFAIR CLAIM SETTLEMENT PRACTICE. (a) A contracting entity that violates this chapter commits an unfair claim settlement practice under Subchapter A, Chapter 542, and is subject to sanctions under that subchapter as if the contracting

entity were an insurer.

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

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

SECTION 17.002. The change in law made by this article applies only to a provider network contract entered into or renewed on or after January 1, 2012. A provider network contract entered into 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 18. FAIR PLAN ASSOCIATION

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

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

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

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

(b) An insured may not recover consequential, punitive, or exemplary damages in a cause of action against the association, including damages under Section 541.152(b) of this code or Section 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~~]

(B) holds a certificate of authority from the United States secretary of the treasury to qualify as a surety or reinsurer on obligations permitted or required under federal law.

SECTION 20.002. Section 3503.004(b), Insurance Code, is repealed.

ARTICLE 21. APPRAISALS UNDER PROPERTY INSURANCE POLICIES

SECTION 21.001. Subchapter B, Chapter 542, Insurance Code, is amended by adding Section 542.063 to read as follows:

Sec. 542.063. APPRAISALS. (a) A request for appraisal with respect to a claim under a property insurance policy shall not stay court proceedings during the appraisal process.

(b) A decision resulting from the appraisal process under a property insurance policy is binding only as to the amount of loss. An appraisal may not be used to determine liability issues such as coverage, causation, or conditions or limits imposed by the policy. The appraisal decision does not affect any other remedy available at law.

SECTION 21.002. The heading to Subchapter B, Chapter 542, Insurance Code, is amended to read as follows:

SUBCHAPTER B. PROMPT PAYMENT OF CLAIMS; APPRAISALS

SECTION 21.003. Section 542.063, Insurance Code, as added by this article, applies only to a dispute that arises on or after the effective date of this Act. A dispute that arises 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 22. EMPLOYER CONTRIBUTIONS TO INDIVIDUAL HEALTH INSURANCE POLICIES

SECTION 22.001. Subtitle A, Title 8, Insurance Code, is amended by adding Chapter 1221 to read as follows:

CHAPTER 1221. EMPLOYER CONTRIBUTIONS TO INDIVIDUAL HEALTH INSURANCE POLICIES

Sec. 1221.001. RULES; EMPLOYER CONTRIBUTIONS. The commissioner by rule, unless it would violate state or federal law, may develop procedures to allow an employer to make financial contributions to or premium payments for an employee or retiree's individual consumer directed health insurance policy in a manner that eliminates or minimizes the state or federal tax consequences, or provides positive state or federal tax consequences, to the employer.

ARTICLE 23. REQUIRED OFFER TO EXCLUDE NAMED DRIVERS FROM PERSONAL AUTOMOBILE INSURANCE POLICIES

SECTION 23.001. Subchapter B, Chapter 1952, Insurance Code, is amended by adding Section 1952.059 to read as follows:

Sec. 1952.059. REQUIRED OFFER: EXCLUSION OF NAMED DRIVERS. (a) In addition to applying to the insurers subject to this chapter under Section 1952.001, this section applies to a county mutual insurance company.

(b) An insurer that delivers or issues for delivery in this state a personal automobile insurance policy, including a policy provided through the Texas Automobile Insurance Plan Association under Chapter 2151, that covers liability arising out of the ownership, maintenance, or use of a motor vehicle and that would

otherwise cover all residents in the named insured's household must offer the insured a provision that would exclude from coverage under the policy any resident of the named insured's household who is specifically named as being excluded.

(c) An exclusion under this section must be in writing and must:

(1) include the name of the person excluded from coverage;

(2) be signed by the named insured; and

(3) be attached to the policy and stated on the liability insurance card or any other form of proof of liability insurance verification.

ARTICLE 24. RESIDENTIAL FIRE ALARM TECHNICIANS

SECTION 24.001. Section 6002.158(e), Insurance Code, is amended to read as follows:

(e) The curriculum for a residential fire alarm technician course must consist of at least seven [~~eight~~] hours of instruction on installing, servicing, and maintaining single-family and two-family residential fire alarm systems as defined by National Fire Protection Standard No. 72 and an examination on National Fire Protection Standard No. 72 for which at least one hour is allocated for completion. The examination must consist of at least 25 questions, and an applicant must accurately answer at least 80 percent of the questions to pass the examination.

SECTION 24.002. The changes in law made by this Act to Section 6002.158, Insurance Code, apply only to an application for 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

commissioner shall be considered to comply with this section.

(d) Nothing in this section prohibits title insurance with respect to liens, encumbrances, or other defects to title to land that:

(1) appear in the public records before the date on which the contract of title insurance is made;

(2) occur or result from transactions before the transaction vesting title in the insured or creating the lien of the insured mortgage; or

(3) result from failure to timely perfect or record any instrument before the date on which the contract of title insurance is made.

(e) A title insurance company may not engage in the business of title insurance in this state if the title insurance company provides insurance of the type prohibited by Subsection (a) anywhere in the United States, except to the extent that the laws of another state require the title insurance company to provide that type of insurance.

SECTION 25.002. Section 2502.006, Insurance Code, as added by this Act, applies only to an insurance policy that is 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 26. RESCISSION OF HEALTH BENEFIT PLAN

SECTION 26.001. Chapter 1202, Insurance Code, is amended by

adding Subchapter C to read as follows:

SUBCHAPTER C. RESCISSION OF HEALTH BENEFIT PLAN

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

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

(1) an insurance company;

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

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

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

(5) a reciprocal exchange operating under Chapter 942;

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

(7) a health maintenance organization operating under

Chapter 843;

(8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

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

(b) This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit other than an accident policy;

(B) only for accidental death or dismemberment;

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

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

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

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

(3) a workers' compensation insurance policy;

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

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner

determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan described by Subsection (a);

(6) a Medicaid managed care plan offered under Chapter 533, Government Code;

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

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

Sec. 1202.103. RESCISSION 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

decision to rescind.

