BILL ANALYSIS

Senate Research Center

H.B. 1951
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Government Organization
5/15/2011
Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Texas Department of Insurance (TDI) regulates insurance companies' solvency, rates, forms, and market conduct; licenses individuals and entities involved in selling insurance policies; provides consumer education and resolves consumer complaints; and takes enforcement action against those who violate insurance laws. TDI also regulates workers' compensation insurance, but the Sunset Advisory Commission's (Sunset) recommendations on the Division of Workers' Compensation are contained in separate Sunset legislation.

TDI underwent Sunset review last session, but the bill did not pass. As a result, TDI underwent a special purpose Sunset review, and this bill contains the recommendations that continue to be appropriate of consideration by this legislature. TDI is subject to the Sunset Act and will be abolished on September 1, 2011, unless continued by the legislature.

H.B. 1951 amends current law relating to the continuation and operation of the Texas Department of Insurance and the operation of certain insurance programs, and imposes administrative penalties.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance (commissioner) in SECTION 2.001 (Sections 32.151 and 32.152, Insurance Code), SECTION 3.010 (Section 2251.151, Insurance Code), SECTION 4.001 (Section 417.008, Government Code), SECTION 4.002 (Section 417.0081, Government Code), SECTION 4.004 (Section 417.010, Government Code), SECTION 5.001 (Section 2501.009, Insurance Code), SECTION 6.001 (Section 35.004, Insurance Code), SECTION 7.001 (Sections 38.403 and 38.404, Insurance Code), SECTION 7.002 (Section 1953.152, Insurance Code), SECTION 9.008 (Section 2210.2551, Insurance Code), SECTION 9.012 (Section 2210.260, Insurance Code), SECTION 15.001 (Section 1102.002, Insurance Code), SECTION 22.001 (Section 1221.001, Insurance Code), SECTION 25.001 (Section 2502.006, Insurance Code), and SECTION 26.001 (Section 1202.105, Insurance Code) of this bill.

Rulemaking authority previously granted to the commissioner is modified in SECTION 2.003 (Section 1660.004, Insurance Code), SECTION 2.006 (Section 4102.005, Insurance Code), and SECTION 2.007 (Section 2154.052, Occupations Code) of this bill.

Rulemaking authority previously granted to the Texas Building and Procurement Commission is transferred to the Texas Facilities Commission in SECTION 4.003 (Section 417.0082, Government Code) of this bill.

Rulemaking authority previously granted to commissioner is rescinded in SECTION 15.001 (Section 1102.005, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

ARTICLE 1. GENERAL PROVISIONS

SECTION 1.001. Amends Section 31.002, Insurance Code, to require the Texas Department of Insurance (TDI), in addition to the other duties required of TDI, to perform certain actions,

including to protect and ensure the fair treatment of consumers, and ensure fair competition in the insurance industry in order to foster a competitive market.

SECTION 1.002. Amends Section 31.004(a), Insurance Code, to provide that unless continued in existence as provided by Chapter 325 (Texas Sunset Act), Government Code, TDI is abolished September 1, 2023, rather than September 1, 2011.

SECTION 1.003. Amends Subchapter B, Chapter 36, Insurance Code, by adding Section 36.110, as follows:

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

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

(2) appropriate alternative dispute resolution procedures under Chapter 2009 (Alternative Dispute Resolution for Use by Governmental Bodies), Government Code, to assist in the resolution of internal and external disputes under TDI's jurisdiction.

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

(c) Requires the commissioner to:

(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. Amends Section 559.003, Insurance Code, to require TDI to update insurer profiles maintained on TDI's Internet website to provide information to consumers stating whether or not an insurer uses credit scoring; and post on TDI's Internet website the report required under former Section 15, Article 21.49-2U, and 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.

SECTION 1.005. Amends Subchapter A, Chapter 2301, Insurance Code, by adding Section 2301.010, as follows:

Sec. 2301.010. CONTRACTUAL LIMITATIONS PERIOD AND CLAIM FILING PERIOD IN CERTAIN PROPERTY INSURANCE FORMS. (a) Authorizes a policy form or printed endorsement form for residential or commercial property insurance that is filed by an insurer or adopted by TDI under this subchapter to provide for a contractual limitations period for filing suit on a first-party claim under the policy. Prohibits the contractual limitations period from ending before the earlier of two years from the date the insurer accepts or rejects the claim, or three years from the date of the loss that is the subject of the claim.

(b) Authorizes a policy or endorsement described by Subsection (a) to 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. Requires that a provision under this subsection 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) Provides that a contractual provision contrary to Subsection (a) or (b) is void. Provides that 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. Amends Section 16.070, Civil Practice and Remedies Code, by amending Subsection (a) and adding Subsection (c), as follows:

(a) Creates an exception to this subsection under Subsection (c). Makes no further changes to this subsection.

(c) Provides that 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) Requires TDI to 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) Requires that the study conducted under this section:

(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) Authorizes TDI to 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) Requires TDI to include the results of the study conducted under this section in the biennial report submitted to the legislature under Section 32.022 (Biennial Report to Legislature), Insurance Code, nearest to December 31, 2012.

SECTION 1.008. Makes application of Section 2301.010, Insurance Code, as added by this article, only to an insurance policy that is delivered, issued for delivery, or renewed on or after January 1, 2012, prospective.

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

SECTION 2.001. Amends Chapter 32, Insurance Code, by adding Subchapter E, as follows:

SUBCHAPTER E. RULES REGARDING USE OF ADVISORY COMMITTEES

Sec. 32.151. RULEMAKING AUTHORITY. (a) Requires the commissioner to adopt rules, in compliance with Section 39.003 (Public Representation on Advisory Body) of this code and Chapter 2110 (State Agency Advisory Committees), 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) Requires an advisory committee to be structured and used to advise the commissioner, the state fire marshal, or department staff. Prohibits an advisory committee from being responsible for rulemaking or policymaking.

Sec. 32.152. PERIODIC EVALUATION. Requires the commissioner by rule to establish a process by which TDI shall periodically evaluate an advisory committee to ensure its continued necessity. Authorizes TDI to retain or develop committees as appropriate to meet changing needs.

Sec. 32.153. COMPLIANCE WITH OPEN MEETINGS ACT. Requires a department advisory committee to comply with Chapter 551 (Open Meetings), Government Code.

SECTION 2.002. Transfers Section 843.441, Insurance Code, to Subchapter L, Chapter 843, Insurance Code, redesignates it as Section 843.410, Insurance Code, and amends it as follows:

Sec. 843.410. ASSESSMENTS. Redesignates existing Section 843.441 as Section 843.410. (a) Requires the commissioner, to provide funds for the administrative expenses of the commissioner regarding rehabilitation, liquidation, supervision, conservatorship, or seizure of a health maintenance organization (HMO) in this state that is placed under supervision or in conservatorship under Chapter 441 (Supervision and Conservatorship) or against which a delinquency proceeding is commenced under Chapter 443 (Insurer Receivership Act) and that is found by the commissioner to have insufficient funds to pay the total amount of health care claims and the administrative expenses incurred by the commissioner regarding the rehabilitation, liquidation, supervision, conservatorship, or seizure, rather than requires the committee, to provide funds for the administrative expenses of the commissioner regarding rehabilitation, liquidation, supervision, or conservation of an impaired HMO in this state, including expenses incurred by the commissioner acting as receiver or by a special deputy receiver, at the commissioner's direction, to assess each HMO in the proportion that the gross premiums of the HMO 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 HMOs, as found, rather than as provided to the committee by the commissioner, after review of annual statements and other reports the commissioner considers necessary.

(b) Redesignates existing Subsection (c) as Subsection (b). Authorizes the amount of an abatement or deferral, if an assessment is abated or deferred in whole or in part, to be assessed against the remaining HMOs in a manner consistent with the calculations made by the commissioner under Subsection (a), rather than with the basis for assessments provided by the approved plan of operation.

(c) Redesignates existing Subsection (d) as Subsection (c). Makes no further changes to this subsection.

(d) Redesignates existing Subsection (e) as Subsection (d). Prohibits funds derived from an assessment made under this section, notwithstanding any other provision of this subchapter, from being used for more than 180 consecutive days

for the expenses of administering the affairs of an HMO the surplus of which is impaired and that is in supervision or conservatorship, rather than for the expenses of administering the affairs of an impaired HMO while in supervision, rehabilitation, or conservation for more than 150 days. Authorizes the commissioner to extend the period during which the commissioner makes assessments for the administrative expenses, rather than authorizes the committee to extend the period during which it makes assessments for the administrative expenses of an impaired HMO as it considers appropriate.

SECTION 2.003. Amends Section 1660.004, Insurance Code, to authorize the commissioner to adopt rules as necessary to implement this chapter, rather than to 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. Amends Section 1660.102(b), Insurance Code, to authorize the commissioner to consider recommendations or any other information provided, rather than to consider the recommendations of the advisory committee or any information provided, in response to a TDI-issued request for information relating to electronic data exchange, including identification card programs, before adopting rules regarding information to be included on the identification cards, technology to be used to implement the identification card pilot program, and confidentiality and accuracy of the information required to be included on the identification cards.

