TEXAS INSURANCE REFORM 2003

A Potpourri From Mold To Credit Scoring

by Jay A. Thompson[1]

"No man's life, liberty or property are safe while the Legislature is in session."

1 Tucker 248 (N.Y. Surr. 1866)

I. INTRODUCTION

The 78th Legislature was the first Legislature controlled entirely by Republicans since Reconstruction. Speaker Tom Craddick presided over the House that was composed of 88 Republicans and 62 Democrats. House members filed 3,636 bills and 100 Joint Resolutions (Constitutional amendments). 824 House bills and 15 Joint Resolutions were passed.

Lt. Governor David Dewhurst presided over the Senate comprised of 19 Republicans and 12 Democrats. Senators filed 1,956 bills. 559 Senate bills and 6 Senate Joint Resolutions passed. Governor Rick Perry vetoed 48 bills compared to 82 two years ago.

Insurance Reform and Tort Reform were among the leading issues considered. The Governor designated homeowner's insurance and medical professional liability insurance as emergency issues. The recent problems in these lines have been well documented and publicized.

Virtually every politician elected or otherwise espoused solutions. The insurance reform legislation that finally passed was brewed in a boiling cauldron of political and emotional rhetoric. A few examples follow:

- Gov. Rick Perry today called for major changes in Texas law to give the state total rate oversight of the homeowners insurance industryincluding the ability to impose across-the-board rate freezes and to restrict the use of "credit scoring" to set rates.
- "As a Republican, I generally support deregulation as a means to lower cost and improve services for consumers," Perry said. "But like former President Teddy Roosevelt, I disdain unfair market practices where one, or a handful of companies, use their power to manipulate the market."

—Gov. Rick Perry, Press Release, May 15, 2002.

- "The Governor has marked two proposals as emergency legislation, and both of them have my strong support. The first is homeowners insurance. There are hundreds of thousands, if not millions, of homeowners who either lost their insurance, as I did, or still are suffering from sticker shock from premiums they are paying to maintain it. We are going to make homeowners insurance available, affordable, and we are going to make it happen."

—Speaker Tom Craddick, Acceptance Speech, January 24, 2003.

- "Today I'm filing HB 600 – comprehensive insurance reform legislation – designed to protect Texas families, not insurance companies," said Wolens. "The Insurance Reform and Consumer protection Act will roll back

insurance rates, implement a prior approval process, make insurance information public, prohibit credit scoring, and assure that companies don't just stick with us in good times."

—Representative Steve Wolens, Press Release, January 29, 2003.

- "If we come out with mainline regulations that are not severely out of line with other states, the larger insurance players will ease back (to Texas) and will start writing policies. The capacity problem (availability of insurance) will resolve itself. Even before we see rate reductions that will be the biggest benefit."

—Representative John Smithee, Floor Debate, SB 14 May 2003.

- "We did what we set out to do," Perry said. "We kept the trust by keeping our promises."
- Perry said the homeowners' insurance reform legislation passed this session offers future relief for every Texan who has experienced skyrocketing homeowne'rs' insurance costs. That help will come through tougher regulation of insurance companies in Texas. Perry had declared homeowner's insurance reform an emergency issue before the session began.

— Gov. Rick Perry, Press Release, June 3, 2003.

The objectives of insurance reform included:

- Greater consumer choice through use of more "national forms".
- Improved claims response.
- Tort reform measures to prohibit collusion between lawyers, remediators and public adjusters in inflating claims.
- More rate regulation of all insurers to end unfair and deceptive rating practices.
- End abusive credit scoring.
- Lower rates.
- Make homeowners' insurance available and affordable.

Over 250 bills were filed dealing with insurance and tort reform during the regular session. Forty-one bills were passed including some sweeping reforms in rate regulation. A discussion of these new laws, how they were crafted, and how they may be implemented will be the focus of this presentation.

A. Insurance Reform Over the Years.

Texas is no stranger to insurance reform. In fact, in the last fifty years, insurance reform has taken place several times. Since the 1970's, the rally cries for tort reform are always coupled with the cry for insurance reform. The following summary illustrates how often Texas has reformed insurance:

1947-1957	86 Texas Insurance companies become insolvent.
1951	Major overhaul and re-codification of the Texas Insurance Code. Rates continue to be promulgated.[2]
1955	County Mutual's power to write auto expended. Formation of new charters prohibited.[3]
1957	After years of scandal, corruption, fraud and insolvencies, the Legislature reforms insurance.[4] The three commissioners—Life, Casualty, and Fire were stripped of individual areas and required to jointly supervise and appoint the Commissioner who was granted broad executive powers.
1971	Gov. Smith vetoes a bill in special session to reform rate laws that would have provided a more competitive rating law.
1973	Unfair Trade practices legislation.[5]
1977	Medical malpractice tort reform and insurance reform passes.[6]
1980s	Cash flow underwriting accelerates as interest rates reach 18%. TDI pioneers rating reforms by requiring consideration of investment income in ratemaking.[7]
1983	Insurance Sunset Bill includes insurance reform.[8] The use of Lloyds has started.
1987	Insurance Reform and Tort Reform debated by the Texas Legislature.[9] The workers' compensation crisis brews.
1988	National County Mutual's demise sparks the beginning of the end for the 3-member board.
1989-1990	Major reform of workers' compensation.[10]
1991	Gov. Richards is elected. HB 2 passes sweeping reforms of insurance.[11] The promulgated rate system changes to a more flexible benchmark system. Commercial property and liability insurance moves to "file and use."
1992	Major reforms change TDI supervision over insolvencies; elimination of the WC Pool; creation of the WC Fund (now the Texas Mutual Insurance Company); and more rate flexibility for workers' compensation.[12]
1993	TDI Sunset legislation reforms insurance. The 3-member board is eliminated and Benchmark rate hearings move to SOAH.[13]
1995	Supreme Court decisions make it easier to make water damage claims on homeowner's HOB policy form.[14] Texas Legislature passes tort reforms, rate rollbacks, standby FAIR PLAN and unfair discrimination laws.[15]
1997	Texas legislature passes insurance reform to allow insurers to file national policy forms for residential property.[16]
2001	The benchmark rate hearing process moves from SOAH to rulemaking. The homeowners' crisis begins.[17]
2003	SB 14 and HB 4 are the centerpieces of major reform legislation.

B. Rating Laws – A gradual shift to more reliance on competition to regulate rates.

Between 1951 and 1991, the Texas Department of Insurance, then known as the State Board of Insurance (SBI), promulgated a maximum rate for homeowners' insurance and commercial property insurance.[18] Regulated insurers were allowed to file downward deviations up to 25%.[19]

Automobile insurance rates for both personal and commercial lines were promulgated by the SBI.[20] Individual insurers could file prior approval of deviations either above or below the promulgated rate.[21] Insurers using deviations for rates above the promulgated rate, however, were required to stamp on the face of their policy that the rate exceeded the rate set by the SBI.[22]

Other lines of insurance such as workers' compensation were heavily rate regulated.[23] Rates were either promulgated or subject to strict prior approval. In all of the promulgated lines of insurance, the SBI rates but also promulgated the policy forms and rating classifications to be utilized.

The Benchmark System was the result of insurance reform in 1991. Instead of promulgated rates with deviations, the SBI set a "benchmark" rate for auto and residential property.[24] Rate regulated insurers were allowed to "file and use" rates within the flexibility bands. Strict prior approval was required for any rate outside the flexibility bands, 25% and minus 30%, but the SBI had authority to change to lesser amounts.