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

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

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

(d) The commissioner shall adopt rules necessary to implement and enforce this section, including rules establishing certification standards for independent review organizations for purposes of this chapter.

Sec. 1202.106. BURDEN OF PROOF. In an appeal to an independent review organization under Section 1202.105 or an enforcement action or cause of action based on a violation of this subchapter by a health benefit plan issuer, the health benefit plan issuer must prove that the issuer did not violate this subchapter.

SECTION 26.002. The change in law made by this article applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2012. A health benefit plan that is 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 27. TRANSITION; EFFECTIVE DATE

SECTION 27.001. Except as otherwise provided by this Act,

this Act applies only to an insurance policy, contract, or evidence of coverage that is delivered, issued for delivery, or renewed on or after January 1, 2012. A policy, contract, or evidence of coverage 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.

SECTION 27.002. This Act takes effect September 1, 2011.

ADOPTED

MAY 20 2011

Secretary of the Senate

By: Hegar, Taylor, Lamy H.B. No. 1951

Substitute the following for H.B. No. 1951:

By: Hegar C.S.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. Subsection (a), Section 31.004, 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, 2017 [~~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.

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

appropriate to meet changing needs.

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

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

Sec. 843.410 [~~843.441~~]. ASSESSMENTS. (a) To provide funds for the administrative expenses of the commissioner regarding rehabilitation, liquidation, supervision, conservatorship, or seizure [~~conservation~~] of a [~~an impaired~~] health maintenance organization in this state that is placed under supervision or in conservatorship under Chapter 441 or against which a delinquency proceeding is commenced under Chapter 443 and that is found by the commissioner to have insufficient funds to pay the total amount of health care claims and the administrative[~~, including~~] expenses incurred by the commissioner regarding the rehabilitation, liquidation, supervision, conservatorship, or seizure, the commissioner [~~acting as receiver or by a special deputy receiver, the committee, at the commissioner's direction,~~] shall assess each health maintenance organization in the proportion that the gross premiums of the health maintenance organization that were written in this state during the preceding calendar year bear to the aggregate gross premiums that were written in this state by all health maintenance organizations, as found [~~provided to the 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. Subsection (b), Section 1660.102, Insurance Code, is amended to read as follows:

(b) The commissioner may consider [~~the~~] recommendations [~~of the advisory committee~~] or any other 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. Subsection (a), Section 4001.009, 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, 1205-1208 [~~1205-1209~~], 1211, 1213, 1214 [~~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. Subsection (a), Section 2154.052, 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) Subsection (d), Article 3.70-3D, 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) Subdivision (2), Section 1660.002, Insurance Code;

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

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

(10) Sections 4002.004, 4004.002, 4101.006, and 4102.059, Insurance Code;

(11) Subsections (c) and (d), Section 4201.003, 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) Subsection (c), Section 2154.055, 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;

(10) the public insurance adjusters examination advisory committee;

(11) the utilization review agents advisory committee;

(12) the fire extinguisher advisory council;

(13) the fire detection and alarm devices advisory council;

(14) the fire protection advisory council; and

(15) the fireworks advisory council.

(b) All powers, duties, obligations, rights, contracts, funds, records, and real or personal property of a board, committee, council, or task force listed under Subsection (a) of this section shall be transferred to the Texas Department of Insurance not later than February 28, 2012.

SECTION 2.010. The changes in law made by this Act by repealing Sections 523.003 and 843.439, Insurance Code, apply only to a cause of action that accrues 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 immediately before that date, and that law is continued in effect for that purpose.

ARTICLE 3. RATE REGULATION

SECTION 3.001. 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;

(B) [~~(2)~~] statistics or other information to support the rates to be used by the insurer, including information necessary to evidence that the computation of the rate does not include disallowed expenses; and

(C) [~~(3)~~] information concerning policy fees, service fees, and other fees that are charged or collected by the insurer under Section 550.001 or 4005.003; and

(2) prescribe the process through which the department requests supplementary rating information and supporting information under this section, including:

(A) the number of times the department may make a request for information; and

(B) the types of information the department may request when reviewing a rate filing.

SECTION 3.002. Section 2251.103, Insurance Code, is amended

to read as follows:

Sec. 2251.103. COMMISSIONER ACTION CONCERNING [~~DISAPPROVAL OF RATE IN~~] RATE FILING NOT YET IN EFFECT; HEARING AND ANALYSIS. (a) Not later than the earlier of the date the rate takes effect or the 30th day after the date a rate is filed with the department under Section 2251.101, the [~~The~~] commissioner shall disapprove the [~~a~~] rate if the commissioner determines that the rate [~~filing made under this chapter~~] does not comply with the requirements of this chapter [~~meet the standards established under Subchapter B~~].

(b) Except as provided by Subsection (c), if a rate has not been disapproved by the commissioner before the expiration of the 30-day period described by Subsection (a), the rate is not considered disapproved under this section.

(c) For good cause, the commissioner may, on the expiration of the 30-day period described by Subsection (a), extend the period for disapproval of a rate for one additional 30-day period. The commissioner and the insurer may not by agreement extend the 30-day period described by Subsection (a) or this subsection.

(d) If the commissioner disapproves a rate under this section [~~filing~~], the commissioner shall issue an order specifying in what respects the rate [~~filing~~] fails to meet the requirements of this chapter.

(e) An insurer that files a rate that is disapproved under this section [~~(c) The filer~~] is entitled to a hearing on written request made to the commissioner not later than the 30th day after the date the order disapproving the rate [~~filing~~] takes effect.