SECTION 2.005. Amends Section 4001.009(a), Insurance Code, as follows:

(a) Provides that, 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 (Retaliatory Provisions), 402 (Disclosure of Material Transactions), 421 (Reserves in General), 422 (Asset Protection Act), 423 (Transactions with Money and Other Assets), 441 (Supervision and Conservatorship), 444 (Agency Contracts with Certain Insurers), 461 (General Provisions), 462 (Texas Property and Casualty Insurance Guaranty Association), 463 (Texas Life, Accident, Health, and Hospital Service Insurance Guaranty Association), 541 (Unfair Methods of Competition and Unfair or Deceptive Acts or Practices), 542 (Processing and Settlement of Claims), 543 (Prohibited Practices Related to Policy or Certificate of Membership), 544 (Prohibited Discrimination), 545 (HIV Testing), 546 (Use of Genetic Testing Information), 547 (False Advertising by Unauthorized Insurers), 548 (Insurer Insider Trading and Proxy Regulation), 549 (Prohibited Practices Relating to Property Insurance), 550 (Prohibited Practices Relating to Payments), 551 (Practices Relating to Declination, Cancellation, and Nonrenewal of Insurance Policies), 552 (Illegal Pricing Practices), 553 (Enforcement of Insurance Policies Regarding Holocaust Victims), 554 (Burden of Proof and Pleading), 555 (Failure to Satisfy Judgment), 556 (Unfair Methods of Competition and Unfair Practices by Financial Institutions), 558 (Refund of Unearned Premium), 559 (Credit Scoring and Credit Information), 703 (Covered Entity's Antifraud Action), 705 (Misrepresentation by Policyholders), 821 (General Provisions), 823 (Insurance Holding Company Systems), 824 (Merger and Consolidation of Stock Insurance Corporations), 825 (Conversion of Stock Insurance Company to Mutual Insurance Company), 827 (Withdrawal and Restriction Plans), 828 (Purchase of Stock for Total Assumption Reinsurance), 844 (Certification of Certain Nonprofit Health Corporations), 963 (Automobile Clubs), 1108 (Benefits Exempt from Seizure), 1205 (Certification of Creditable Coverage), 1206 (Denial of Health Benefit Plan Enrollment Based on Existing Coverage Prohibited), 1207 (Enrollment of Medical Assistance Recipients and Children Eligible for State Child Health Plan), 1208 (Identify of Available Employee of Health Benefit Plan Issuer), 1211 (Waivers Regarding Certain Federal Health Plans), 1213 (Electronic Health Care Transactions), 1214 (Advertising for Certain Health Benefits), 1352 (Brain Injury), 1353

(Immunization or Vaccination Protocols Under Managed Care Plans), 1357 (Mastectomy), 1358 (Diabetes), 1360 (Diagnosis and Treatment Affecting Temporomandibular Joint), 1361 (Detection and Prevention of Osteoporosis), 1362 (Certain Tests for Detection of Prostate Cancer), 1363 (Certain Tests for Detection of Colorectal Cancer), 1369 (Benefits Related to Prescription Drugs and Devices and Related Services), 1453 (Disclosure of Reimbursement Guidelines under Managed Care Plan), 1454 (Equal Health Care for Women), 1455 (Telemedicine and Telehealth), 1503 (Coverage of Certain Students), 1550 (Certain Requirements for Insurers Contracting with Governmental Entities), 1801 (Property and Casualty Insurance Legislative Oversight Committee), 1803 (Reports of Insurance Coverage for State Agencies), 2151 (Texas Automobile Insurance Plan Association), 2152 (Group Insurance in Underserved Areas), 2153 (Group Marketing of Automobile Insurance for Persons Over 55 Years of Age), 2154 (Volunteer Fire Department Motor Vehicle Self-Insurance Program), 2201 (Risk Retention Groups and Purchasing Groups), 2202 (Joint Underwriting), 2203 (Medical Liability Insurance Joint Underwriting Association), 2205 (Texas Child-Care Facility Liability Pool), 2206 (Risk Management Pools for Certain Educational Entities), 2207 (Excess Liability Pools for Counties and Certain Educational Entities), 2208 (Texas Public Entity Excess Insurance Pool), 2209 (Texas Nonprofit Organizations Liability Pool), 2210 (Texas Windstorm Insurance Association), 2211 (Fair Plan), 2212 (Self-Insurance Trusts for Health Care), 2213 (Self-Insurance Trusts for Banks and Savings and Loan Associations), 3501 (Credit Involuntary Unemployment Insurance), 3502 (Mortgage Guaranty Insurance), 4007 (Notice to Department by Certain Property and Casualty Insurance Companies Regarding Agents), 4102 (Public Insurance Adjusters), and 4201 (Utilization Review Agents), 4202 (Independent Review Organizations, 4203 (Prohibited Consultant Activities), rather than Chapters 281, 402, 421-423, 441, 444, 461-463, 523 (Market Assistance Program for Residential Property Insurance), 541-556, 558, 559, 702, 703, 705, 821, 823-825, 827, 828, 844, 963, 1108, 1205-1209, 1211, 1212 (Technical Advisory Committee on Claims Processing), 1213, 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 (Dividends), excluding Section 403.002 (Dividends to Policyholders in Commercial Lines);

(3) Subchapter A (Reinsurance), Chapter 491 (General Reinsurance Requirements);

(4) Subchapter C (Health Maintenance Organization or Insurer Toll-Free Number for Information and Complaints), Chapter 521 (Consumer Information and Complaints);

(5) Subchapter A (Insurance Proceeds Held by Lender Pending Repair of Residential Real Property), Chapter 557 (Insured Property Subject to Security Interest);

(6) Subchapter B (Certain Payments by Directors, Officers, and Trustees), Chapter 805 (Directors, Officers, and Other Interested Persons);

(7) Subchapters D (Trusteed Assets of Alien Insurance Companies), E (Trusteed Surplus of Alien Insurance Companies), and F (Provisions Applicable to Certain Companies), Chapter 982 (Foreign and Alien Insurance Companies);

(8) Subchapter D (Forfeiture of Beneficiary's Rights), Chapter 1103 (Life Insurance Policy Beneficiaries);

(9) Subchapters B (Assignment of Benefit Payments), C (Uniform Claim Billing Forms), D (Payments for Certain Publicly Provided Services), and E

(Exclusionary Clauses), Chapter 1204 (Procedures for Payment of Certain Health and Accident Insurance Policy or Plan Benefits), excluding Sections 1204.153 (Payments to Texas Department of Human Services for Certain Children) and 1204.154 (Uniform Provisions);

(10) Subchapter B (Minimum Inpatient Stay Following Birth of Child and Postdelivery Care), Chapter 1366 (Benefits Related to Fertility and Childbirth);

(11) Subchapters B (Childhood Immunizations), C (Hearing Test), and D (Child Craniofacial Abnormalities), Chapter 1367 (Coverage of Children), excluding Section 1367.053(c) (relating to plan coverage for immunization against rotovirus and any other immunization required for a child by law);

(12) Subchapters A (General Provisions), C (Selection of Practitioners), D (Access to Optometrists and Ophthalmologists Used Under Managed Care Law), E (Dental Care Benefits in Health Insurance Policies or Employee Benefit Plans), F (Access to Obstetrical or Gynecological Care), H (Disability Certified by Podiatrist), and I (Use of Osteopathic Hospital), Chapter 1451 (Access to Certain Practitioners and Facilities);

(13) Subchapter B (Standardized Forms), Chapter 1452 (Physician and Provider Credentials);

(14) Sections 551.004 (Transfer Not Considered a Refusal to Renew), 841.303 (Entire Contract), 982.001 (Definitions), 982.002 (Applicability of Chapter), 982.004 (Financial Statements of Foreign or Alien Insurance Companies), 982.052 (Certificate of Authority Required for Other Companies), 982.102 (Filing of Financial Statement by Other Insurance Company; Examination), 982.103 (Filing of Financial Statement by Alien Insurance Company), 982.104 (Filing of Articles of Incorporation), 982.106 (Capital Stock and Surplus Requirements for Other Insurance Companies), 982.107 (Applicability of Other Law), 982.108 (Deposit Requirements for Alien Insurance Company), 982.110 (Duration of Deposit for Other Insurance Companies), 982.111 (Exception to Deposit Requirement; Trusteed Assets), 982.112 (Exception to Deposit Requirement; Deposit with Officer in Another State), and 1802.001 (Property and Casualty Insurance Initiatives Task Force); and

(15) Chapter 107 (Intractable Pain Treatment), Occupations Code.

SECTION 2.006. Amends Section 4102.005, Insurance Code, as follows:

Sec. 4102.005. CODE OF ETHICS. Requires the commissioner, rather than requires the commissioner, with guidance from the public insurance adjusters examination advisory committee, by rule to 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. Amends Section 2154.052(a), Occupations Code, to provide that the commissioner is required to administer this chapter through the state fire marshal, and is authorized to issue rules to administer this chapter, rather than to administer this chapter in compliance with Section 2154.054.