The Texas "file and use" benchmark system for auto and homeowners became antiquated because it was too slow to respond to changes and was based largely on outdated territory and rating classifications developed during the 1970's. Many consumers, insurers and agents have come to realize the benefit of increased competition in the rating process. In order to meet consumer demands, many insurers have been able to respond quickly to current demands and also achieve increased market share, not only through price competition, but also especially in refinement of rating classes. Many, if not most, of the non-rate regulated insurers use rating classes that fit their needs and the needs of their customers.

While Texas was considered to be a heavily regulated state, Texas law allowed some insurers to be completely free of rate regulation in some lines of insurance. This includes:

Type of Insurer	Lines Exempt from Rate Regulation
Lloyds[25]	Residential and Commercial Property
Reciprocals[26]	Residential and Commercial Property
County Mutuals[27]	Automobile; Dwelling
Farm Mutuals[28]	Dwelling
Medical Self-Ins. Trusts[29]	Medical Prof. Liability

The 2003 Legislature dramatically changed the laws, especially for homeowners and other residential property insurers, requiring rate regulation for virtually all insurances. The summaries presented in this paper outline the highlights. You should carefully review the language in the laws actually passed. I am sure you may find that there will still be a need for lawyers whether you represent consumers, insurers or other interests.

II. RESIDENTIAL PROPERTY INSURANCE REFORM

A. Rate Regulation

1. **SB 310**. Insurance reform started in March 2003 with the enactment of SB 310.[30] This bill required all insurers to file rates and supporting data. Thirty days later, the TDI published a report finding that homeowners' rates of some insurers were excessive by as much as 25%. This early bill and its resulting analysis was an important factor in the final reforms enacted in SB 14.

2. **Rate Standards**. SB 14 adds rate standards in several provisions of the Insurance Code, including new Articles 5.142, 5.101, 5.13-2 and 1.02. The rate standards are definitions of excessive, inadequate and unfair discrimination. The following definitions are used:

- Excessive: A rate is excessive if it is likely to produce a long-term profit that is unreasonably high in relation to the coverage provided.
- Inadequate: A rate is inadequate if it is insufficient to sustain projected losses and expenses and endangers solvency or lessens competition or creates a monopoly.
- Unfairly discriminatory. A rate that is not based on sound actuarial principles; does not bear a reasonable relationship to expected loss and expense experience; or is based on whole or in part on race, color, creed, ethnicity or national origin.[31]

3. **Initial Rate Filings**. (New Article 5.26-1). SB14 enacts new Art. 5.26-1, Insurance Code, that requires all residential property insurers to make an initial rate filing. This statute requires:

- All insurers (no exemptions or exceptions) must file rates 20 days after effective date of SB14.
- TDI must approve or modify initial rates not later than 60 days for insurers writing $10 million or more.
- TDI must approve or modify not later than 90 days for an insurers writing $10 million or less.
- TDI staff must either approve or modify rates.
- Insurers have 10 days to appeal staff action to the Commissioner.
- Appeals are directly before the Commissioner.
- Commissioners may approve rate as filed; approve rate as modified; or impose greater modifications.
- Insurers may appeal by filing in district court within 10 days after receipt of an Order.
- Refunds are required after judicial appeal of any rate found to be excessive.[32]

Does this mean refunds are not required if an insurer does not appeal and changes its rates? What is the difference between an excessive and a modified rate? How about an unfairly discriminatory rate?

4. **Prior Approval Under Art. 5.142**: This new statute is effective until December 1, 2004.
   - This statute also applies to residential property insurance. It governs rate filings until December 1, 2004.
   - A filing is subject to a 30-day demurrer that can be extended an additional 30 days.
   - The Commissioner is given broad authority to withdraw approval.[33]

5. **Simplified Filings**
   - The Commissioner is given authority to simplify filing requirements under Art. 5.142 by Rule for small insurers or new insurers.
   - Small insurer is defined as a Lloyds or reciprocal with less than 2% of the market.
   - New insurer would be a company not authorized to write on June 11, 2004. File and use is allowed for new insurers if the Commissioner determines by rule that a new insurer's filed rates do not constitute a significant overall increase.[34]

6. **Exemptions**
   - New Art. 5.13-2C creates a separate exemption that applies to all types of companies writing residential property that have less than 2% market share and more than 50% of its premiums covering properties which are:

     (1) valued less than $100,000, and
     (2) located in underserved areas.

     - Art. 5.142 and 5.13-2 do not apply to exempt insurers.[35]

7. **Rating Territories** must be actuarially sound.[36] Rates within a county subdivision may not be greater than 15% except where Commissioner by rule determines otherwise.[37] Rulemaking is limited to personal auto and residential property. Serious questions are unanswered as to whether this applies to all lines of insurance.

8. **Refunds of Excessive or Discriminatory Premium**. The Commissioner is given broad power to order refunds if rates are determined to be excessive or unfairly discriminatory.[38] New Art. 5.144 applies prospectively to rates filed after the effective date of SB 14. An insurer can be required to issue a refund of the excessive or unfairly discriminatory portion of the premium if the amount of that portion is at least 7.5% of the total premium charged for the coverage. If the amount is less than 7.5%, the Commissioner may order a future premium discount.[39] A refund order does not apply to rates for residential property insurance for which an insurer has obtained prior approval under Sec. 5A, Art. 5.13-2, Insurance Code (which becomes effective December 1, 2004).

Important issues about a Refund Order include:
- Orders for refunds can be issued prior to hearing.
- Insurers can appeal an order 20 days after an order is issued. Appeals are to SOAH.
- OPIC has the right to participate in any appeal.

9. **File and Use Under Art. 5.13-2 after December 1, 2004**.

- Rate filings are "file and use" under Art. 5.13-2, as amended.[40]
- The Commissioner may withdraw approval only <u>after</u> notice and hearing.[41] However, the refund statute, Art. 5.144, will apply.
- Disallowed Expenses defined. SB 14 adds a definition of disallowed expenses to Art. 5.13-2 that is similar to current law except for new language in two areas.
  - Current law disallows amounts paid for bad faith, fraud, etc.

SB 14 adds "any other matters other than payment under the insurance contract" to this definition.

  - Also added as disallowed expenses are amounts determined to be excess premiums.[42]
- Prior Approval for Certain Insurers. Art. 5.13-2 § 5A is added, which allows the Commissioner to require prior approval for the following:
  - An insurer's financial condition requires rate supervision.
  - An insurer's rating practices requires supervision. Rating practices is not defined.
  - A statewide emergency exists.[43]
- OPIC is given authority to review and object to all rate filings.[44]

10. **Notice of Rate Increases**. SB 14 requires notice of any rate increase scheduled to take effect on renewal that will result in an increase of premium of 10%. A thirty-day notice is required. The Commissioner, by Rule, may exempt insurers that write short-term policies.[45]

11. **Statutory Discounts**

Two discounts were added and one was repealed.

- Insulating Concrete. SB 581 passed, which requires a discount for homes built with insulating concrete. The Commissioner shall determine the amount of the discount by rule.[46]
- Fire Supplement Discount is repealed. Art. 5.33C
- Claims Free Discounts. SB 113 adds new Art. 5.43, Insurance Code, to require a three percent discount for residential property policyholders who have been continually insured by an insurance group and have not filed claims.

B. Policy Form Regulation

1. SB 14 MOVES POLICY FORM REGULATION TO NEW ARTICLE 5.145. This new statute moves form regulation to prior approval under Art. 5.13-2, Insurance Code.[47] Definitions are set forth in Art. 5.145. Forms are deemed approved after 60 days.[48] The Commissioner can extend this time an additional 10 days.
2. Standards for Disapproval are set forth in Art. 5.13-2 §8(e). Current law allows disapproval if a form:
   - Violates law or a rule;
   - Contains provisions that are unjust, encourage misrepresentations, are deceptive or violate public policy.
3. Important Changes. The most important change is that insurers can file their own forms for approval.
   - Promulgated forms may be used but are not required.
   - Use of national forms is not required.