(f) The department shall track, compile, and routinely

analyze the factors that contribute to the disapproval of rates under this section.

SECTION 3.003. Subchapter C, Chapter 2251, Insurance Code, is amended by adding Section 2251.1031 to read as follows:

Sec. 2251.1031. REQUESTS FOR ADDITIONAL INFORMATION. (a) If the department determines that the information filed by an insurer under this subchapter or Subchapter D is incomplete or otherwise deficient, the department may request additional information from the insurer.

(b) If the department requests additional information from the insurer during the 30-day period described by Section 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 3.004. 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 3.005. Section 2251.107, Insurance Code, is amended to read as follows:

Sec. 2251.107. PUBLIC [~~INSPECTION OF~~] INFORMATION. (a) Each filing made, and any supporting information filed, under this chapter is open to public inspection as of the date of the filing.

(b) Each year the department shall make available to the public information concerning the department's general process and methodology for rate review under this chapter, including factors that contribute to the disapproval of a rate. Information provided under this subsection must be general in nature and may not reveal proprietary or trade secret information of any insurer.

SECTION 3.006. Section 2251.151, Insurance Code, is amended by adding Subsections (c-1) and (f) and amending Subsection (e) to read as follows:

(c-1) If the commissioner requires an insurer to file the insurer's rates under this section, the commissioner shall periodically assess whether the conditions described by Subsection (a) continue to exist. If the commissioner determines that the conditions no longer exist, the commissioner shall issue an order excusing the insurer from filing the insurer's rates under this

section.

(e) If the commissioner requires an insurer to file the insurer's rates under this section, the commissioner shall issue an order specifying the commissioner's reasons for requiring the rate filing and explaining any steps the insurer must take and any conditions the insurer must meet in order to be excused from filing the insurer's rates under this section. An affected insurer is entitled to a hearing on written request made to the commissioner not later than the 30th day after the date the order is issued.

(f) The commissioner by rule shall define:

(1) the financial conditions and rating practices that may subject an insurer to this section under Subsection (a)(1); and

(2) the process by which the commissioner determines that a statewide insurance emergency exists under Subsection (a)(2).

SECTION 3.007. Section 2251.156, Insurance Code, is amended to read as follows:

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

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

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

SECTION 3.008. Section 2254.003, Insurance Code, is amended by amending Subsection (a) and adding Subsections (a-1), (a-2), and (a-3) to read as follows:

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

(a-1) If the department provides an insurer with formal written notice that a rate is excessive or unfairly discriminatory, then the insurer may file a new rate or take other corrective action to substantially address the department's concerns. The new rate or other corrective action must be filed on or before the 60th day following the date of formal written notice. At the commissioner's discretion, the commissioner may extend the deadline to file by an additional 30 days. If the department accepts the new rate or other corrective action, then the insurer shall, according to commissioner order, refund or issue a premium discount directly to each affected policyholder on the portion of the premium found to be excessive or unfairly discriminatory, plus interest on that amount. The interest rate to be paid on refunds or discounts under this subsection is the sum of six percent and the prime rate for the calendar year in which formal written notice is given. For purposes of this subsection, the prime rate is the prime rate as published in The Wall Street Journal for the first day of the calendar year that is not a Saturday, Sunday, or legal holiday.

(a-2) If the insurer does not file or take, or the department does not accept, a new rate or other corrective action as

provided under Subsection (a-1), and the commissioner issues an order disapproving the rate as excessive or unfairly discriminatory under Section 2251.104, then the insurer must refund or issue a premium discount directly to each affected policyholder on the portion of the premium found to be excessive or unfairly discriminatory, plus interest on that amount. The interest rate to be paid on refunds or discounts under this subsection is 18 percent. An insurer is not required to pay any interest penalty if the insurer prevails in an appeal of the commissioner's order under Subchapter D, Chapter 36.

(a-3) The period for the refund and interest begins on the date the department first provides the insurer with formal written notice that the insurer's filed rate is excessive or unfairly discriminatory, and interest continues to accrue until the refund or discount is paid or issued.

SECTION 3.009. Section 2251.154, Insurance Code, is repealed.

SECTION 3.010. Subsection (c), Section 2254.003, Insurance Code, is repealed.

SECTION 3.011. Section 2251.103, Insurance Code, as amended by this Act, and Section 2251.1031, Insurance Code, as added by this Act, apply only to a rate filing made on or after the effective date of this Act. A rate filing made before the effective date of this Act is governed by the law in effect at the time the filing was made, and that law is continued in effect for that purpose.

SECTION 3.012. Subsection (c-1), Section 2251.151, Insurance Code, as added by this Act, applies to an insurer that is

required to file the insurer's rates for approval under Section 2251.151, Insurance Code, on or after the effective date of this Act, regardless of when the order requiring the insurer to file the insurer's rates for approval under that section is first issued.

SECTION 3.013. Subsection (e), Section 2251.151, Insurance Code, as amended by this Act, applies only to an order issued by the commissioner of insurance on or after the effective date of this Act. An order of the commissioner issued before the effective date of this Act is governed by the law in effect on the date the order was issued, and that law is continued in effect for that purpose.

ARTICLE 4. STATE FIRE MARSHAL'S OFFICE

SECTION 4.001. Section 417.008, Government Code, is amended by adding Subsection (f) to read as follows:

(f) The commissioner by rule shall prescribe a reasonable fee for an inspection performed by the state fire marshal that may be charged to a property owner or occupant who requests the inspection, as the commissioner considers appropriate. In prescribing the fee, the commissioner shall consider the overall cost to the state fire marshal to perform the inspections, including the approximate amount of time the staff of the state fire marshal needs to perform an inspection, travel costs, and other expenses.