SECTION 2.008. Repealers: (1) Article 3.70-3D(d) (relating to establishing an advisory committee), 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 (Market Assistance Program for Residential Property Insurance), Insurance Code;

(3) Section 524.061, Insurance Code;

(4) the heading to Subchapter M (Health Maintenance Organization Solvency Surveillance Committee), Chapter 843 (Health Maintenance Organizations), Insurance Code;

(5) Sections 843.435 (Definition), 843.436 (Composition and Administration), 843.437 (Plan of Operation), 843.438 (Examination and Regulation), 843.439 (Immunity From Liability), and 843.440 (General Powers and Duties), Insurance Code;

(6) Chapter 1212 (Technical Advisory Committee on Claims Processing), Insurance Code;

(7) Section 1660.002(2) (defining "advisory committee"), Insurance Code;

(8) Subchapter B (Advisory Committee), Chapter 1660 (Electronic Data Exchange), Insurance Code;

(9) Section 1660.101(c) (relating to implementing an identification card pilot program), Insurance Code;

(10) Sections 4002.004 (Advisory Board), 4004.002 (Advisory Council), 4101.006 (Advisory Board), and 4102.059 (Examination Advisory Committee), Insurance Code;

(11) Sections 4201.003(c) (relating to the appointment of an advisory committee) and (d) (relating to advisory committee deliberations), Insurance Code;

(12) Subchapter C (Fire Extinguisher Advisory Council), Chapter 6001 (Fire Extinguisher Service and Installation), Insurance Code;

(13) Subchapter C (Fire Detection and Alarm Devices Advisory Council), Chapter 6002 (Fire Detection and Alarm Device Installation), Insurance Code;

(14) Subchapter C (Fire Protection Advisory Council), Chapter 6003 (Fire Protection Sprinkler System Service and Installation), Insurance Code;

(15) Section 2154.054 (Advisory Council), Occupations Code; and

(16) Section 2154.055(c) (relating to administering a fireworks safety and education program by the advisory council), Occupations Code.

SECTION 2.009. (a) Abolishes the following boards, committees, councils, and task forces 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) Requires that 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 be transferred to TDI not later than February 28, 2012.

SECTION 2.010. Makes application of the changes in law made by this Act by repealing Sections 523.003 and 843.439, Insurance Code, only to a cause of action that accrues on or after the effective date of this Act, prospective.

ARTICLE 3. RATE REGULATION

SECTION 3.001. Amends Subchapter F, Chapter 843, Insurance Code, by adding Section 843.2071, as follows:

Sec. 843.2071. NOTICE OF INCREASE IN CHARGE FOR COVERAGE. (a) Requires an HMO, not less than 60 days before the date on which an increase in a charge for coverage under this chapter takes effect, to:

(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) Requires that the notice required by this section be based on coverage in effect on the date of the notice.

(c) Prohibits this section from being construed to prevent an HMO, at the request of an enrollee, from negotiating a change in benefits or rates after delivery of the notice required by this section.

(d) Prohibits an HMO from requiring an enrollee entitled to notice under this section to respond to the HMO 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) Requires that the notice required by this section include:

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

(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 TDI and the United States Department of Health and Human Services.

SECTION 3.002. Amends Subchapter C, Chapter 1201, Insurance Code, by adding Section 1201.109, as follows:

Sec. 1201.109. NOTICE OF RATE INCREASE. (a) Requires the insurer, 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, to:

(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) Requires that the notice required by this section be based on coverage in effect on the date of the notice.

(c) Prohibits this section from being 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) Prohibits an insurer from requiring 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) Requires that the notice required by this section include:

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

(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 TDI and the United States Department of Health and Human Services.

SECTION 3.003. Amends Subchapter E, Chapter 1501, Insurance Code, by adding Section 1501.216, as follows:

Sec. 1501.216. PREMIUM RATES: NOTICE OF INCREASE. (a) Requires the insurer, 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, to:

(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) Requires that the notice required by this section be based on coverage in effect on the date of the notice.

(c) Prohibits this section from being 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) Prohibits an insurer from requiring 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) Requires that the notice required by this section include:

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

(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 TDI and the United States Department of Health and Human Services.

SECTION 3.004. Amends Section 2251.002(8), Insurance Code, to redefine "supporting information."

SECTION 3.005. Amends Section 2251.101, Insurance Code, as follows:

Sec. 2251.101. RATE FILINGS AND SUPPORTING INFORMATION. (a) Authorizes an insurer to use a rate filed under this subchapter on and after the date the rate is filed.

(b) Requires the commissioner by rule to:

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

(A) categories of supporting information and supplementary rating information;

(B) 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) information concerning policy fees, service fees, and other fees that are charged or collected by the insurer under Section 550.001 (Solicitation or Collection of Certain Payments) or 4005.003 (Fees); and

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

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

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

Makes nonsubstantive changes.

SECTION 3.006. Amends Section 2251.103, Insurance Code, as follows:

Sec. 2251.103. New heading: COMMISSIONER ACTION CONCERNING RATE FILING NOT YET IN EFFECT; HEARING AND ANALYSIS. (a) Requires the commissioner, not later than the earlier of the date the rate takes effect or the 30th day after the date a rate is filed with TDI under Section 2251.101 (Rate Filings and Supporting Information), to disapprove the rate if the commissioner determines that the rate does not comply with the requirements of this chapter. Deletes existing text requiring the commissioner to disapprove a rate if the commissioner determines that the rate filing made under this chapter does not meet the standards established under Subchapter B.

(b) Provides that, 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) Authorizes the commissioner, for good cause, on the expiration of the 30-day period described by Subsection (a), to extend the period for disapproval of a rate for one additional 30-day period. Prohibits the commissioner and the insurer from by agreement extending the 30-day period described by Subsection (a) or this subsection.

(d) Creates this subsection from existing text. Requires the commissioner, if the commissioner disapproves a rate under this section, rather than a rate filing, to

issue an order specifying in what respects the rate, rather than the filing, fails to meet the requirements of this chapter.

(e) Creates this subsection from existing text. Entitles an insurer that files a rate that is disapproved under this section to a hearing on written request made to the commissioner not later than the 30th day after the date the order disapproving the rate, rather than the filing, takes effect.

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

SECTION 3.007. Amends Subchapter C, Chapter 2251, Insurance Code, by adding Section 2251.1031, as follows:

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

(b) Provides that if TDI requests additional information from the insurer during the 30-day period described by Section 2251.103(a) or 2251.153(a) (relating to approving or disapproving a rate filing) or under a second 30-day period described by Section 2251.103(c) or 2251.153(c) (relating to extending the period of time for approving or disapproving a rate filing), as applicable, the time between the date TDI submits the request to the insurer and the date TDI 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) Provides that for purposes of this section, the date of TDI's submission of a request for additional information is the earlier of:

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

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

(d) Requires TDI to 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. Amends the heading to Section 2251.104, Insurance Code, to read as follows:

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

SECTION 3.009. Amends Section 2251.107, Insurance Code, as follows:

Sec. 2251.107. New heading: PUBLIC INFORMATION. Provides that each filing made, and any supporting information filed, under this chapter is public information subject to Chapter 552 (Public Information), Government Code, including any applicable exception from required disclosure under that chapter, rather than is open to public inspection as of the date of the filing.

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

(c-1) Requires the commissioner, if the commissioner requires an insurer to file the insurer's rates under this section, to periodically assess whether the conditions described by Subsection (a) (relating to requiring certain information to be filed with TDI) continue

to exist. Requires the commissioner, if the commissioner determines that the conditions no longer exist, to issue an order excusing the insurer from filing the insurer's rates under this section.

(e) Requires the commissioner, if the commissioner requires an insurer to file the insurer's rates under this section, to 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.

(f) Requires the commissioner by rule to define:

(1) the financial conditions and rating practices that may subject an insurer to this section under Subsection (a)(1) (relating to certain insurer's rates requiring supervision in certain circumstances); and

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

SECTION 3.011. Amends Section 2251.156, Insurance Code, as follows:

Sec. 2251.156. RATE FILING DISAPPROVAL BY COMMISSIONER; HEARING. (a) Requires the commissioner, if the commissioner disapproves a rate filing under Section 2251.153(a)(2), to issue an order disapproving the filing in accordance with Section 2251.103(d), rather than Section 2251.103(b).

(b) Entitles an insurer whose rate filing is disapproved to a hearing in accordance with Section 2251.103(e), rather than Section 2251.103(c).

(c) Requires TDI to track precedents related to disapprovals of rates under this subchapter to ensure uniform application of rate standards by TDI.

SECTION 3.012. Amends Section 2254.003(a), Insurance Code, to provide that 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. Repealer: Section 2251.154 (Additional Information), Insurance Code.

SECTION 3.014. Makes application of Sections 843.2071, 1201.109, and 1501.216, Insurance Code, as added by this Act, to an HMO 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, prospective.

SECTION 3.015. Makes application of Sections 2251.002(8) and 2251.107, Insurance Code, as amended by this Act, to a request to inspect information or to obtain public information made to TDI, prospective.

SECTION 3.016. Makes application of Section 2251.103, Insurance Code, as amended by this Act, and Section 2251.1031, Insurance Code, as added by this Act, prospective.

SECTION 3.017. Makes application of Section 2251.151(c-1), Insurance Code, as added by this Act, 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. Makes application of Section 2251.151(e), Insurance Code, as amended by this Act, to an order issued by the commissioner, prospective.

ARTICLE 4. STATE FIRE MARSHAL'S OFFICE

SECTION 4.001. Amends Section 417.008, Government Code, by adding Subsection (f), as follows:

(f) Requires the commissioner by rule to 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. Requires the commissioner, in prescribing the fee, to 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. Amends Section 417.0081, Government Code, as follows:

Sec. 417.0081. New heading: INSPECTION OF CERTAIN STATE-OWNED OR STATE-LEASED BUILDINGS. (a) Creates this subsection from existing text. Requires the state fire marshal, at the commissioner's direction, to periodically inspect public buildings under the charge and control of the Texas Facilities Commission (TFC), rather than the General Services Commission, and buildings leased for the use of a state agency by TFC.

(b) Requires the commissioner, for the purpose of determining a schedule for conducting inspections under this section, by rule to adopt guidelines for assigning potential fire safety risk to state-owned and state-leased buildings. Requires that rules adopted under this subsection 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) Requires the state fire marshal, on or before January 1 of each year, to 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. Amends Section 417.0082, Government Code, as follows:

Sec. 417.0082. PROTECTION OF CERTAIN STATE-OWNED OR STATE-LEASED BUILDINGS AGAINST FIRE HAZARDS. (a) Requires the state fire marshal, under the direction of the commissioner, to take any action necessary to protect a public building under the charge and control of TFC, rather than the Texas Building and Procurement Commission, and the building's occupants, and the occupants of a building leased for the use of a state agency by TFC, against an existing or threatened fire hazard. Makes a conforming change.