4. Notice of Changes in Policy Forms (SB 115). This bill adds new Article 5.45 to the Insurance Code which requires an insurer who renews a policy of homeowners, fire and residential, or farm and ranch owners insurance to provide the policyholder with written notice of any difference between the renewal form and the expiring form.[49]

C. Underwriting

1. **FILING OF UNDERWRITING GUIDELINES FOR PERSONAL AUTO AND RESIDENTIAL PROPERTY**
   - SB 14 amends Section 38.002, Insurance Code, for personal auto/residential property. All insurers must file underwriting guidelines.
   - A broad definition of underwriting guideline is added.[50]
   - Guidelines must be sound, actuarially justified or otherwise commensurate with contemplated risk.
   - Guidelines are only confidential if it is a trade secret.[51]

2. **ALL OTHER LINES**
   - SB 14 adds new Section 38.003, Insurance Code, for all other lines, including life insurance, which requires the filing of underwriting guidelines. Under this statute, underwriting guidelines are confidential by law.[52]

3. **MEMBERSHIP DUES**. SB 14 adds new Article 21.49-2V. This new statute provides that, except as otherwise provided by law, an insurer may require membership dues in a sponsoring organization be paid as a condition for issuance or renewal of a policy.[53]

4. **WATER/MOLD CLAIMS.** SB 127 adds new Article 5.35-4, which restricts use of claims history for water damage. It creates restrictions on the use of claims history for water damage and limits premium surcharges for water damage claims that are not repaired to an amount determined by the Commissioner, not to exceed 15% of the total premium.[54]

HB 329 adds a new Art. 21.21-11, which prohibits an insurer from making an underwriting decision regarding a residential property insurance policy based on previous mold damage if the property has had mold remediation performed as evidenced by a certificate of mold remediation or by an independent inspection. This provision takes effect September 1, 2003. Insurers also may not use a prior appliance related water claim, which was promptly remediated and inspected after remediation, except where a person has made three or more appliance related claims in a three-year period. The Commissioner will have to promulgate rules including underwriting guidelines that must be used.[55] "Water damage" and "appliance-related claims" are not defined.

5. **CANCELLATION.** SB 14 amended Art. 21.49-2B, Insurance Code to shorten the insurer's "free look" on a new homeowner's insurance policy to 60 days and further restrict the right of cancellation by requiring an insurer to justify the cancellation.[56] An insurer must either:

(1) identify a condition that creates an increased risk of hazard that was not disclosed in the application for insurance and is not the subject of a prior claim; or

(2) before the effective date of the policy, the insurer does not accept a copy of a required inspection report made by "an inspector licensed by the Texas Real Estate Commission" which is dated not earlier than the 90th day before the effective date of the policy.

The inspection report is deemed accepted unless rejected before the 11th day after the insurer receives the inspection report.[57]

6. **MAXIMUM LIMITS.** HB 1338 prohibits lenders from requiring borrowers to carry homeowners insurance with

A person may not act as a public adjuster unless licensed by the Commissioner.

limits in excess of the replacement value of the dwelling and its contents, regardless of the amount of the mortgage.[58] Lenders are prohibited from including fair market value of the land in the replacement value of the dwelling and its contents.[59]

D. Claims

1. **WATER/MOLD.** SB 127 adds new Article 21.55A, Insurance Code to provide minimum standards for notice of claims and the acceptance or rejection of claims. The Commissioner is given authority to adopt rules, to identify types of claims requiring more prompt, efficient, and effective notice, acceptance or rejection, and processing and handling procedures.[60]

2. **PUBLIC ADJUSTERS.** SB 127 adds new Art. 21.07-5, Insurance Code, which regulates the practice of public insurance adjusting and requires public adjusters to be licensed. *A "public adjuster" or "public insurance adjuster" is defined as a person, resident or nonresident, who acts on behalf of an insured, or another public adjuster, in negotiating the settlement of a claim for loss or damage under any policy of insurance covering real or personal property.*

There are eight exceptions to the term including public employees, attorneys in the practice of law, insurance company adjusters, insurance agents, holders of mortgage on personal property, salaried office employees doing any clerical or administrative duties for public adjusters, photographers, estimators or engineers employed by a public adjuster, licensed private investigators, full-time salaried employees who are property owners or a property management company.[61]

A person may not act as a public adjuster unless licensed by the Commissioner. Any contract for services regulated by this article made by a person who is not licensed as a public adjuster is voidable at the option of the insured, and the insured is not liable for payment of any past or future services.[62]

The license authorizes the adjusting of claims on behalf of insureds for all fire and allied coverages and all other property claims, including loss of income, but only when the client is an insured under a policy.

A licensee may not receive compensation for services of more than 10% of the amount of insurance settlement on the claim. A licensee is prohibited from receiving a commission where the insurer, within 72 hours after the date on which the loss is reported, either pays or commits in writing to pay the policy limit in accordance with Art. 6.13 or Sec. 862.053.[63]

3.**MOLD ASSESSORS, REMEDIATORS.** HB 329 added Chapter 1958, Occupations Code, to license and regulate mold assessors and remediators.[64] The statute is effective September 1, 2003. However, licensing requirements are not effective until the Texas Board of Health has adopted appropriate rules. Rules must be adopted before April 1, 2004. The new chapter would apply only to regulation of mold-related activities that affect indoor air quality and specifically does not apply to routine cleaning when not conducted for the purpose of mold remediation.[65] There is a license for mold assessment and a separate license for mold remediation. The board is required to establish mold safety standards and a code of ethics.[66] At least 10 days before the start of mold remediation, the license holder must notify the Department about the project, and report not later than the 10th day after completion that the project is completed.[67] The chapter is regulated by the Texas Department of Health through the Board and the Commissioner of Public Health.

The new law authorizes civil penalties not to exceed $2,000 for the first violation and $10,000 for a second.[68] Property owners are given an exemption for liability for damages related to mold remediation if a Certificate of Remediation has been issued and damages accrued before the issuance of a certificate.[69]

E. Residual Markets

1. Texas Windstorm Insurance Association (TWIA). SB 14 made several changes to the TWIA statute, Art. 21.49, including:

- Allows repairs to structure other than roof that exceeds 100 sq. ft. to be built back to original condition.
- Allows Commissioner to use the International Residential Code to supplement the TWIA building code.
- For code structures built after January 1, 2004, the Commissioner must adopt the 2003 IRC building code.
- Deletes UC Standard 997 for roofing materials.
- Provides that licensed engineers that commit fraud on an inspection can have revocation of appointment but no monetary fines.
- Requires the appointment of licensed engineers to perform inspections.
- Removes the sunset date on the 10% rate cap change; *i.e.*, rates cannot increase more than 10%.[70]

2. **Fair Plan.** (SB 14) (SB 1606). SB 1606 amended Art. 21.49A, Insurance Code which governs the FAIR Plan to eliminate the requirement that the FAIR Plan activation follow the use of a mandatory market assistance program and allows the Commissioner to establish the FAIR Plan if, after a public hearing, it is determined that in all or any part of the state residential property insurance is not reasonably available in the voluntary market. That public hearing has already occurred.[71]

Authorizes revenue bonds. One of the provisions of SB 14 was to enact new Art. 21.49A-1, Insurance Code which gives the FAIR Plan association stand by authority to issue as much as $75 million in bonds to fund the association to establish and maintain loss reserves, pay operating expenses or purchase reinsurance. The bonds and the expenses associated with the bonds are payable from a service fee assessed against each insurer and the FAIR Plan association. The service fee is to be set by the

Commissioner in an amount sufficient to pay all debt service and to be paid as required by the Commissioner by rule. Insurers can surcharge their policyholders for assessments.[72]

FAIR Plan must retain its profits. Finally, SB 14 contains a provision that requires the FAIR Plan to retain its profits from its operations rather than distribute them to participating insurers.[73]

III. PERSONAL AUTOMOBILE INSURANCE REFORM

A. Rate Regulation. Even though auto was not part of the crisis, important changes for rate regulation of this line were enacted.