SECTION 4.002. Section 417.0081, Government Code, is amended to read as follows:

Sec. 417.0081. INSPECTION OF CERTAIN STATE-OWNED OR STATE-LEASED BUILDINGS. (a) The state fire marshal, at the commissioner's direction, shall periodically inspect public

buildings under the charge and control of the Texas Facilities [~~General Services~~] Commission and buildings leased for the use of a state agency by the Texas Facilities Commission.

(b) For the purpose of determining a schedule for conducting inspections under this section, the commissioner by rule shall adopt guidelines for assigning potential fire safety risk to state-owned and state-leased buildings. Rules adopted under this 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; ADMINISTRATIVE PENALTIES [~~ALTERNATE REMEDIES~~]. (a) This section applies to each person and firm licensed, registered, or otherwise regulated by the department through the state fire marshal, including:

(1) a person regulated under Title 20, Insurance Code; and

(2) a person licensed under Chapter 2154, Occupations Code.

(b) The commissioner by rule shall delegate to the state fire marshal the authority to take disciplinary and enforcement actions, including the imposition of administrative penalties in accordance with this section on a person regulated under a law listed under Subsection (a) who violates that law or a rule or order adopted under that law. In the rules adopted under this subsection, the commissioner shall:

(1) specify which types of disciplinary and enforcement actions are delegated to the state fire marshal; and

(2) outline the process through which the state fire marshal may, subject to Subsection (e), impose administrative

penalties or take other disciplinary and enforcement actions.

(c) The commissioner by rule shall adopt a schedule of administrative penalties for violations subject to a penalty under this section to ensure that the amount of an administrative penalty imposed is appropriate to the violation. The department shall provide the administrative penalty schedule to the public on request. The amount of an administrative penalty imposed under this section must be based on:

(1) the seriousness of the violation, including:

(A) the nature, circumstances, extent, and gravity of the violation; and

(B) the hazard or potential hazard created to the health, safety, or economic welfare of the public; and

(2) the economic harm to the public interest or public confidence caused by the violation;

(3) the history of previous violations;

(4) the amount necessary to deter a future violation;

(5) efforts to correct the violation;

(6) whether the violation was intentional; and

(7) any other matter that justice may require.

(d) In [~~The state fire marshal, in~~] the enforcement of a law that is enforced by or through the state fire marshal, the state fire marshal may, in lieu of cancelling, revoking, or suspending a license or certificate of registration, impose on the holder of the license or certificate of registration an order directing the holder to do one or more of the following:

(1) cease and desist from a specified activity;

(2) pay an administrative penalty imposed under this section [~~remit to the commissioner within a specified time a monetary forfeiture not to exceed $10,000 for each violation of an applicable law or rule~~]; or [~~and~~]

(3) make restitution to a person harmed by the holder's violation of an applicable law or rule.

(e) The state fire marshal shall impose an administrative penalty under this section in the manner prescribed for imposition of an administrative penalty under Subchapter B, Chapter 84, Insurance Code. The state fire marshal may impose an administrative penalty under this section without referring the violation to the department for commissioner action.

(f) An affected person may dispute the imposition of the penalty or the amount of the penalty imposed in the manner prescribed by Subchapter C, Chapter 84, Insurance Code. Failure to pay an administrative penalty imposed under this section is subject to enforcement by the department.

ARTICLE 5. TITLE INSURANCE

SECTION 5.001. Subsection (c), Section 2703.153, Insurance Code, is amended to read as follows:

(c) Not less frequently than once every five years, the commissioner shall evaluate the information required under this section to determine whether the department needs additional or different information or no longer needs certain information to promulgate rates. If the department requires a title insurance company or title insurance agent to include new or different information in the statistical report, that information may be

considered by the commissioner in fixing premium rates if the information collected is reasonably credible for the purposes for which the information is to be used.

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;

(L) a statewide mutual assessment company;

(M) a local mutual aid association;

(N) a local mutual burial association;

(O) an association exempt under Section 887.102;

(P) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 842;

(Q) a county mutual insurance company; and

(R) a farm mutual insurance company.

Sec. 35.002. CONSTRUCTION WITH OTHER LAW. (a) Notwithstanding any other provision of this code, a regulated entity may conduct business electronically in accordance with this chapter and the rules adopted under Section 35.004.

(b) To the extent of any conflict between another provision of this code and a provision of this chapter, the provision of this chapter controls.

Sec. 35.003. ELECTRONIC TRANSACTIONS AUTHORIZED. A regulated entity may conduct business electronically to the same extent that the entity is authorized to conduct business otherwise if before the conduct of business each party to the business agrees to conduct the business electronically.

Sec. 35.004. RULES. (a) The commissioner shall adopt rules necessary to implement and enforce this chapter.

(b) The rules adopted by the commissioner under this section must include rules that establish minimum standards with which a regulated entity must comply in the entity's electronic conduct of

business with other regulated entities and consumers.

SECTION 6.002. Chapter 35, Insurance Code, as added by this Act, applies only to business conducted on or after the effective date of this Act. Business conducted before the effective date of this Act is governed by the law in effect on the date the business was conducted, and that law is continued in effect for that purpose.

ARTICLE 7. DATA COLLECTION

SECTION 7.001. Chapter 38, Insurance Code, is amended by adding Subchapter I to read as follows:

SUBCHAPTER I. DATA COLLECTION RELATING TO CERTAIN PERSONAL LINES OF INSURANCE

Sec. 38.401. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to an insurer who writes personal automobile insurance or residential property insurance in this state.