(b) Makes a conforming change.

SECTION 4.004. Amends Section 417.010, Government Code, as follows:

Sec. 417.010. New heading: DISCIPLINARY AND ENFORCEMENT ACTIONS; ADMINISTRATIVE PENALTIES. (a) Provides that this section applies to each person and firm licensed, registered, or otherwise regulated by TDI through the state fire marshal, including a person regulated under Title 20 (Regulation of Other Occupations), Insurance Code, and a person licensed under Chapter 2154 (Regulation of Fireworks and Fireworks Displays), Occupations Code.

(b) Requires the commissioner by rule to 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. Requires the commissioner, in the rules adopted under this subsection, to:

(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) Requires the commissioner by rule to 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. Requires TDI to provide the administrative penalty schedule to the public on request. Requires that the amount of an administrative penalty imposed under this section 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) Creates this subsection from existing text. Authorizes the state fire marshal, in the enforcement of a law that is enforced by or through the state fire marshal, in lieu of cancelling, revoking, or suspending a license or certificate of registration, to 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, rather than 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, rather than and

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

Makes nonsubstantive changes.

(e) Requires the state fire marshal to impose an administrative penalty under this section in the manner prescribed for imposition of an administrative penalty under Subchapter B (Imposition of Administrative Penalty), Chapter 84 (Administrative Penalties), Insurance Code. Authorizes the state fire marshal to impose an administrative penalty under this section without referring the violation to TDI for commissioner action.

(f) Authorizes an affected person to dispute the imposition of the penalty or the amount of the penalty imposed in the manner prescribed by Subchapter C (Procedural Requirements), Chapter 84, Insurance Code. Provides that failure to pay an administrative penalty imposed under this section is subject to enforcement by TDI.

ARTICLE 5. TITLE INSURANCE

SECTION 5.001. Amends Chapter 2501, Insurance Code, by adding Section 2501.009, as follows:

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

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

SECTION 5.002. Amends Section 2502.055(a), Insurance Code, as follows:

(a) Provides that nothing in this subchapter prohibits a title insurance company or a title insurance agent from:

(1) engaging in promotional and educational activities, rather than in legal promotional and educational activities, that are not conditioned on the referral of title insurance business and not prohibited by Subchapter B (Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined), 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;

(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. Amends Section 2551.302, Insurance Code, as follows:

Sec. 2551.302. REQUIREMENTS FOR REINSURING POLICIES. Authorizes a title insurance company to 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 (Title Insurance for Personal Property Interests), if:

(1) the reinsuring title insurance company is authorized to engage in business in this state under this title; or, rather than and

(2) the title insurance company acquires reinsurance in accordance with Section 2551.305, rather than TDI first approves the form of the reinsurance contract.

SECTION 5.004. Amends Section 2551.305, Insurance Code, as follows:

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

(1) the 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 TDI 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) Requires that 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) Redesignates existing Subsection (a) as Subsection (c). Authorizes TDI, notwithstanding any other provision of this subchapter, on application and hearing, to 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 million, rather than $1.4 million, as stated in its annual statement preceding the acceptance of reinsurance.

(d) Redesignates existing Subsection (b) as Subsection (d). Makes a conforming change.

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

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

(e) Requires TDI, not later than the fifth business day after the date the renewal application is complete, to notify the applicant in writing of the date that the renewal application is complete.

(f) Provides that 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 TDI

notifies the applicant in writing of the factual grounds on which TDI proposes to deny the license under Section 2651.301 (Grounds for License Denial or Disciplinary Action).

(g) Authorizes TDI to provide a notice required under this section by e-mail.

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

(c) Requires TDI, not later than the 20th business day after the date TDI receives a notice under Subsection (b) (relating to additional title insurance companies), to notify the title insurance agent and appointing title insurance company in writing of any deficiencies in the notice that render the notice incomplete. Provides that a notice under Subsection (b) is considered complete on the date TDI receives the notice, unless TDI provides notice of the deficiencies under this section.

(c-1) Requires TDI, not later than the fifth business day after the date the notice under Subsection (b) is complete, to 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) Redesignates existing Subsection (c) as Subsection (c-2). Provides that the appointment is effective on the eighth business day following the date the notice of appointment is complete and TDI receives the fee, unless TDI proposes to reject the appointment. Requires TDI, if TDI proposes to reject the appointment, to notify the title insurance agent and the appointing title insurance company in writing of the factual grounds on which TDI proposes to reject the appointment not later than the seventh business day after the date on which the notice of appointment is complete. Deletes existing text providing that the appointment is effective on the eighth day following the date TDI receives the completed notice of appointment and the fee, unless TDI rejects the appointment. Deletes existing text requiring TDI, if TDI rejects the appointment to state in writing the reasons for rejection not later than the seventh day after the date on which TDI receives the completed notice of appointment.

(c-3) Authorizes TDI to provide a notice required under this section by e-mail.

SECTION 5.007. Amends Subchapter G, Chapter 2651, Insurance Code, by adding Sections 2651.3015 and 2651.303, as follows:

Sec. 2651.3015. PROHIBITED GROUNDS FOR REJECTION, DELAY, OR DENIAL. (a) Prohibits TDI, except as provided by Subsection (b) or (c), from rejecting, delaying, or denying 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 TDI.

(b) Authorizes TDI to reject a notice of appointment under Section 2651.009 if TDI 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) Authorizes TDI to 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 TDI 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) Prohibits TDI, except as provided by Subsection (e) or (f), from delaying or denying 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) Authorizes TDI to deny a renewal application under Section 2651.007 (License Renewal) if TDI 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) Authorizes TDI to 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 TDI 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) Requires TDI to 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 TDI 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 TDI 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) Provides that a notice required by Subsection (a) is authorized to be provided by e-mail and is required to provide a license holder fair notice of the alleged facts known by TDI on the date of the notice that constitute grounds for the action.

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

(d) Authorizes TDI to 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. Amends Subchapter B, Chapter 2652, Insurance Code, by adding Section 2652.059, as follows:

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

(b) Requires TDI, not later than the fifth business day after the date the application is complete, to notify the applicant or license holder in writing of the date that the license application or license renewal is complete.

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

(d) Authorizes TDI to provide a notice required under this section by e-mail.

SECTION 5.009. Amends Subchapter E, Chapter 2652, Insurance Code, by adding Sections 2652.2015 and 2652.203, as follows:

Sec. 2652.2015. PROHIBITED GROUNDS FOR DELAY OR DENIAL. (a) Prohibits TDI, except as provided by Subsection (b) or (c), from delaying or denying 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) Authorizes TDI to 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 TDI 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) Authorizes TDI to deny a license application or license renewal if TDI 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) Requires TDI to 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 TDI 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 TDI 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) Requires that a notice required by Subsection (a) provide a license holder fair notice of the alleged facts known by TDI on the date of the notice that constitute grounds for the action.

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

(d) Authorizes TDI to 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. Amends Subchapter B, Chapter 2703, Insurance Code, by adding Section 2703.0515, as follows:

Sec. 2703.0515. CERTAIN REQUIREMENTS PROHIBITED. (a) Provides that 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) Defines, in this section, "general exception or exclusion."

(c) Prohibits an additional premium or other amount from being 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. Amends Subchapter B, Chapter 2703, Insurance Code, by adding Sections 2703.055 and 2703.056, as follows:

Sec. 2703.055. REQUIREMENT OF CERTAIN PROVISIONS PROHIBITED. Prohibits the commissioner from requiring 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) Authorizes a title insurance company, subject to the underwriting standards of the title insurance company, in a commitment for title insurance or a title insurance policy to 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) Provides that 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. Amends Section 2703.153, Insurance Code, by amending Subsections (c) and (d) and adding Subsections (h) and (i), as follows:

(c) Requires the commissioner, not less frequently than once every five years, to evaluate the information required under this section to determine whether TDI needs additional or different information or no longer needs certain information to promulgate rates.

(d) Authorizes a title insurance company or a title insurance agent aggrieved by a department requirement concerning the submission of information to 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 hearing, rather than the biennial hearing, and is not a request reasonably designed to lead to the discovery of that information.

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

(i) Prohibits an amendment to the contents of the statistical report from applying retroactively.

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

(b) Requires the commissioner to order a public hearing to consider changing a premium rate, including fixing a new premium rate, in response to a written 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 TDI;

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

(4) the office of public insurance counsel.

Makes nonsubstantive changes.

(d) Requires that a public hearing held under Subsection (a) (relating to a premium rate previously fixed by the commissioner) or under Section 2703.206 (Commissioner Authority to Hold Hearings as Necessary), notwithstanding Subsection (c) (relating to a public hearing), be conducted by the commissioner as a contested case hearing under Subchapters C (Contested Cases: General Rights and Procedures) through H (Court Enforcement) and Subchapter Z (Miscellaneous), 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 TDI;

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

(4) the office of public insurance counsel.

Makes nonsubstantive changes.

(g) Requires the commissioner, if a hearing held under Subsection (a) is not conducted as a contested case hearing, to 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) Provides that 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) Prohibits a party's presentation of relevant, admissible oral testimony in a hearing under this section from being limited.