1. **Prior to December 1, 2004**
   - Rate Regulation continues under the Benchmark Rate law, Art. 5.101, as amended until December 2004.
   - Benchmark Rate law is amended to include:
     - A definition of rating standards such as excessive, inadequate, unfairly discriminatory, as defined in other new laws.
     - TDI is allowed to order refunds under Art. 5.144.
   - Art. 5.101 applies only to personal auto.
   - County mutuals are still exempt from the benchmark rate law.
   - The definition of disallowed expenses in Art. 5.101 is not changed.
2. **After December 1, 2004**
   - Moves rate regulation to file and use in Art. 5.13-2, as amended.
   - A definition of disallowed expenses added to Art. 5.13-2.
   - The Commissioner may order refunds (New Art. 5.144).
   - The Commissioner may order certain insurers to file rates for approval. Art. 5.13-2 § 5A.

3. **County Mutual Exemption from Rate Regulation**

a. **Prior to December 1, 2004**. The role of county mutuals has expanded since they were first authorized to write auto liability coverage in 1957. County mutuals are the only type of insurer exempt from rate regulation for automobile insurance. The exemption from rate regulation under Art. 5.101 will continue for all county mutuals until December 1, 2004. Four important new laws that impact rating will apply to county mutuals. These include the following:

(1) County mutuals will be subject to the territory rating restrictions in Art. 5.171 on January 1, 2004.[74]
(2) County Mutuals will be subject to rate collars on the use of credit scoring. Art. 21.49-2U, TEX. INS. CODE. Rate collars will be determined by TDI rule and apply to policies issued on or after January 1, 2004.[75]
(3) County mutuals will be subject to rate standards in Art. 1.02.[76]
(4) County mutuals will be subject to rate regulation for residential property and commercial auto insurance.[77]

All county mutuals will be exempt from TAIPA assignments until December 2004. County mutuals will be subject to TWIA assessments. County mutuals are not subject to FAIR PLAN assessments.

b. **After December 1, 2004**

(1) All county mutuals will be subject to regulation for personal auto under Art. 5.13-2 unless exempted.[78]
(2) On December 1, 2004, there is a partial exemption that may apply to some county mutuals and other insurers that are "nonstandard insurers."[79]
(3) Nonstandard insurers are subject to filing requirements as determined by TDI rule. Nonstandard rates are rates that are 30% or more above an index rate. A county mutual may not qualify for exemption if it and its affiliates have a market share of more than 3.5%.
(4) Commissioner shall compute, update and publish a rate index. The Commissioner must use the benchmark rate in effect on June 11, 2004 in computing this index. Annual adjustments are required.
(5) "Standard" county mutuals are subject to filing TAIPA assignments on December 1, 2004.
(6) The Commissioner, by rule, may also designate other types of insurers as exempt, nonstandard carriers.[80]

c. **Territory Rating Restrictions**. New Article 5.171 is effective immediately for regulated insurers. It is effective January 1, 2004 for county mutuals, Lloyds and reciprocals.

B. Policy Form Regulation

1. SB 14 moves the regulation of personal auto forms to Art. 5.145, which refers to prior approval under Art. 5.13-
2. This change accomplishes two important changes:
   - Eliminates requirements to use Promulgated Forms. Promulgated Forms are not the minimum standard.
   - Eliminates National Policy Forms as alternative.[81]

C. Other Issues

Insurance Verification. HB 3588 amended Chap. 601, Transp. Code to direct TxDOT and TDI to conduct a study on the "feasibility, affordability, and practicability of using a database interface software system for verification of whether owners of motor vehicles have established financial responsibility." If the system meets these standards and others as contained in the statute, the two agencies are authorized to establish such a program. It will be funded by an additional $1 fee paid at the time of

application for registration or renewal of registration of a motor vehicle.

Salvage Titles.[82] HB 3588 makes significant changes to the manner in which insurers must deal with salvage and non-repairable vehicles. These changes appear in Chap. 501, Transp. Code. When an insurer acquires ownership or possession of a salvage or non-repairable motor vehicle, it must surrender the certificate of title or exchange it for a salvage or non-repairable title under conditions stated in the statute. Insurers may not sell a damaged vehicle without a salvage or non-repairable vehicle title and may sell the vehicle only to a salvage vehicle dealer, an out of state buyer, a buyer in a casual sale at auction, or a metal recycler.

IV. CREDIT SCORING

Recent years have seen increased use of credit histories for underwriting decisions. The indisputable correlation between credit history and prospective lost costs has been recognized in two recent studies, but it is not easily explained or understood by the general public.[83] Two significant pieces of legislation address the subject of credit histories.

Credit Freezes. Changes were made to Chap. 20, Bus. & Com. Code regulating credit reporting agencies. A significant change is that a consumer can make a request to require a security alert or require a consumer reporting agency to place a "security freeze" on that consumer's consumer file. When the freeze is implemented, the consumer reporting agency must notify a person who requests a consumer report that a security freeze is in effect for the consumer file involved and credit information cannot be supplied while the freeze is in effect.

Insurance Credit Scoring. The use of credit scoring comes under regulation by new Art. 21.49-2U, Ins. Code.[84] The statute applies to an insurer that writes personal insurance coverage and uses credit information or credit reports for the underwriting or rating of that coverage.

Insurers choosing to use credit scoring may do so to develop rates, rating classifications or underwriting criteria except for factors that constitute unfair discrimination. A definition of unfair discrimination was not included in the final version of this new law.

An insurer that uses credit scoring must disclose that fact to each applicant. If the insurer takes action resulting in an adverse effect, notice must be supplied to the applicant or insured. An insurer that uses credit scores to underwrite and rate risks must file the credit scoring models with the department. A vendor may file credit scoring models on behalf of an insurer. A credit-scoring model is public information, is not subject to any exceptions to disclosure under the Open Records Act and cannot be withheld from disclosure under any other law.[85]

Prohibited Factors. Insurers may not use as a negative factor any of the following factors in credit scoring:

- A credit inquiry not initiated by the consumer.
- An inquiry related to insurance coverage if so identified on a consumer's credit report
- A medical industry collective, if so identified.
- Multiple lender inquiries within 30 days of a prior inquiry if coded from the home mortgage industry or auto lending industry. Such inquiries shall be coded as one inquiry.[86]

Extraordinary Events. Insurers shall, on written request, provide exception to rates, classes or underwriting rules for credit reports influenced by:

- Catastrophic illness or injury;
- Death of a spouse, child or parent;
- Temporary loss of employment;
- Divorce; or
- Identity theft.[87]

Dispute Resolution and Error Correction. Inaccurate credit reports or disputes must use the process required by federal law.

Insurers must re-evaluate or re-rate within 30 days of receipt of a notice from the credit-reporting agency.

Insurers must credit any overpayment from an erroneous credit report back to the shorter of:

1). The last 12 months of coverage; or
2). The actual policy period.[88]

Enforcement. A violation of this article or rules adopted thereunder is a violation of Art. 21.21, Insurance Code. The TDI may also order sanctions under Ch. 82. [89]

An insurer that is using an insurance credit score system on June 11, 2003 must file the credit-scoring model not later than the 90th day thereafter.