Sec. 38.402. FILING OF CERTAIN CLAIMS INFORMATION. (a) The commissioner shall require each insurer described by Section 38.401 to file with the commissioner aggregate personal automobile insurance and residential property insurance claims information for the period covered by the filing, including the number of claims:

(1) filed during the reporting period;

(2) pending on the last day of the reporting period, including pending litigation;

(3) closed with payment during the reporting period;

(4) closed without payment during the reporting period; and

(5) carrying over from the reporting period

immediately preceding the current reporting period.

(b) An insurer described by Section 38.401 must file the information described by Subsection (a) on an annual basis. The information filed must be broken down by quarter.

Sec. 38.403. PUBLIC INFORMATION. (a) The department shall post the data contained in claims information filings under Section 38.402 on the department's Internet website. The commissioner by rule may establish a procedure for posting data under this subsection that includes a description of the data that must be posted and the manner in which the data must be posted.

(b) Information provided under this section must be aggregate data by line of insurance for each insurer and may not reveal proprietary or trade secret information of any insurer.

Sec. 38.404. RULES. The commissioner may adopt rules necessary to implement this subchapter.

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. TRANSITION; EFFECTIVE DATE

SECTION 9.001. Except as otherwise provided by this Act, this Act applies only to an insurance policy, contract, or evidence of coverage that is delivered, issued for delivery, or renewed on or after January 1, 2012. A policy, contract, or evidence of coverage 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.

SECTION 9.002. This Act takes effect September 1, 2011.

ADOPTED

MAY 2 0 2011

Secretary of the Senate

FLOOR AMENDMENT NO. 3 BY: Robert Ellis

Amend C.S.H.B. No. 1951 (senate committee printing) by adding the following appropriately numbered ARTICLE to the bill and renumbering subsequent ARTICLES accordingly:

ARTICLE ____. INDIVIDUAL HEALTH COVERAGE FOR CHILDREN

SECTION ____.001. Section 1502.002, Insurance Code, is amended to read as follows:

Sec. 1502.002. RULES. (a) The commissioner may adopt rules to implement this chapter, including rules necessary to:

(1) increase the availability of coverage to children younger than 19 years of age;

(2) establish open enrollment periods; and

(3) establish qualifying events as exceptions to the open enrollment periods, including loss of coverage when a child becomes ineligible for coverage under the state child health plan.

(b) The commissioner may adopt rules on an emergency basis using the procedures established under Section 2001.034, Government Code.

(c) Notwithstanding Subsection (b), the commissioner is not required to make a finding under Section 2001.034(a), Government Code before adopting rules on an emergency basis.

ADOPTED

MAY 20 2011

Secretary of the Senate

FLOOR AMENDMENT NO. 5 BY: Leticia Van de Putte

Amend H.B. No. 1951 (senate committee printing) by adding the following appropriately numbered ARTICLE to the bill and renumbering subsequent ARTICLES and SECTIONS of the bill accordingly:

ARTICLE __. LIMITED PROPERTY AND CASUALTY INSURANCE LICENSES

SECTION __. Section 4051.101(c), Insurance Code, is amended to read as follows:

(c) This section does not apply to a person who wrote for the previous calendar year:

(1) policies authorized by Chapter 911 for a farm mutual insurance company that generated, in the aggregate, less than $50,000 in direct premium; [~~or~~]

(2) industrial fire insurance policies that generated, in the aggregate, less than $20,000 in direct premium; or

(3) policies authorized by Chapter 962 for an insurer that generated, in the aggregate, less than $40,000 in direct premium.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 82ND LEGISLATIVE REGULAR SESSION

May 22, 2011

TO: Honorable Joe Straus, Speaker of the House, House of Representatives

FROM: John S O'Brien, Director, Legislative Budget Board

IN RE: **HB1951** by Taylor, Larry (Relating to the continuation and operation of the Texas Department of Insurance and the operation of certain insurance programs; imposing administrative penalties.), **As Passed 2nd House**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code relating to the continuation and operation of the Texas Department of Insurance (TDI) and the operation of certain insurance programs; imposing administrative penalties. TDI is subject to the Sunset Act and will be abolished on September 1, 2011, unless continued by the Legislature. The bill would continue TDI until September 1, 2017, and would take effect on September 1, 2011. The bill would also require TDI to clearly define the processes it uses to regulate property and casualty insurance in Texas, to develop and encourage the use of appropriate alternative dispute resolution procedures, and to develop and implement a plan to collect from insurers and publish certain information relating to the processing of personal automobile and residential property claims. The bill would authorize TDI to adopt rules relating to child-only insurance coverage and open enrollment periods. Additionally, the bill would require TDI to determine, at least every six years, which areas of the state should be designated as underserved and to study the accuracy of certain designations for the purpose of increasing access to insurance in those areas.

The bill would authorize the State Fire Marshal's Office (SFMO), housed at TDI, to charge a fee for inspections of privately owned buildings. The provision will be revenue neutral. Authorizing the SFMO to institute a fee for conducting inspections of privately owned buildings would result in a gain in revenue, but this gain would offset the SFMO's costs in providing the inspections, and the revenue should be redirected to those functions. The gain could not be estimated as it is dependent upon the fee level to be determined by the SFMO and the number of requests that continue to come in once the SFMO charges for this service. Since General Revenue-Dedicated Texas Department of Insurance Fund 36 is a self-leveling account, this analysis also assumes that any additional revenue resulting from the implementation of the bill would accumulate in the account fund balances and that the department would adjust the assessment of the maintenance tax or other fees accordingly in the following year. The bill would require the SFMO to periodically inspect state-leased buildings and requires the SFMO to create a risk-based approach to conducting its routine inspections of state buildings.