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

(k) Authorizes a party described by Subsection (b) to 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) Authorizes a combination of at least three associations, persons, or entities listed in Subsection (b), subject to Subsection (m), if the commissioner fails to comply with the requirements under Subsection (g) or (h)(6), to 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) Requires the court, 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), to hold an evidentiary hearing to establish a record before adopting the premium rate.

(n) Prohibits the commissioner, after a petition has been filed under Subsection (l), from issuing findings or an order related to the subject matter of the petition until after the date the court enters a final judgment.

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

SECTION 5.014. Amends Section 2703.203, Insurance Code, as follows:

Sec. 2703.203. New heading: PERIODIC HEARING. Requires the commissioner to hold a public hearing not earlier than July 1 after the fifth anniversary of the closing of a

hearing held under this chapter, rather than a biennial public hearing not earlier than July 1 of each even-numbered year, to consider adoption of premium rates and other matters relating to regulating the business of title insurance that an association, title insurance company, title insurance agent, or member of the public admitted as a party under Section 2703.204 requests to be considered or that the commissioner determines necessary to consider.

SECTION 5.015. Amends Section 2703.204, Insurance Code, as follows:

Sec. 2703.204. New heading: ADMISSION AS PARTY TO PERIODIC HEARING. (a) Requires 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) (relating to a public hearing to consider changing a premium rate), or TDI staff, rather than requires an individual or association or other entity recommending adoption of a premium rate or another matter relating to regulating the business of title insurance, subject to this section, to be admitted as a party to the periodic hearing under Section 2703.203 (Biennial Hearing), rather than to the biennial hearing.

(b) Authorizes a party to any portion of the periodic hearing relating to ratemaking, rather than a party to the ratemaking phase of the biennial hearing, to request that the commissioner remove any other party to that portion of the hearing, rather than to the ratemaking phase of the hearing, on the grounds that the other party does not have a substantial interest in title insurance.

SECTION 5.016. Amends Section 2703.207, Insurance Code, as follows:

Sec. 2703.207. NOTICE OF CERTAIN HEARINGS. Requires that notice of the hearing and of each item to be considered at the hearing, not later than the 60th day before the date of a hearing under Section 2703.202, 2703.203, or 2703.206, 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, rather than to all title insurance companies and title insurance agents; and

(2) published in the Texas Register and on TDI's Internet website, rather than provided to the public in a manner that gives fair notice concerning the hearing.

SECTION 5.017. Repealer: Section 2551.303 (Form of Reinsurance Contract), Insurance Code.

SECTION 5.018. Repealer: Section 2703.205 (Phases of Biennial Hearing), Insurance Code.

SECTION 5.019. Makes application of Section 2703.0515, Insurance Code, as added by this article, to a title insurance policy that is delivered or issued for delivery, prospective to January 1, 2012.

SECTION 5.020. Makes application of Sections 2703.055 and 2703.056, Insurance Code, as added by this article, to a title insurance policy that is delivered or issued for delivery, prospective to January 1, 2012.

SECTION 5.021. Makes application of 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, prospective.

ARTICLE 6. ELECTRONIC TRANSACTIONS

SECTION 6.001. Amends Subtitle A, Title 2, Insurance Code, by adding Chapter 35, as follows:

CHAPTER 35. ELECTRONIC TRANSACTIONS

Sec. 35.001. DEFINITIONS. Defines, in this chapter, "conduct business" and "regulated entity."

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

(b) Provides that 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. Authorizes a regulated entity to 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) Requires the commissioner to adopt rules necessary to implement and enforce this chapter.

(b) Requires that the rules adopted by the commissioner under this section 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. Makes application of Chapter 35, Insurance Code, as added by this Act, prospective.

ARTICLE 7. DATA

SECTION 7.001. Amends Chapter 38, Insurance Code, by adding Subchapter I, as follows:

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

Sec. 38.401. APPLICABILITY OF SUBCHAPTER. Provides that 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) Requires the commissioner to 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) Requires an insurer described by Section 38.401 to file the information described by Subsection (a) on an annual basis. Requires that the information filed be broken down by quarter.

Sec. 38.403. PUBLIC INFORMATION. (a) Requires TDI to post the data contained in claims information filings under Section 38.402 on TDI's Internet website. Authorizes the commissioner by rule to 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) Provides that information provided under this section is required to be aggregate data by line of insurance for each insurer and is prohibited from revealing proprietary or trade secret information of any insurer.

Sec. 38.404. RULES. Authorizes the commissioner to adopt rules necessary to implement this subchapter.

SECTION 7.002. Amends Chapter 1953, Insurance Code, by adding Subchapter D, as follows:

SUBCHAPTER D. DATA MINING AND PATTERN RECOGNITION

Sec. 1953.151. APPLICABILITY OF SUBCHAPTER. Provides that this subchapter applies to an insurer writing automobile insurance in this state, including an insurance company, reciprocal or interinsurance exchange, county mutual insurance company, farm mutual insurance company, Lloyd's plan, or other insurer.

Sec. 1953.152. COLLECTION OF INFORMATION CONCERNING DATA MINING AND PATTERN RECOGNITION. (a) Authorizes the commissioner by rule to require an insurer to report to TDI concerning:

(1) technologies to be used by the insurer to identify relationships among variables that are used to predict differences in expected losses of covered persons or applicants for automobile insurance coverage or are otherwise used in the activities of regulated entities;

(2) the manner in which the insurer intends to use the relationships derived from the technologies described by Subdivision (1) in:

(A) underwriting and creating and defining risk classifications;

(B) setting rates and premiums, as applicable;

(C) detecting fraudulent claims;

(D) identifying subrogation opportunities;

(E) improving marketing; or

(F) performing other activities identified by the commissioner; and

(3) services provided by third party loss-evaluation services to identify loss statistics and information for the purpose of evaluating claims, loss-settlement reserves, and losses paid and the manner in which the insurer uses those services and the information obtained.

(b) Authorizes the commissioner, in exercising the commissioner's authority under this section, to require that insurers report with respect to selected segments of the market and to limit the reporting to specific uses of relationships derived from the technologies.

(c) Provides that underwriting guidelines, loss and claims evaluation data, and related information obtained by the commissioner under this section are subject to

Section 38.003 (Underwriting Guidelines for Other Lines; Confidentiality). Provides that other information obtained under this section is commercial information not subject to the disclosure requirements of Chapter 552, Government Code.

Sec. 1953.153. ADMINISTRATIVE PENALTIES. Requires TDI, if TDI determines that an insurer has violated this chapter or a rule adopted under this chapter, to assess administrative penalties against the insurer in the manner provided by Chapter 84. Requires that the amount of an administrative penalty imposed under this section be based on:

(1) the seriousness of the violation, including the nature, circumstances, extent, or gravity of the violation; and

(2) the economic harm caused by the violation.

Sec. 1953.154. REPORT TO LEGISLATURE. Requires TDI to include in its biennial report to the legislature under Section 32.022 (Biennial Report to Legislature) information concerning the use of relationships derived from the technologies described by Section 1953.152 by insurers. Requires that the information include the impact of the use of those relationships on insurance and other coverage to covered persons and applicants for coverage in this state. Requires that the report include, as applicable, recommendations for:

(1) proposed legislation appropriate to regulate the use of relationships derived from the technologies; and

(2) means to facilitate availability of insurance in underserved markets and to maintain fair and equitable loss-evaluation and claims settlement practices in this state.

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

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

(b) Requires the commissioner, in determining which areas to designate as underserved, to consider:

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

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

(d) Requires the commissioner to 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. Amends Subchapter F, Chapter 2251, Insurance Code, by adding Section 2251.253, as follows:

Sec. 2251.253. REPORT. (a) Requires the commissioner to 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 (Amounts Added to Reserve for Calendar Year 1997; Reductions).

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

(c) Provides that this section expires September 1, 2013.

ARTICLE 9. TEXAS WINDSTORM INSURANCE ASSOCIATION

SECTION 9.001. Amends Section 83.002, Insurance Code, by adding Subsection (c) to provide that this chapter also applies to a person appointed as a qualified inspector under Section 2210.254 or 2210.255, and a person acting as a qualified inspector under Section 2210.254 (Qualified Inspectors) or 2210.255 (Appointment of Licensed Engineer as Inspector) without being appointed as a qualified inspector under either of those sections.

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

(b) Provides that except for a closed meeting authorized by Subchapter D (Exceptions to Requirement that Meetings Be Open), Chapter 551, Government Code, a meeting of the board of directors or of the members of the Texas Windstorm Association (TWIA) is open to the public, rather than is open to the commissioner or the commissioner's designated representative, and the public.

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

(e) Requires TWIA to:

(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) Requires that a recording of a meeting be maintained in the archive required under Subsection (e) through and including the fifth anniversary of the meeting. Authorizes a recording of a meeting to be maintained for a period longer than the period required by this subsection.

SECTION 9.003. Amends Subchapter C, Chapter 2210, Insurance Code, by adding Section 2210.108, as follows:

Sec. 2210.108. OPEN MEETINGS AND OPEN RECORDS. Provides that except as specifically provided by this chapter or another law, TWIA is subject to Chapters 551 and 552, Government Code.

SECTION 9.004. Amends Section 2210.202(b), Insurance Code, as follows:

(b) Requires a property and casualty agent to submit an application for initial insurance coverage, rather than for the insurance coverage, on behalf of the applicant on forms prescribed by the association. Requires TWIA to 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. Requires that an application for initial or renewal coverage, rather than the application, 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) a statement that the agent acting on behalf of the applicant possesses proof of the declination described by Subsection (a) (relating to an insurable interest in insurable property) and proof of flood insurance coverage or unavailability of that coverage as described by Section 2210.203(a-1) (relating to application of this section to certain properties).