The department is required to promulgate a rule that sets an allowable difference in rates charged due solely to the difference in credit scores. Additionally, the TDI will have to promulgate a standard disclosure form advising applicants that credit information will be obtained and used as part of the insurance process.[90]

Health insurance is always an issue that draws a lot of legislation and attention from legislators, provider groups, consumers, business and insurers.

V. LIFE & ANNUITY INSURANCE

Very little legislation ultimately passed relating directly to life insurance and annuities.

A. Small Face Amount Insurance. There were several bills introduced dealing with small face amount life insurance. In particular, SB 1618 was a broad bill by Senator Ellis that required disclosures every 5 years. It was much broader than the NAIC model law on disclosures. Even though this legislation did not pass during the regular session, it is certain to be revisited in two years.

B. Corporate-Owned Life Insurance (COLI). Several bills were introduced that would have eliminated or regulated corporate-owned life insurance. SB 137 ultimately was a bill that would have regulated corporate-owned life insurance in a manner that would have been acceptable to agents, insurers, and consumer groups. This legislation died but both issues are expected to be hot topics in the next session of the legislature.

C. Nonforfeiture Law for Annuities.[91] The legislature amended the standard nonforfeiture law for annuities. The new Texas nonforfeiture law adopts new section 1107.055, Insurance Code, to provide for a sliding scale minimum nonforfeiture interest rate. Companies are given the option to issue annuity contracts under either the old law or the new law until August 1, 2005. After August 1, 2005, only the new law will apply. The new sections adopt a sliding scale rate of interest as a minimum nonforfeiture rate. Interest is determined the lesser of 3% per annum and the 5-year constant maturity treasury rate specified in the contract no longer than 15 months prior to the contract issue, reduced by 125 basis points where the resulting interest rate is not less than 1%. The interest rate shall apply for an initial period and may be re-determined for additional periods. The Commissioner is given rule-making authority to provide for further adjustments for annuity contracts that provide subsidy participation in an equity index benefit. The minimum nonforfeiture amount may be decreased for withdrawals or partial surrenders; an annual contract charge of $50; premium tax paid, if any, by the insurer; and, any indebtedness to the company on the contract, including accrued interest on the indebtedness. Net consideration for purposes of calculating minimum of nonforfeiture amounts shall be equal to 87.5% of gross considerations credited to a contract during the contract year.

D. Electronic Delivery of Life Insurance Policies. HB 1799 authorizes the electronic delivery of a certificate of insurance for a group life insurance policy by agreement between the insured and the policyholder. The bill amends Section 1131.108(a) of the Insurance Code and is effective September 1, 2003.

VI. HEALTH INSURANCE

Health insurance is always an issue that draws a lot of legislation and attention from legislators, provider groups, consumers, business and insurers. Generally, the Legislature avoided its usual temptation to add new mandates to Texas law. Instead, the Legislature passed laws that will provide an opportunity for companies to offer mandate-free type of policies and benefits. Provider groups were successful in passing legislation dealing with prompt pay and clean claims. This was an emotionally charged issue that will continue in the rulemaking process. A summary of some of the important health insurance bills that passed follows:

A. Prompt Pay/Clean Claims. SB 418. Issues relating to the prompt payment of physicians' claims under preferred provider contracts or HMO contracts has confounded lawmakers since 1997. Texas providers contend that insurers are slow to pay or refuse to pay for services rendered to insured patients. Insurers contend that providers do not provide complete and accurate billing information. Passage of a state law in 1999 did not resolve the problems. In 2001, the Legislature enacted HB 1862 to further revise prompt payment requirements and establish uniform requirements for submission of a clean claim. The bill was vetoed and a virtual firestorm developed during the elections of 2002. SB 418 passed this session and was promptly signed by the Governor. SB 418 amends the prompt pay law in some ways similar to HB 1862, and in many ways broader than HB 1862 that was vetoed. Among the important changes in SB 418 include the following:

1. **Verification.**[92] One of the most bitterly fought issues was the definition added by SB 418 for verification. Verification is defined as a reliable representation by an insurer that the insurer will pay the preferred provider for medical services rendered. A preferred provider is able to request verification of a particular healthcare service that the preferred provider proposes to provide to a patient. The insurer is required to inform the preferred provider, *without delay*, whether the service to be provided will be paid and must also specify any deductibles, co-payments, or co-insurance. Insurers are required to maintain toll-free numbers between 6:00 a.m. and 6:00 p.m., Monday through Friday and between 9:00 a.m. and noon Central Standard Time on Saturday and Sunday and legal holidays. Insurers must have persons capable of providing verifications. An insurer may decline to determine eligibility for payment if the insurer notifies the physician or preferred provider of the specific reason the verification or determination was not made. Verifications are valid for a period of not less than 30 days. An insurer that has provided

verification may not deny or reduce payment to the physician unless the preferred provider has materially misrepresented the proposed services or has substantially failed to perform the proposed healthcare services. The provisions of verification may not be waived, voided, or nullified by contract.

2. **Clean Claim Elements**.[93] SB 418 adopts uniform elements for clean claims. A non-electronic clean claim is a "clean claim" if it is submitted using the CMS Form 1500 or a successor form. An electronic claim is a clean claim if the claim is submitted using the data elements in Professional 837 (ASC X12N 837) format. Institutional providers such as hospitals may submit non-electronic claims on the CMS Form UB92. Electronic claims are clean claims if submitted using and containing the data elements in Institutional 837.

3. **Processing and Payment of Clean Claims**.[94] Claims may be submitted by mail, electronically, faxed, or hand delivered. The statute sets various presumptions for when a claim is presumed to have been received, depending on how it was transmitted to the carrier. Claims received from a preferred provider in an electronic format require determination by insurers within 30 days after the date the insurer receives the clean claim. Non-electronic claims must be paid or determined within 45 days after receipt. Insurers are required to pay the claim or determine the portion of the claim that is payable or not payable.

Pharmacy claims must be adjudicated not later than the 21st day after it is electronically submitted.

4. **Audits.**[95] The law relating to audits was changed. Under the prior law, insurers were required to pay 85% of the contracted rate of a claim it intended to audit. Under the new law, insurers are required to pay 100% of a clean claim that the insured intends to audit if the claim is submitted electronically. If it received non-electronically, it must be paid not later than the 45th day after the insurer receives the clean claim. Insurers must state that the clean claim is being paid at the contracted rate subject to completion of an audit. If preferred providers do not comply with supplying the information reasonably requested, insurers may notify a provider that if the information is not provided that the provider may have to forfeit the amounts previously paid. Insurers must complete the audit 180 days after the date the clean claim is received.

5. **Additional information**.[96] There are instances where the insurer from either a treating preferred provider or another provider needs additional information. The new law provides standards by which the insurer may request this additional information. Generally, requests must be made not later than the 30th day after the date the insurer receives a clean claim. Any request for additional information must describe with specificity the information requested and relate only to the information the insurer can demonstrate is specific to the claim or related episode of care. Providers are not required to provide information contained in patients' medical or billing records. Insurers must determine whether the claim is payable on or before the later of 15 days after the date the insurer receives the requested additional information. If information is needed from a person other than a preferred provider, an insurer may not withhold payment pending receipt of the attachment or information requested.