Based on the analysis provided by the Sunset Advisory Commission and the Texas Department of Insurance, implementation of this bill will have no fiscal impact.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 116 Sunset Advisory Commission, 454 Department of Insurance

LBB Staff: JOB, KM, SD, MW, CH

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 82ND LEGISLATIVE REGULAR SESSION

May 13, 2011

TO: Honorable Rodney Ellis, Chair, Senate Committee on Government Organization

FROM: John S O'Brien, Director, Legislative Budget Board

IN RE: **HB1951** by Taylor, Larry (Relating to the continuation and operation of the Texas Department of Insurance and the operation of certain insurance programs; imposing administrative penalties.), **Committee Report 2nd House, Substituted**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code relating to the continuation and operation of the Texas Department of Insurance (TDI) and the operation of certain insurance programs; imposing administrative penalties. TDI is subject to the Sunset Act and will be abolished on September 1, 2011, unless continued by the Legislature. The bill would continue TDI until September 1, 2017, and would take effect on September 1, 2011. The bill would also require TDI to clearly define the processes it uses to regulate property and casualty insurance in Texas, to develop and encourage the use of appropriate alternative dispute resolution procedures, and to develop and implement a plan to collect from insurers and publish certain information relating to the processing of personal automobile and residential property claims. Additionally, the bill would require TDI to determine, at least every six years, which areas of the state should be designated as underserved and to study the accuracy of certain designations for the purpose of increasing access to insurance in those areas.

The bill would authorize the State Fire Marshal's Office (SFMO), housed at TDI, to charge a fee for inspections of privately owned buildings. The provision will be revenue neutral. Authorizing the SFMO to institute a fee for conducting inspections of privately owned buildings would result in a gain in revenue, but this gain would offset the SFMO's costs in providing the inspections, and the revenue should be redirected to those functions. The gain could not be estimated as it is dependent upon the fee level to be determined by the SFMO and the number of requests that continue to come in once the SFMO charges for this service. Since General Revenue-Dedicated Texas Department of Insurance Fund 36 is a self-leveling account, this analysis also assumes that any additional revenue resulting from the implementation of the bill would accumulate in the account fund balances and that the department would adjust the assessment of the maintenance tax or other fees accordingly in the following year. The bill would require the SFMO to periodically inspect state-leased buildings and requires the SFMO to create a risk-based approach to conducting its routine inspections of state buildings.

Based on the analysis provided by the Sunset Advisory Commission and the Texas Department of Insurance, implementation of this bill will have no fiscal impact.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 116 Sunset Advisory Commission, 454 Department of Insurance

LBB Staff: JOB, KM, SD, MW, CH

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 82ND LEGISLATIVE REGULAR SESSION

May 16, 2011

TO: Honorable Rodney Ellis, Chair, Senate Committee on Government Organization

FROM: John S O'Brien, Director, Legislative Budget Board

IN RE: **HB1951** by Taylor, Larry (Relating to the continuation and operation of the Texas Department of Insurance and the operation of certain insurance programs; imposing administrative penalties.), **As Engrossed**

Estimated Two-year Net Impact to General Revenue Related Funds for HB1951, As Engrossed: an impact of $0 through the biennium ending August 31, 2013.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2012	$0
2013	$0
2014	$0
2015	$0
2016	$0

All Funds, Five-Year Impact:

Fiscal Year	Probable Revenue Gain/(Loss) from *Dept Ins Operating Acct* 36	Probable Savings/ (Cost) from *Dept Ins Operating Acct* 36	Probable Revenue Gain/(Loss) from *Insurance Maint Tax Fees* 8042	Probable Savings/ (Cost) from *Insurance Maint Tax Fees* 8042
2012	$61,608	($61,608)	$1,197,355	($1,197,355)
2013	$56,903	($56,903)	$963,300	($963,300)
2014	$56,903	($56,903)	$696,678	($696,678)
2015	$56,903	($56,903)	$768,381	($768,381)
2016	$56,903	($56,903)	$696,678	($696,678)

Fiscal Year	Change in Number of State Employees from FY 2011
2012	11.5
2013	11.5
2014	10.5
2015	10.5
2016	10.5

Fiscal Analysis

The bill would amend the Insurance Code relating to the continuation and operation of the Texas Department of Insurance (TDI) and the operation of certain insurance programs; imposing administrative penalties. TDI is subject to the Sunset Act and will be abolished on September 1, 2011, unless continued by the Legislature. The bill would continue TDI for 12 years and would take effect on September 1, 2011.

Article 1 would provide for contractual limits and claims filings periods for residential and commercial insurance policies and would require TDI to develop and encourage the use of appropriate alternative dispute resolution procedures. Additionally, Article 1 would require TDI to conduct a study concerning the feasibility and effectiveness of the establishment of a mandatory medical reinsurance program in the state through which issuers of group health benefit plans offered by employers of 100 or fewer employees would be required to purchase reinsurance. The bill would require TDI to post information on its website on how to obtain credit and claims history reports.

Article 2 would eliminate unnecessary advisory committees in statute, and requires TDI to ensure that agency-created advisory committees meet standard criteria.

Article 3 would require HMO's, accident and health insurance companies, and companies providing insurance to small business to send a 60-day notice before a rate increase and the actual dollar amount of the increase, and would set a 30-day time limit for the Department to review and administratively disapprove a property and casualty insurance rate under the file-and-use system. Additionally, Article 3 would remove the discretion of the department to request additional supporting information for a claim and replace it with the discretion of the filer to include additional supporting information.

Article 4 would authorize the State Fire Marshal's Office (SFMO), housed at TDI, to charge a fee for inspections of privately owned buildings. The bill would require the SFMO to periodically inspect state-leased buildings and requires the SFMO to create a risk-based approach to conducting its routine inspections of state buildings. Article 4 would require the Commissioner of Insurance to establish a penalty matrix for violations by SFMO licensees, and to delegate administration of these penalties to the SFMO.