Makes nonsubstantive changes.

SECTION 9.005. Amends Sections 2210.203(a) and (c), Insurance Code, as follows:

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

(c) Provides that if TWIA determines that the property for which an application for renewal insurance coverage is made is insurable property, TWIA is required to direct the issuance of a renewal insurance policy as provided by the plan of operation and is authorized to collect the premium for the policy directly from the applicant for renewal insurance coverage.

SECTION 9.006. Amends Sections 2210.204(d) and (e), Insurance Code, as follows:

(d) Requires the property and casualty agent who received a commission as the result of the issuance of a TWIA policy providing the canceled coverage, rather than who submitted the application, to refund the agent's commission on any unearned premium in the same manner.

(e) Requires that the minimum retained premium in the plan of operation, for cancellation of insurance coverage under this section, be for a period of not less than 90 days, rather than 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 the purchase of similar coverage in the voluntary market, sale of the property to an unrelated party, death of the policyholder, or total loss of the property.

SECTION 9.007. Amends Section 2210.254, Insurance Code, by adding Subsection (e) to authorize TDI to establish an annual renewal period for persons appointed as qualified inspectors.

SECTION 9.008. Amends Subchapter F, Chapter 2210, Insurance Code, by adding Section 2210.2551, as follows:

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

(b) Requires the commissioner by rule to 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) Provides that Subsection (b) applies only to a determination concerning the appointment of a qualified inspector under this chapter. Provides that the exclusive jurisdiction of TDI under this section does not apply to the practice of engineering as defined by Section 1001.003 (Practice of Engineering),

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. Provides that in the event of conflict, the authority of that board prevails with regard to the practice of engineering.

SECTION 9.009. Amends the heading to Section 2210.256, Insurance Code, to read as follows:

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

SECTION 9.010. Amends Section 2210.256, Insurance Code, by adding Subsection (a-2), as follows:

(a-2) Authorizes the commissioner ex parte, in addition to any other action authorized under this section, to enter an emergency cease and desist order under Chapter 83 (Emergency Cease and Desist Orders) 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 TDI 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 TDI 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. Amends Section 2210.258(b), Insurance Code, to prohibit TWIA from insuring a structure described by Subsection (a) until the structure has been inspected for compliance with the plan of operation in accordance with Section 2210.251(a) (relating to a required inspection to be considered eligible for windstorm and hail insurance coverage), and, except as provided by Section 2210.260, a certificate of compliance has been issued for the structure in accordance with Section 2210.251(g) (relating to a certificate of compliance for a structure that qualifies for coverage).

SECTION 9.012. Amends Subchapter F, Chapter 2210, Insurance Code, by adding Section 2210.260, as follows:

Sec. 2210.260. ALTERNATIVE ELIGIBILITY FOR COVERAGE. (a) Authorizes a person who has an insurable interest in a residential structure, on and after January 1, 2012, to obtain insurance coverage through TWIA 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) Authorizes TDI to 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 TDI 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) Requires the commissioner to adopt reasonable and necessary rules to implement this section. Requires that the rules adopted under this section 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 TWIA's policyholders and the cost to upgrade those items.

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

(e) Requires that each residential structure for which a person obtains an alternative certification under this section comply with:

(1) the requirements of this chapter, including Section 2210.258 (Mandatory Compliance with Building Codes; Eligibility); and

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

(f) Requires TWIA to 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. Authorizes a rate, credit, or surcharge under this subsection to 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. Provides that this article applies only to a Texas windstorm and hail insurance policy delivered, issued for delivery, or renewed by TWIA on or after the 30th day after the effective date of this Act. Provides that a Texas windstorm and hail insurance policy delivered, issued for delivery, or renewed by TWIA 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. Requires TWIA, not later than January 1, 2012, to amend the TWIA'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) Provides that 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) Prohibits a member who represents the general public from being:

(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 TDI;

(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) Requires the advisory board to 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) Provides that a member of the advisory board serves without compensation. Entitles a member, if authorized by the commissioner, to reimbursement for reasonable expenses incurred in attending meetings of the advisory board.

(e) Provides that the advisory board is subject to Chapter 2110 (State Agency Advisory Committees), Government Code.

ARTICLE 11. TEXLINK TO HEALTH COVERAGE PROGRAM

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

Sec. 524.004. INFORMATION SHARING AGREEMENTS. Authorizes the division of TDI that administers the TexLink to Health Coverage Program (division) to enter into information sharing agreements with federal and state agencies to carry out the division's responsibilities under this chapter. Requires that an agreement entered into under this section include adequate protection with respect to the confidentiality of any information shared and comply with all applicable state and federal law.

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

Sec. 524.051. INFORMATION ABOUT SPECIFIC HEALTH BENEFIT PLAN ISSUERS. (a) Creates this subsection from existing text. Makes no further changes to this subsection.

(b) Authorizes the division to:

(1) establish a procedure by which issuers of health benefit plans, including plans offered by regional or local health care programs under Chapter 75 (Regional or Local Health Care Programs for Employees of Small Employers), 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) Provides that notwithstanding Section 75.104(d) (relating to a governing body operating a regional or local health care program), 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 TDI 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. Amends Section 524.053, Insurance Code, as added by Chapter 721 (S.B. 78), Acts of the 81st Legislature, Regular Session, 2009, by adding Subsection (d) to authorize the division to 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. Amends Chapter 524, Insurance Code, as added by Chapter 721 (S.B. 78), Acts of the 81st Legislature, Regular Session, 2009, by adding Section 524.0545, as follows:

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

(b) Authorizes the division, in coordination with the Health and Human Services Commission, to 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. Amends Chapter 541, Insurance Code, by adding Subchapter D-1, as follows:

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

Sec. 541.181. PRIVATE ACTION SUBJECT TO ALTERNATIVE DISPUTE RESOLUTION PROCEDURE. (a) Defines, in this subchapter, "alternative dispute resolution procedure" and "residential property insurance."

(b) Requires 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, before filing a private action for damages under this chapter, to:

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

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

(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) Prohibits an insurer from executing, collecting, or enforcing an award under Subsection (a)(2) before initiating the alternative dispute resolution procedure.

(c) Provides that 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) Prohibits an insurer from recovering 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. Requires an insurer, on receipt of written notice from the insured of a dispute arising under the policy, to 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. Amends Section 542.058(b), Insurance Code, to provide that 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. Makes application of Subchapter D-1, Chapter 541, Insurance Code, as added by this Act, and Section 542.058(b), Insurance Code, as amended by this Act, prospective to January 1, 2012.

ARTICLE 13. CLAIMS REPORTING BY INSURERS

SECTION 13.001. Amends Subtitle C, Title 5, Insurance Code, by adding Chapter 563, as follows:

CHAPTER 563. PRACTICES RELATING TO CLAIMS REPORTING

Sec. 563.001. DEFINITIONS. Defines, in this chapter, "claims database" and "insurer."

Sec. 563.002. REPORTING TO CLAIMS DATABASE. Prohibits an insurer or an insurer's agent from reporting 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. Amends Section 843.002, Insurance Code, by amending Subdivision (9-a) and adding Subdivision (9-b), to define "extrapolation" and to make a nonsubstantive change.

SECTION 14.002. Amends Section 843.338, Insurance Code, as follows:

Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Requires an HMO, except as provided by Sections 843.3385 (Additional Information) and 843.339, not later than the 45th day after the date on which an HMO receives a clean claim from a participating physician or provider in a nonelectronic format or the 30th day after the date the HMO receives a clean claim from a participating physician or provider that is electronically submitted, to make a determination of whether the claim is payable and:

(1) if the HMO 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 HMO;

(2) if the HMO 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 HMO determines that the claim is not payable, notify the physician or provider in writing why the claim will not be paid.

SECTION 14.003. Amends Section 843.339, Insurance Code, as follows:

Sec. 843.339. New heading: DEADLINE FOR ACTION ON PRESCRIPTION CLAIMS; PAYMENT. (a) Creates this subsection from existing text. Requires an HMO, or a pharmacy benefit manager that administers pharmacy claims for the HMO, that affirmatively adjudicates a pharmacy claim that is electronically submitted to 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. Deletes existing text requiring an HMO, not later than the 21st day after the date the HMO affirmatively adjudicates a pharmacy claim that is electronically submitted, to pay the total amount of the claim.

(b) Requires an HMO, or a pharmacy benefit manager that administers pharmacy claims for the HMO, that affirmatively adjudicates a pharmacy claim that is not electronically submitted to 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. Amends Subchapter J, Chapter 843, Insurance Code, by adding Section 843.3401, as follows:

Sec. 843.3401. AUDIT OF PHARMACIST OR PHARMACY. (a) Prohibits an HMO or a pharmacy benefit manager that administers pharmacy claims for the HMO from using extrapolation to complete the audit of a provider who is a pharmacist or pharmacy. Prohibits an HMO from requiring extrapolation audits as a condition of participation in the HMO's contract, network, or program for a provider who is a pharmacist or pharmacy.

(b) Requires an HMO or a pharmacy benefit manager that administers pharmacy claims for the HMO that performs an on-site audit under this chapter of a provider who is a pharmacist or pharmacy to provide the provider reasonable notice of the audit and accommodate the provider's schedule to the greatest extent possible. Requires that the notice required under this subsection be in writing and 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. Amends Section 843.344, Insurance Code, as follows:

Sec. 843.344. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. Provides that this subchapter applies to a person, including a pharmacy benefit manager, with whom an HMO 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. Amends Subchapter J, Chapter 843, Insurance Code, by adding Section 843.354, as follows:

Sec. 843.354. LEGISLATIVE DECLARATION. Provides that 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 HMOs and pharmacy benefit managers unless otherwise prohibited by federal law.