6. **Coding and Bundling Methodologies**[97]. SB 418 requires insurers claim payment processes to use nationally recognized and generally accepted procedural terminology codes, notes and guidelines and be consistent with nationally recognized, generally accepted bundling edits and logic. Additionally, the bill specifies contract requirements that a PPO or HMO must include in contracts relating to coding guidelines. Essentially, a PPO or HMO must provide certain information to the preferred provider regarding bundling and unbundling software. The legislation does set forth provisions to protect the confidentiality, use and disclosure of coding guidelines, and fee schedule information as provided by the carrier.

7. **Overpayment**.[98] Insurers are permitted to recover overpayments from physicians or providers not later than the 180th day after the date the provider receives a payment. Insurers must provide written notice of overpayment to the provider with specific reasons for the request for recovery of funds. Insurers are required to provide physicians with an opportunity to appeal a request or recovery for overpayment. Providers must make arrangements for repayment of requested funds on or before the 45th day after the provider receives a notice.

8. **Coordination of Benefits**.[99] SB 14 authorizes an individual or group policy to contain a coordination of payment provision in accordance with TDI rules. An insurer may require a PPO or HMO physician to retain information concerning other sources of payments and to provide this information to the PPO or HMO. The bill prohibits a PPO or HMO from requiring a physician or provider to investigate coordination of payment. Issues relating to coordination of payment do not extend the period for determining whether a claim is payable or for auditing a claim. SB 418 specifies procedures for submitting a claim that requires coordination between a primary and secondary payor and for the collection of an overpayment by a secondary payor.

9. **Pre-authorization**.[100] SB 14 requires a PPO or HMO to provide a list of services that require pre-authorization. An HMO must provide a list of services that do not require pre-authorization. A PPO or HMO must determine whether services are medically necessary and appropriate if payment for such services is conditioned on pre-authorization. Insurers must maintain a toll-free number within the same hours as verification to provide pre-authorization services. The provisions of the law may not be waived, voided or nullified by contract.

10. **Penalty Provisions**.[101] SB 14 sets forth penalties for a violation of the claim payment requirements. SB 418 deletes existing provisions relating to penalties and deletes provisions that allow insurers to provide for contract penalties. A claim that is not paid timely is subject to a penalty in the amount of the lesser of: (1) 50% of the difference between billed charges as submitted on the claim and contracted rate, or (2) $100,000. A significant issue exists as to what is meant or intended by the term "billed charges" as opposed to "contracted charges."

The Commissioner is authorized to determine by rule the manner in which an employer may terminate participation in a cooperative.

If the claim is paid after the 46th day and before the 91st after the date the insurer is required to determine or adjudicate the claim, the penalty is the lesser of: (1) 100% of billed charges, or (2) $200,000.
A clean claim paid after the 91st day is subject to the lesser of: (1) 100% of billed charges, or (2) $200,000 plus 18% annual interest. Interest begins on the date the insurer was required to pay the claim. Similar penalties are provided for underpayment of claims.

Exceptions to the penalties exist for a catastrophic event that substantially interferes with normal business operations. Insurers must indicate the explanation of penalties when those are paid.

Administrative penalties are allowed for insurers that process more than 2% of clean claims in violation of the payment provisions in Art. 3.70-3C. Penalties may not exceed $1,000 for each claim.

11. **Application to Out-of-Network Providers**.[102] The provisions of the clean claims apply to an out-of-network provider that provides either emergency care or is in specialty services not reasonably available from a preferred provider who is included in the network.

12. **I.D. Cards**.[103] I.D. Cards must display the first date on which the individual became insured and a toll-free number for the physician or provider to obtain that date.

B. HEALTH INSURANCE COOPERATIVES.[104] SB 10 amends current law relating to private purchasing cooperatives and health group cooperatives to add a new provision for certain health care cooperatives. This bill by Senator Averitt allows a cooperative to consist of only small employers or both small and large employers. The sponsoring entity of a cooperative is required to inform its members about the cooperative and health benefit plans. The Commissioner is authorized to determine by rule the manner in which an employer may terminate participation in a cooperative. Participation by an employer is voluntary, however employers are required to commit to purchasing coverage for two years. Certain exceptions exist to this requirement. The health care provider issuing coverage to a cooperative is required to use a standard form to be prescribed by rule.

Insurers that provide coverage for persons previously uninsured would be exempt from premium and retaliatory taxes.

The most important feature of SB 10 is that the health benefit plan issued by a carrier to a cooperative would be exempt from certain mandated benefits that relate to a particular illness or disease or treatment, regulate differences in rates applicable to services within a health network or outside the network. Cooperatives can offer more than one plan, but each plan offered must be available to all employees covered by the cooperative. Coverage for diabetes equipment is not exempt from the mandates.

Cooperatives are not allowed to limit, restrict or condition employers or employees' membership in the cooperative based on risk characteristics. A health group cooperative must have at least 10 participating employers.

C. Cooperatives Under HB 897.[105] This bill allows a small employer health coalition to form cooperatives. Under HB 897, the cooperative may not limit, restrict or condition employers or employees' membership in a cooperative based on health status related factors. The most important feature of this law, however, is that a small employer coalition is considered a single small employer for all purposes of the chapter. This allows a coalition to benefit from the guaranteed issue benefits in the small employer group law.

D. Mandate Free Plans.[106] **SB 541** by Senator Williams enacts new Article 3.80, Insurance Code entitled *Texas Consumer Choice of Benefits Health Plan*. Under this new Act, state mandated health benefits are defined as coverage required under this Code or any other laws of the state to be included in individual or blanket group policy for either specific health care or a specific category of licensed practitioner. This would not include benefits that are mandated by federal law.

SB 541, however, does contain 12 exceptions to what is a mandate. These include issues such as continuation of coverage, termination of coverage, pre-existing conditions, coverage of children; coverage for diabetes supplies, coverage of certain mental illness, coverage for childhood immunizations, coverage for reconstructive surgery, certain cranial facial abnormalities of children, coverage of certain dietary treatments under Art. 3.79, coverage for referral to non-network providers when medically necessary, and coverages for cancers and certain cancer screenings required by current law.

SB 541 requires notice to the policyholders of the option to choose coverage for a mandate if the plan does not provide for certain state mandated benefits. Disclosures provided to an insured must be signed by the applicant and maintained by the insurer. Rates must be filed for informational purposes, but nothing is construed to give the Commissioner the power to determine, fix, prescribe or promulgate rates.

Finally, SB 541 amends the Small Employer Group Act on the compensation of agents. Small employer carriers are prohibited from using an agent compensation that provides compensation in a specific dollar amount for each individual covered during a specified period or group of individuals covered.

E. Joint Negotiations.[107] **SB 752** extends the expiration date of provisions relating to joint negotiations by physicians with health benefit plans. Few physicians have entered into joint negotiations under current law provisions. Some members of

the medical community believe that joint negotiations would be more fully utilized if given more time to develop. Effective September 1, 2003, the expiration date in Article 29.14 of the Insurance Code is amended to September 1, 2007, rather than September 1, 2003. The purpose of this law is to create some state action for joint negotiations. This gives providers the opportunity to jointly negotiate reimbursement rates with insurers without fear of anti-trust concerns that such activities may be price fixing.

F. Independent Review Organizations.[108] HB 3109 provides for the confidentiality of the identity of health care providers or physicians making review determinations for independent review organizations. The bill adds Subsection (h) to Section 2, Article 21.58C of the Insurance Code, making information that reveals the identity of a physician or individual health care provider who makes a review determination for an independent review organization confidential. The bill is effective September 1, 2003.