Article 5 would set deadlines for TDI to send notifications to title insurance agents and appoint title insurance companies during the licensing and licensing renewal process. Article 5 would set guidelines for TDI regarding licensing and disciplinary notifications. Additionally, the bill would remove the requirement of TDI approval of reinsurance contracts forms for title companies that wish to reinsure any of its policies and contracts. The bill would require the Commissioner to assess what information is needed to promulgate title insurance rates every five years.

Article 6 would clarify provisions in the Insurance Code to clearly permit the use of electronic commerce transactions.

Article 7 would require TDI to develop and implement a plan to collect from insurers and publish certain information relating to the processing of personal automobile and residential property claims. Additionally Article 7 would create a Health Innovations Program and require TDI to study the demographics of uninsured Texans and reasons why individuals are uninsured. The bill would authorize TDI to receive gifts or grants to assist with funding this program.

Article 8 would require TDI to determine, at least every six years, which areas of the state should be designated as underserved and to study the accuracy of current designations for the purpose of increasing access to insurance in those areas.

Article 9 would make several procedural changes to the Texas Windstorm Insurance Association (TWIA), including subjecting TWIA to open meetings and open records provisions, providing that any closed meetings are open to the Commissioner of Insurance, and making changes to the policy renewal and eligibility processes.

Article 10 would create a Public Insurance Adjusters advisory board.

Article 11 would allow TDI to enter into information sharing agreements with federal and state

agencies, establish a procedure to certify and rate qualified health plans, and provide comparative and eligibility information.

Article 12 would require a residential property policy to require the insured to participate in an alternative resolution procedure before filing a private action.

Article 13 would prohibit insurance companies from reporting claims to a database until the claim has been filed.

Article 14 would provide for prompt pay requirements for Pharmacy Benefits Management.

Article 15 would require life insurance companies to obtain beneficiary authorization before depositing funds into a retained asset account.

Article 16 would prohibit managed care plans from requiring that therapeutic optometrists or ophthalmologists participate in a payment plan that they do not wish to participate in.

Article 17 would allow for the regulation of preferred provider organizations.

Article 18 would limit FAIR plan liability to amounts for loss of the insured structure, contents, and additional living expenses.

Article 19 would require the Commissioner to adopt standard forms that an insurer is required to use in addition to its own forms.

Article 20 would increase liability on surety bonds from $100,000 to $1 million for requiring reinsurance.

Article 21 would provide that property insurance appraisal decisions are binding only as to the amount of loss, and prohibits them from being used to determine liability issues.

Article 22 would allow employers to make financial contributions to or premium payments for an employee or retiree's individual consumer directed health insurance policy, in a way that does not have negative tax consequences.

Article 23 would provide that the insured has the right to exclude named persons from an automobile policy.

Article 24 would amend the entrance exam and hours of instruction requirements for residential fire alarm technicians.

Article 25 would provide that a title company is not required to offer an endorsement insuring a loss from the extraction of cola, lignite, oil, or gas.

Article 26 would prohibit rescission of health insurance, absent fraud or intentional misrepresentation.

This legislation would do one or more of the following: create or recreate a dedicated account in the General Revenue Fund, create or recreate a special or trust fund either with or outside of the Treasury, or create a dedicated revenue source. Legislative policy, implemented as Government Code 403.094, consolidated special funds (except those affected by constitutional, federal, or other restrictions) into the General Revenue Fund as of August 31, 1993 and eliminated all applicable statutory revenue dedications as of August 31, 1995. Each subsequent Legislature has reviewed bills that affect funds consolidation. The fund, account, or revenue dedication included in this bill would be subject to funds consolidation review by the current Legislature.

The bill would take effect on September 1, 2011.

Methodology

Based on information provided by TDI, this analysis assumes that implementation of Article 3, 14, 15, and 26 of the bill could result in a one-time revenue gain ($52,500 in fiscal year 2012) in General Revenue-Dedicated Texas Department of Insurance Fund 36 from filing fees. Since General Revenue-Dedicated Texas Department of Insurance Fund 36 is a self-leveling account, this analysis also assumes that any additional revenue resulting from the implementation of the bill would accumulate in the account fund balances and that the department would adjust the assessment of the maintenance tax or other fees accordingly in the following year.

Article 1: Based on the analysis by TDI, a majority of the work in conducting a study on mandatory medical reinsurance would be performed by an outside actuarial consulting firm, but 1.0 full-time equivalents (FTEs) would be needed to manage and administer other facets of the study. The cost of the outside actuarial consulting firm is anticipated to be $375,000 in fiscal year 2012 and $125,000 in fiscal year 2013. Additionally, the 1.0 FTE would cost $74,624 in fiscal year 2012 and $69,919 in fiscal year 2013 from General Revenue – Insurance Maintenance Tax.

Article 4: Based on the analysis provided by the Sunset Advisory Commission (SAC), the provision will be revenue neutral. Authorizing the SFMO to institute a fee for conducting inspections of privately owned buildings would result in a gain in revenue, but this gain would offset the SFMO's costs in providing the inspections, and the revenue should be redirected to those functions. The gain could not be estimated as it is dependent upon the fee level to be determined by the SFMO and the number of requests that continue to come in once the SFMO charges for this service. Since General Revenue-Dedicated Texas Department of Insurance Fund 36 is a self-leveling account, this analysis also assumes that any additional revenue resulting from the implementation of the bill would accumulate in the account fund balances and that the department would adjust the assessment of the maintenance tax or other fees accordingly in the following year.