SECTION 14.007. Amends Section 1301.001, Insurance Code, by amending Subdivision (1) and adding Subdivision (1-a), to define "extrapolation" and to redefine "health care provider."

SECTION 14.008. Amends Section 1301.103, Insurance Code, as follows:

Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. Requires an insurer, except as provided by Sections 1301.104 and 1301.1054 (Requests for Additional Information), not later than the 45th day after the date the insurer receives a clean claim from a preferred provider in a nonelectronic format or the 30th day after the date the insurer receives a clean claim from a preferred provider that is electronically submitted, to 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. Amends Section 1301.104, Insurance Code, as follows:

Sec. 1301.104. New heading: DEADLINE FOR ACTION ON PHARMACY CLAIMS; PAYMENT. (a) Requires 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 to 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. Deletes existing text requiring an insurer, not later than the 21st day after the insurer affirmatively adjudicates a pharmacy claim that is electronically submitted, to pay the total amount of the claim.

(b) Requires 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 to 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. Amends Subchapter C, Chapter 1301, Insurance Code, by adding Section 1301.1041, as follows:

Sec. 1301.1041. AUDIT OF PHARMACIST OR PHARMACY. (a) Prohibits an insurer or a pharmacy benefit manager that administers pharmacy claims for the insurer from using extrapolation to complete the audit of a preferred provider that is a pharmacist or pharmacy. Prohibits an insurer from requiring 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) Requires 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 to provide the provider reasonable notice of the audit and accommodate the provider's schedule to the greatest extent possible. Requires that the notice required under this subsection be in writing and 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. Amends Section 1301.109, Insurance Code, to provide that this subchapter applies to a person, including a pharmacy benefit manager, with whom an insurer contracts to process or pay claims, obtain the services of physicians and health care providers to provide health care services to insureds, or issue verifications or preauthorizations.

SECTION 14.012. Amends Subchapter C-1, Chapter 1301, Insurance Code, by adding Section 1301.139, as follows:

Sec. 1301.139. LEGISLATIVE DECLARATION. Provides that 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) Provides that 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. Provides that 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) Provides that 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. Provides that 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) Provides that 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. Amends Chapter 1102, Insurance Code, is amended to read as follows:

CHAPTER 1102. New heading: PAYMENT OF INSURANCE BENEFITS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1102.001. DEFINITIONS. Defines, in this chapter, "life insurance policy" and "retained asset account."

Sec. 1102.002. RULES. Authorizes the commissioner to 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. BENEFITS PAYABLE IN CURRENCY. Redesignates existing Section 1102.002 as Section 1102.051. Makes no further changes to this section.

Sec. 1102.052. STATEMENT REGARDING VALUE OF FOREIGN CURRENCY. Redesignates existing Section 1102.003 as Section 1102.052. Makes a conforming and nonsubstantive change.

Sec. 1102.053. PREVIOUSLY APPROVED INSURANCE POLICY FORM PAYABLE IN FOREIGN CURRENCY. Redesignates existing Section 1102.004 as Section 1102.053. Deletes existing Section 1102.005 authorizing the commissioner to adopt reasonable rules to accomplish the purposes of this chapter, including rules requiring appropriate reserves for insurance policies subject to this chapter, or 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) Prohibits an insurer from transferring 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) Requires a beneficiary to 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) Prohibits an insurer, when the insurer offers multiple modes of settlement to a beneficiary, from using a retained asset account as the default mode of settlement unless the insurer conspicuously discloses that fact.

Sec. 1102.102. DISCLOSURE REQUIREMENTS. (a) Requires that the claim form for payment of proceeds under a life insurance policy 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) Prohibits an insurer from transferring 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. Makes application of Chapter 1102, Insurance Code, as amended by this article, to a claim made under a life insurance policy, prospective to September 1, 2011.

ARTICLE 16. PROHIBITION OF COERCION OF PRACTITIONERS BY MANAGED CARE PLANS

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

(a) Prohibits a managed care plan from:

(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;

(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) Provides that for the purposes of Subsection (a)(5), "medical panel" and "vision panel" have the meanings assigned by Section 1451.154(a) (relating to definitions of certain terms).

SECTION 16.002. Makes application of the change in law made by Section 16.001 of this Act to a contract entered into or renewed by a therapeutic optometrist or ophthalmologist and an issuer of a managed care plan, prospective to January 1, 2012.

ARTICLE 17. PROVIDER NETWORK CONTRACT ARRANGEMENTS

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

CHAPTER 1458. PROVIDER NETWORK CONTRACT ARRANGEMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1458.001. GENERAL DEFINITIONS. Defines, in this chapter, "affiliate" "contracting entity," "covered individual," "direct notification," "health care services," "person," "provider," "provider network contract," and "third party."

Sec. 1458.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) Defines, in this chapter, "health benefit plan."

(b) Provides that "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) Provides that "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 (Medicare Supplement Benefit Plan).

(d) Provides that "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. Provides that 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 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, or the comparable plan under Chapter 63 (Health Benefits Plan for Certain Children), 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 (Definitions).

[Reserves Sections 1458.004-1458.050 for expansion.]

SUBCHAPTER B. REGISTRATION REQUIREMENTS

Sec. 1458.051. REGISTRATION REQUIRED. (a) Requires a person, unless the person holds a certificate of authority issued by TDI to engage in the business of insurance in this state or operate an HMO under Chapter 843 (Health Maintenance Organizations), to register with TDI not later than the 30th day after the date on which the person begins acting as a contracting entity in this state.

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

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

(d) Provides that 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) Requires a person required to register under Section 1458.051 to 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 TDI; and

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

(b) Requires that the disclosure made under Subsection (a) 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. Requires that information required under this subchapter be submitted in a written or electronic format adopted by the commissioner by rule.

Sec. 1458.054. FEES. Authorizes TDI to collect a reasonable fee set by the commissioner as necessary to administer the registration process. Requires that fees collected under this chapter be deposited in the Texas Department of Insurance operating fund.

Sec. 1458.055. EXEMPTION FOR AFFILIATES. (a) Requires the commissioner to grant an exemption for affiliates of a contracting entity if the contracting entity holds a certificate of authority issued by TDI to engage in the business of insurance in this state or is an HMO if the commissioner determines that the affiliate is not subject to a disclaimer of affiliation under Chapter 823 (Insurance Holding Company Systems), and 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) Provides that an exemption granted under this section applies only to registration. Provides that an entity granted an exemption is otherwise subject to this chapter.

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

[Reserves Sections 1458.056-1458.100 for expansion.]

SUBCHAPTER C. RIGHTS AND RESPONSIBILITIES OF A CONTRACTING ENTITY

Sec. 1458.101. CONTRACT REQUIREMENTS. Prohibits a contracting entity from providing a person access to health care services or contractual discounts under a provider network contract unless the provider network contract specifically states that 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 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) Requires a contracting entity that has granted access to health care services and contractual discounts under a provider network contract to:

(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) Requires the contracting entity, if a contracting entity knows that a third party is making claims under a terminated contract, to take reasonable steps to cause the third party to cease making claims under the provider network contract. Requires the contracting entity, if the steps taken by the contracting entity are unsuccessful and the third party continues to make claims under the terminated provider network contract, to terminate the contracting entity's contract with the third party, or notify the commissioner, if termination of the contract is not feasible.

(c) Requires that any notice provided by a contracting entity to a third party under Subsection (b) 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) Sets forth the form and requirements of the e-mail notice required under Subsection (a)(1).

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

(f) Provides that the notice described by Subsection (a)(1) is not required to include information regarding payors who are insurers or HMOs.

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

(1) a third party is prohibited from accessing 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 are prohibited from being 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 are authorized to be processed and paid under the provider network contract after the date of termination.

Sec. 1458.104. AVAILABILITY OF CODING GUIDELINES. (a) Requires that a contract between a contracting entity and a provider 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) Authorizes a provider who receives information under Subsection (a) to only use or disclose the information for the purpose of practice management, billing activities, and other business operations, and disclose the information to a governmental agency involved in the regulation of health care or insurance.

(c) Requires the contracting entity to, 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) Prohibits the provisions of this section from being waived, voided, or nullified by contract.

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

[Reserves Sections 1458.105-1458.150 for expansion.]

SUBCHAPTER D. RIGHTS AND RESPONSIBILITIES OF THIRD PARTY

Sec. 1458.151. THIRD-PARTY RIGHTS AND RESPONSIBILITIES. Requires 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 to comply with the responsibilities of a contracting entity under Subchapters C and E.

Sec. 1458.152. DISCLOSURE BY THIRD PARTY. (a) Requires a third party to 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) Requires a third party that uses an Internet website under this section to update the website on a quarterly basis. Requires a contracting entity, on request, to disclose the information by telephone or through direct notification.

[Reserves Sections 1458.153-1458.200 for expansion.]

SUBCHAPTER E. UNAUTHORIZED ACCESS TO PROVIDER NETWORK CONTRACTS

Sec. 1458.201. UNAUTHORIZED ACCESS TO OR USE OF DISCOUNT. (a) Provides that 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. Provides that 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 (Private Action for Damages), Chapter 541, or a class action under Subchapter F (Class Actions by Attorney General or Private Individual), Chapter 541.