VII. PRIVACY, CONFIDENTIALITY AND OPEN RECORDS ISSUES FOR LIFE & HEALTH INSURERS.

Privacy was not the hot-button issue this Session as it was in 2001. A few of the changes made are summarized below:

A. Confidentiality of Underwriting Guidelines.[109] SB 14 now requires all insurers, including life and health insurers, to file underwriting guidelines with the Texas Department of Insurance (TDI) and OPIC on request. Guidelines filed with the TDI or OPIC are confidential as a matter of law. This is to be distinguished from guidelines for residential property and private passenger automobile insurance.

B. Assisting Consumers to Prevent and Detect Identity Theft and Confidentiality of Social Security Numbers.[110] SB 473 allows a victim of identity theft to place a freeze, for a fee, on his or her credit report and provides for confidentiality of social security numbers. The act seeks to prevent identity theft, and is patterned after California law. The amendments are extensive and include the following:

The addition of Subdivisions (7) and (8) to Section 20.01 of the Business & Commerce Code, defining "security alert" and "security freeze." A security alert means a notice placed on a consumer file that alerts a recipient of a consumer report that the consumer's identity may have been used without the consumer's consent. A security freeze means a notice placed on a consumer file that prohibits a consumer-reporting agency from releasing a consumer report without the express authorization of the consumer.

The addition of Subsection (d) to Section 20.03 of the Business & Commerce Code requires written disclosure to consumers of the process for requesting or removing a security alert or freeze.

Sections 20.031 through 20.039 to Chapter 20 of the Business & Commerce Code are added requiring the following:

§20.031: This section requires that a security alert be placed on the consumer's consumer file not later than 24 hours after receiving a security alert request. An alert must remain in effect not less than 45 days after the date the agency places the security alert on the file. There is no limit on the number of security alerts a consumer may request.
§20.033: Requires credit agencies to maintain a toll-free security alert request number.
§20.034: Deals with procedures for requesting a security freeze.
§20.035: If a freeze is in place, the consumer reporting agency is required to give notice to the consumer of changes in the consumer file to the consumer's name, date of birth, social security number, or address not later than 30 calendar days after the date the change is made.
§20.036: Requires notice to persons who request a consumer report of a security freeze.
§20.037: Sets forth procedures for removing or temporarily lifting a security freeze.
§20.038: Exemption. A security freeze does not apply to a consumer report provided to government entities, child support agencies, tax collection agencies, and fraud prevention service companies, among others.
§20.0385: The requirement to place a security alert or security freeze on a consumer file does not apply to a check service or fraud prevention service company that issues consumer reports, nor does it apply to a deposit account information service company that issues consumer reports related to account closures, caused by fraud and abuse, to an inquiring financial institution.
§20.039: A security freeze placed on a consumer file by another consumer reporting agency must be respected.

Amendments to Section 20.04 of the Business & Commerce Code allow an agency to impose charges for certain disclosures or for placing security freezes on a file.

The addition of Sections 20.11, 20.12, and 20.13 to Chapter 20 of the Business & Commerce Code allows relief for consumers, including injunctive relief, civil penalties, deceptive trade practice actions, and venue. A violation of Chapter 20 is a deceptive act or practice under the Deceptive Trade Practices Act.

C. Confidentiality of Social Security Numbers.[111] Section 35.58, Tex. Bus. & Com. Code, requires confidentiality of social security numbers, addresses the applicability of the section to non-governmental uses, and elaborates on both prohibited and permitted uses. Prohibited uses include:

(1) publicly displaying in any manner an individual's social security number;

(2) requiring an individual to transmit a social security number over the Internet, unless the connection is secure or the social security number is encrypted;
(3) requiring an individual to use a social security number to access an Internet website, unless a password, unique personal identification number, or other authentication device is also required to access the website;
(4) printing an individual's social security number on any card required for the individual to have access to products or services provided by the person; or
(5) printing an individual's social security number on any materials that are mailed to the individual, unless state or federal law requires the social security number to be printed on the document to be mailed.

Several important exceptions to this subsection were part of SB 473. It does not apply to: (1) an application form sent by mail that is part of an application or enrollment price; (2) the establishment, amendment or termination of an account, contract or policy; or, (3) the confirmation of the accuracy of a social security number.[112]

Exceptions:[113]

Permitted uses include:

(a) the collection, use, or release of a social security number for internal verification or administrative purposes;
(b) the continued use of an individual's social security number since before January 1, 2005, in the same manner, if the use of the social security number is continuous, and if the person provides the individual with an annual disclosure, beginning January 1, 2005, informing the individual of the right to stop the use of the social security number; and
(c) the collection, use, or release of a social security number as required by federal or state law, or the use of the social security number by an institution of higher education as regulated under the Education Code.

Subsection (i) to Section 1701.253 of the Occupations Code requires establishment of a statewide comprehensive education and training program on identity theft.

Section 35.59 to Subchapter D, Chapter 35 of the Business & Commerce Code is added regarding verification of consumer identity.

This act takes effect September 1, 2003. Section 35.58 of the Business & Commerce Code, as added by this act, takes effect January 1, 2005.

VIII. CONCLUSIONS

Insurance Reform and Tort Reform enacted in Texas in 2003 will change many things. When Governor Perry signed SB 14, he furnished a fact sheet of what to expect. Governor Perry stated:

Consumers Can Expect to See:

- An Insurance Commissioner with the authority to ensure that insurance companies can only charge fair rates for their products.
- A Commissioner with more tools to fight excessive rates and unfair pricing practices.
- More choices and more options offered from insurance companies in the future.
- A healthy, competitive marketplace where all lines of insurance are priced fairly.

The Insurance Industry in Texas Can Expect to See:

- Equal and fair treatment by TDI.
- A level-playing field with uniform rate standards that apply to everyone.
- Greater form flexibility so that they may offer more choices to consumers.
- Greater filing flexibility and more incentives to allow smaller companies to compete with larger companies.
- TDI working to create a healthy, stable, competitive marketplace.

While many of the changes may appear to give an illusion of reform, the reality of reform will be determined in the future. Many people will be instrumental in this process. Time will tell if this is the beginning of a Golden Age or the beginning of an era similar to New Jersey. It is safe to conclude that the enhanced powers and discretion given to the Commissioner of Insurance will place the Commissioner and his staff in a pivotal position in determining whether all consumers benefit and stability is restored. As important a role as the regulator will play, the role of each company, agent and individual cannot be overlooked.

This reform legislation gives insurers the chance to develop new ideas, especially new policy forms or rating classifications, that could give consumers more choices in the marketplace.

I am hopeful that the creativity and resilience shown by the people interested in this industry—whether as a consumer, an employee of an insurer or regulatory agency, agent, lawyer, legislator, or individual—will find ways to work together to make the future of this business in Texas better than in the past.