Article 5: Based on the analysis by TDI, implementation of Article 5 of the bill would require 5.5 FTEs in each fiscal year in the enforcement division due to the increased workload created by additional title insurance enforcement cases and increased frequency of rate hearings and 3.0 FTEs in the Title Division for the increased licensing workload. Based on the analysis by TDI, the 8.5 FTEs would cost $663,276 in fiscal year 2012 and $616,631 in fiscal year 2013 through 2016 from General Revenue – Insurance Maintenance Tax. Additionally, expert witnesses will be required for the additional rate cases at a cost of $72,000 in fiscal year 2013 and 2015 and additional operating expenses for updated publications at a cost of $297 is anticipated in fiscal years 2014 and 2016.

Article 7: Based on the analysis by TDI, implementation of Article 7 of the bill would require 1.0 FTEs to execute the statutory charge of developing and implementing the health benefit plan innovations program. The 1.0 FTE would cost $84,455 in fiscal year 2012 and $79,750 each fiscal year of 2013 through 2016 to be funded from General Revenue – Insurance Maintenance Tax.

Article 11: The Health and Human Services Commission (HHSC) indicates it would incur costs to allow its eligibility systems to interface with an exchange and for data center expansion, whether the exchange is established under the authority of this bill or established by the federal government. HHSC estimates an All Funds cost of $12,000,000 in fiscal year 2012 and $12,000,000 in fiscal year 2013 to allow its eligibility systems to interface with an exchange. Over the biennium, it includes $14,000,000 for data center expansion and $10,000,000 for the Texas Integrated Eligibility Redesign System (TIERS) to interface with an exchange. HHSC anticipates receiving a 90 percent federal match for costs associated with technology related changes required to interface with the exchange. Based on this analysis, HHSC systems changes would cost an estimated $2,400,000 in General Revenue for the biennium. HHSC would also need to request increased capital authority for implementing these changes. This analysis assumes that other functions required under the bill can be absorbed within existing resources.

TDI's analysis assumes that implementation of the exchange would have a fiscal impact, but is not able to determine the extent. The degree to which federal funds will be available is uncertain, but implementation could be scaled to available resources as needed.

Article 17: The bill requires that contracting entities register with the TDI and allows for the regulation of certain health care provider network contract arrangements relating to the delivery of and

payment for health care services to individuals covered under a health benefit plan. Based on the analysis provided by TDI, it is assumed that 200 contracting entities will seek registration for the non workers' compensation healthcare. Implementation of the bill will require 1.0 FTEs, an Insurance Specialist III, to perform the registration process and periodic updates for contracting entities. Based on the analysis provided by TDI, the 1.0 FTE would cost $61,608 in fiscal year 2012 and $56,903 in fiscal years 2013 through 2016 from General Revenue – Dedicated Fund 36 (GR-D Fund 36). Implementation of the bill would require TDI to set a reasonable fee by rule as necessary to administer the registration process.

Since insurance maintenance tax is self-leveling, this analysis assumes that the costs to TDI to implement Articles 1, 4, 5, 7, and 17 of this bill would come from fund balances or the maintenance tax would be set to recover a higher level of revenue.

Technology

The bill is anticipated to have a technology impact of $14,700 in fiscal year 2012.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 116 Sunset Advisory Commission, 304 Comptroller of Public Accounts, 454 Department of Insurance, 529 Health and Human Services Commission

LBB Staff: JOB, KM, MW, CH

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 82ND LEGISLATIVE REGULAR SESSION

March 27, 2011

TO: Honorable John T. Smithee, Chair, House Committee on Insurance

FROM: John S O'Brien, Director, Legislative Budget Board

IN RE: **HB1951** by Taylor, Larry (Relating to the continuation and operation of the Texas Department of Insurance and the operation of certain insurance programs; imposing administrative penalties.), **As Introduced**

No significant fiscal implication to the State is anticipated.

The bill would amend the Insurance Code relating to the continuation and operation of the Texas Department of Insurance (TDI) and the operation of certain insurance programs; imposing administrative penalties. TDI is subject to the Sunset Act and will be abolished on September 1, 2011, unless continued by the Legislature. The bill would continue TDI for 12 years and would take effect on September 1, 2011. The bill would also require TDI to clearly define the processes it uses to regulate property and casualty insurance in Texas, to develop and encourage the use of appropriate alternative dispute resolution procedures, and to develop and implement a plan to collect from insurers and publish certain information relating to the processing of personal automobile and residential property claims. Additionally, the bill would require TDI to determine, at least every six years, which areas of the state should be designated as underserved and to study the accuracy of certain designations for the purpose of increasing access to insurance in those areas.

The bill would authorize the State Fire Marshal's Office (SFMO), housed at TDI, to charge a fee for inspections of privately owned buildings. The provision will be revenue neutral. Authorizing the SFMO to institute a fee for conducting inspections of privately owned buildings would result in a gain in revenue, but this gain would offset the SFMO's costs in providing the inspections, and the revenue should be redirected to those functions. The gain could not be estimated as it is dependent upon the fee level to be determined by the SFMO and the number of requests that continue to come in once the SFMO charges for this service. Since General Revenue-Dedicated Texas Department of Insurance Fund 36 is a self-leveling account, this analysis also assumes that any additional revenue resulting from the implementation of the bill would accumulate in the account fund balances and that the department would adjust the assessment of the maintenance tax or other fees accordingly in the following year. he bill would require the SFMO to periodically inspect state-leased buildings and requires the SFMO to create a risk-based approach to conducting its routine inspections of state buildings.

Based on the analysis provided by the Sunset Advisory Commission, the Facilities Commission, and the Texas Department of Insurance, implementation of this bill will have no significant fiscal impact.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 116 Sunset Advisory Commission, 303 Facilities Commission, 454 Department of Insurance

LBB Staff: JOB, KJG, MW, CH, KM