(b) Requires a contracting entity or third party to comply with the disclosure requirements under Sections 1458.102 and 1458.152 concerning the services listed on a remittance advice or explanation of payment. Authorizes a provider to

refuse a discount taken without a contract under this chapter or in violation of those sections.

(c) Authorizes an error in the remittance advice or explanation of payment, notwithstanding Subsection (b), to 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. Prohibits a contracting entity from providing 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.

[Reserves Sections 1458.203-1458.250 for expansion.]

SUBCHAPTER F. ENFORCEMENT

Sec. 1458.251. UNFAIR CLAIM SETTLEMENT PRACTICE. (a) Provides that a contracting entity that violates this chapter commits an unfair claim settlement practice under Subchapter A (Unfair Claim Settlement Practices), Chapter 542 (Processing and Settlement of Claims), and is subject to sanctions under that subchapter as if the contracting entity were an insurer.

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

Sec. 1458.252. REMEDIES NOT EXCLUSIVE. Provides that 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. Makes application of the change in law made by this article prospective to January 1, 2012.

ARTICLE 18. FAIR PLAN ASSOCIATION

SECTION 18.001. Amends Subchapter A, Chapter 2211, Insurance Code, by adding Section 2211.004, as follows:

Sec. 2211.004. APPLICABILITY OF CERTAIN OTHER LAW; LIMITATION ON DAMAGES. (a) Prohibits the Fair Access to Insurance Requirements Plan Association (association) from being held liable for any amount on a claim filed under an insurance policy issued by the association other than 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 court costs and reasonable attorney's fees.

(b) Prohibits an insured from recovering consequential, punitive, or exemplary damages in a cause of action against the association, including damages under Section 541.152(b) (relating to the amount of damages the trier of fact may award) of this code or Section 17.50 (Relief for Consumers), Business & Commerce Code, or interest in the amount described by Section 542.060 (Liability for Violation of Subchapter) of this code.

SECTION 18.002. Makes application Section 2211.004, Insurance Code, as added by this article, prospective.

ARTICLE 19. STANDARD FORMS

SECTION 19.001. Amends Section 2301.008, Insurance Code, as follows:

> Sec. 2301.008. ADOPTION AND USE OF STANDARD FORMS. Requires the commissioner to adopt standard insurance policy forms, printed endorsement forms, and related forms other than insurance policy forms and printed endorsement forms, that an insurer is required to use in addition to the insurer's own forms in writing insurance subject to this subchapter, rather than authorizes the commissioner to adopt standard insurance policy forms, printed endorsement forms, and related forms other than insurance policy forms and printed endorsement forms, that an insurer is authorized to use instead of the insurer's own forms in writing insurance subject to this subchapter

SECTION 19.002. Amends Section 2301.052(b), Insurance Code, to authorize an insurer, subject to Section 2301.0525, to continue to use an insurance policy form or endorsement promulgated, approved, or adopted under Article 5.06 (Policy Forms and Endorsements) or 5.35 (Policy Forms) before June 11, 2003, on written notification to the commissioner that the insurer will continue to use the form or endorsement.

SECTION 19.003. Amends Subchapter B, Chapter 2301, Insurance Code, by adding Section 2301.0525, as follows:

> Sec. 2301.0525. USE OF MINIMUM STANDARD INSURANCE POLICY FORMS REQUIRED. (a) Requires each insurer that writes residential property insurance in this state to use the standard insurance policy forms adopted by the commissioner under Section 2301.008 (Adoption and Use of Standard Forms) for residential property insurance and, subject to Subsection (b), may also use alternative policy forms approved by the commissioner under Section 2301.006 (Filing and Approval of Forms).
>
> (b) Prohibits an insurer from delivering or issuing 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) Requires an insurer that offers coverage under the standard policy forms to 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. Requires that the form of the disclosure be specified by the commissioner, subject to Section 2301.053(c) (relating to required plain language for a form).
>
> (d) Requires an insurer that offers coverage under approved forms other than the standard policy forms to 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. Requires the form of the disclosure be specified by the commissioner, subject to Section 2301.053(c). Requires that the disclosure, at a minimum, refer the applicant or insured to the Internet website described by Section 32.102 (Internet Website) and state that the applicant may compare the rates of insurers at that site.

SECTION 19.004. Makes application of the change in law made by this article prospective to January 1, 2012.

ARTICLE 20. SURETY BONDS AND RELATED INSTRUMENTS

SECTION 20.001. Amends Section 3503.005(a), Insurance Code, as follows:

(a) Authorizes a bond that is made, given, tendered, or filed under Chapter 53 (Mechanic's, Contractor's, or Materialman's Lien), Property Code, or Chapter 2253 (Public Work Performance and Payment Bonds), Government Code, to be executed only by a surety company that is authorized to write surety bonds in this state. Requires that if the amount of the bond exceeds $100,000, the surety company also take certain actions, including having obtained reinsurance for any liability in excess of $1 million, rather than in excess of $100,000, from a reinsurer that is an authorized reinsurer in this state, or, rather than and, 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. Repealer: Section 3503.004(b), Insurance Code.

ARTICLE 21. APPRAISALS UNDER PROPERTY INSURANCE POLICIES

SECTION 21.001. Amends Subchapter B, Chapter 542, Insurance Code, by adding Section 542.063, as follows:

Sec. 542.063. APPRAISALS. (a) Prohibits a request for appraisal with respect to a claim under a property insurance policy from staying court proceedings during the appraisal process.

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

SECTION 21.002. Amends the heading to Subchapter B, Chapter 542, Insurance Code, to read as follows:

SUBCHAPTER B. PROMPT PAYMENT OF CLAIMS; APPRAISALS

SECTION 21.003. Makes application of Section 542.063, Insurance Code, as added by this article, prospective.

ARTICLE 22. EMPLOYER CONTRIBUTIONS TO INDIVIDUAL HEALTH INSURANCE POLICIES

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

CHAPTER 1221. EMPLOYER CONTRIBUTIONS TO INDIVIDUAL HEALTH INSURANCE POLICIES

Sec. 1221.001. RULES; EMPLOYER CONTRIBUTIONS. Authorizes the commissioner by rule, unless it would violate state or federal law, to 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. Amends Subchapter B, Chapter 1952, Insurance Code, by adding Section 1952.059, as follows:

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

(b) Requires 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 (Texas Automobile Insurance Plan Association), 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 to 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) Requires that an exclusion under this section be in writing and:

(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. Amends Section 6002.158(e), Insurance Code, to require that the curriculum for a residential fire alarm technician course consist of at least seven hours, rather than 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. Requires that the examination consist of at least 25 questions, and requires an applicant to accurately answer at least 80 percent of the questions to pass the examination.

SECTION 24.002. Makes application of the changes in law made by this Act to Section 6002.158, Insurance Code, prospective.

ARTICLE 25. EXTRA HAZARDOUS COVERAGES

SECTION 25.001. Amends Subchapter A, Chapter 2502, Insurance Code by adding Section 2502.006, as follows:

Sec. 2502.006. CERTAIN EXTRA HAZARDOUS COVERAGES PROHIBITED. (a) Prohibits a title insurance company from insuring 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 (Transfers Fraudulent as to Present and Future Creditors), 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 (Transfers Fraudulent as to Present Creditors), Business & Commerce Code, or a similar law of another state.

(b) Authorizes the commissioner by rule to designate coverages that violate this section. Provides that 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) Requires that title insurance issued in or on a form prescribed by the commissioner be considered to comply with this section.

(d) Provides that 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) Prohibits a title insurance company from engaging 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. Makes application of Section 2502.006, Insurance Code, as added by this Act, prospective to January 1, 2012.

ARTICLE 26. RESCISSION OF HEALTH BENEFIT PLAN

SECTION 26.001. Amends Chapter 1202, Insurance Code, by adding Subchapter C, as follows:

SUBCHAPTER C. RESCISSION OF HEALTH BENEFIT PLAN

Sec. 1202.101. DEFINITION. Defines, in this subchapter, "rescission."

Sec. 1202.102. APPLICABILITY. (a) Provides that this subchapter applies only to a health benefit plan, including a small or large employer health benefit plan written under Chapter 1501 (Health Insurance Portability and Availability Act), 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 (Group Hospital Service Corporations);

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

(4) a stipulated premium company operating under Chapter 884 (Stipulated Premium Insurance Companies);

(5) a reciprocal exchange operating under Chapter 942 (Reciprocal and Interinsurance Exchanges);

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

(7) an HMO operating under Chapter 843 (Health Maintenance Organizations);

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

(9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844 (Certification of Certain Nonprofit Health Corporations).

(b) Provides that 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 (Medical Assistance Program), 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) Prohibits a health benefit plan issuer, notwithstanding any other law, except as provided by Subsection (b), from rescinding coverage under a health benefit plan with respect to an enrollee in the plan.

(b) Authorizes a health benefit plan issuer to 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) Prohibits a health benefit plan issuer from rescinding 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) Requires that the notice required under Subsection (a) include, as applicable, certain information set forth under this subsection.

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

(b) Requires a health benefit plan issuer to 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) Requires a health benefit plan issuer to pay all otherwise valid medical claims under an individual's plan until the later of the date on which an independent review organization determines that the decision to rescind is appropriate, or the time to appeal to an independent review organization has expired without an affected individual initiating an appeal.

(d) Requires the commissioner to 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. Requires the health benefit plan issuer, 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, to prove that the issuer did not violate this subchapter.

SECTION 26.002. Makes application of the change in law made by this article prospective to January 1, 2012.

ARTICLE 27. TRANSITION; EFFECTIVE DATE

SECTION 27.001. Makes application of this Act prospective to January 1, 2012.

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