(Footnotes)

1. Attorney at Law, Thompson, Coe, Cousins & Irons, L.L.P This article was prepared by the author with the assistance of an excellent article by Bruce McCandless, II, of the Austin firm Long, Burner, Parks & DeLargy, P.C. "You Can Take That or Worse: A Brief History of the Texas Department of Insurance, Part II: 1945 to the Present," Journal of Texas Insurance Law, Winter 2002, Pp. 32-40.
2. Acts 1951, 52d Leg., ch. 491.
3. Acts 1955, 54th Leg., ch. 117.
4. *Id.* Anyone remember the scandal involving Ben Jack Cage? Acts 1957, 55th Leg., ch. 499.
5. Acts 1973, 63rd Leg., ch. 143, amending Tex. Ins. Code Art. 21.21.
6. Acts 1977, 65th Leg. ch. 817. Enacted Art. 4590i, Vernon's Tex. Civ. Stat.
7. McCandless, supra.
8. Acts 1983, 68th Leg., ch. 584.
9. Acts 1987, 70th Leg., 1st C.S., ch. 1. Among other things this Act required liability insurer to report closed claims. Tex. Ins. Code Articles 1.24A and 1.24B.
10. Acts 1989, 71st Leg., 2d C.S., ch. 1.
11. Acts 1991, 72d Leg., ch. 242.
12. Acts 1991, 72d Leg., 2d C.S., ch. 12.
13. Acts 1993, 73d Leg., ch. 1984.
14. *Balandran v. Safeco Ins. Co.*. 972 S.W.2d 738 (Tex. 1998).
15. Acts 1995, 74th Leg., ch. 414; amending Tex. Ins. Code Art. 22.21, §16; Acts 1995, 74th Leg., ch. 415; adding Tex. Ins. Code Art. 21.21-6.
16. Acts 1997, 75th Leg., ch. 1330; amending Tex. Ins. Code Art. 5.35.
17. Acts 2001, 77th Leg., ch. 971 and 1071.
18. Tex. Ins. Code Ann. Art. 5.26; amended by HB2 in 1991.
19. Tex. Ins. Code Ann. Art. 5.26.
20. Tex. Ins. Code Ann. Art. 5.03 and 5.01.
21. *Id.*
22. *Id.*
23. Tex. Ins. Code Ann. Art. 5.55.
24. Tex. Ins. Code Ann. Art. 5.101.
25. Tex. Ins. Code Ann. §941.003; formerly Art. 18.23.
26. Tex. Ins. Code Ann. §942.003; formerly Art. 19.12.
27. Tex. Ins. Code Ann. §912.002; formerly Art. 17.22.
28. Tex. Ins. Code Ann. §911.011; formerly Art. 16.24.
29. Tex. Ins. Code Ann. §21.49-4(e).
30. Tex. Ins. Code Ann. Art. 5.141.
31. Tex. Ins. Code Ann. Articles 1.02(e); 5.142 §2(b); 5.101 §3A; 513-2 §3(b).
32. Tex. Ins. Code Ann. Art. 5.26-1.
33. Tex. Ins. Code Ann. Art. 5.142.
34. Tex. Ins. Code Ann. Art. 5.142 §4(c).
35. Tex. Ins. Code Ann. Art. 5.13-2C.
36. Tex. Ins. Code Ann. Art. 5.142 §4(b); 5.13-2 §4(f).
37. Tex. Ins. Code Ann. Art. 5.171.
38. Tex. Ins. Code Ann. Art. 5.144.
39. Tex. Ins. Code Ann. Art. 5.144(b).
40. Tex. Ins. Code Ann. Art. 5.13-2 §5.
41. Tex. Ins. Code Ann. Art. 5.13-2 §6.
42. Tex. Ins. Code Ann. Art. 5.13-2 §3(a)(1).
43. Tex. Ins. Code Ann. Art. 5.13-2 §5A.
44. Tex. Ins. Code Ann. Art. 5.13-2 §16.
45. Tex. Ins. Code Ann. Art. 5.13-2 §15.
46. Tex. Ins. Code Ann. Art. 5.33E.
47. Tex. Ins. Code Ann. Art. 5.145 §2.
48. Tex. Ins. Code Ann. Art. 5.13-2 §8.
49. Tex. Ins. Code Ann. Art. 5.45.
50. Tex. Ins. Code Ann. §38.002(a)(4).
51. *Id.*
52. Tex. Ins. Code Ann. §38.003(d).
53. Tex. Ins. Code Ann. Art. 21.49-2V.
54. Tex. Ins. Code Ann. Art. 5.35-4.
55. Tex. Ins. Code Ann. Art. 21.11-11.
56. Act of June 21, 2003, 78th Leg., R.S., ch. 206, § 16.01, 2003 Tex. Sess. Law Serv. 206 (Vernon).
57. Tex. Ins. Code Ann. Art. 21.49-2B §4(i) and (j).
58. Tex. Ins. Code Ann. Art. 21.48A §2(g)
59. Tex. Ins. Code Ann. Art. 21.48A §2(g).
60. Tex. Ins. Code Ann. Art. 21.55A.
61. Tex. Ins. Code Ann. Art. 21.07-4 §1(b); Art. 21.07-5 §1(4)(b).
62. Tex. Ins. Code Ann. Art. 21.07-5.
63. Tex. Ins. Code Ann. Art. 21.07-5 §23.
64. Act of June 11, 2003, 78th Leg., R.S., ch. 205, § 1, 2003 Tex. Sess. Law Serv. 205 (Vernon).
65. Tex. Occup. Code §1958.002(b).
66. Tex. Occup. Code §1958.058, §1958.059.
67. Tex. Occup. Code §1958.153, §1958.154.
68. Tex. Occup. Code §1958.058, §1958.301.
69. Tex. Occup. Code §1958.058, §1958.303.
70. Tex. Ins. Code Ann. Art. 21.49.
71. Tex. Ins. Code Ann. Art. 21.49A §1.
72. Tex. Ins. Code Ann. Art. 21.49A.
73. Tex. Ins. Code Ann. 21.49A § 15.
74. Tex. Ins. Code Ann. Art. 5.171
75. Tex. Ins. Code Ann. Art. 21.49-2U
76. Tex. Ins. Code Ann. Art. 1.02
77. Tex. Ins. Code Ann. Art. 5.142 and 5.13-2.
78. Tex. Ins. Code Ann. Art. 5.13-2 § 13.
79. Tex. Ins. Code Ann. Art. 5.13-2 § 13(f).
80. Tex. Ins. Code Ann. Art. 5.13-2 § 13(g).
81. Tex. Ins. Code Ann. Art. 5.145.
82. Tex. Transp. Code §§ 501.091-501.095.
83. University of Texas School of Business Study, Feb. 2003; and EPIC Study Presented to NAIC, Spring 2003.
84. Tex. Ins. Code Ann. Art. 21.49-2U.
85. Tex. Ins. Code Ann. Art. 21.49-2U § 10.
86. Tex. Ins. Code Ann. Art. 21.49-2U § 4(b)(c).
87. Tex. Ins. Code Ann. Art. 21.49-2U § 5
88. Tex. Ins. Code Ann. Art. 21.49-2U § 6(b).
89. Tex. Ins. Code Ann. Art. 21.49-2U § 14.
90. Tex. Ins. Code Ann. Art. 21.49-2U § 13.
91. Tex. Ins. Code Ann. § 1107.001, *et. seq.*
92. Tex. Ins. Code Ann. Art. 3.70-3C § 3E; and § 843.347
93. Tex. Ins. Code Ann. Art. 3.70-3C § 3C; and § 843.336
94. Tex. Ins. Code Ann. Art. 3.70-3C § 3A; and § 843.338
95. Tex. Ins. Code Ann. Art. 3.70-3C § 3A(g); and § 843.340
96. Tex. Ins. Code Ann. Art. 3.70-3C § 3A(j)(k); and § 843.3385
97. Tex. Ins. Code Ann. Art. 3.70-3C § 3H(j)(k); and § 843.319.
98. Tex. Ins. Code Ann. Art. 3.70-3C § 3D(j)(k); and § 843.350.
99. Tex. Ins. Code Ann. Art. 3.70-3C § 3F; and § 843.349.
100. Tex. Ins. Code Ann. Art. 3.70- 3C § 3G; and § 843.348.
101. Tex. Ins. Code Ann. Art. 3.70-3C § 3I; and § 843.342.
102. Tex. Ins. Code Ann. Art. 3.70-3C § 10; and § 843.351.
103. Tex. Ins. Code Ann. Art. 3.70-3C § 11; and § 843.209.
104. Tex. Ins. Code Ann. Art. 26.14-26.15.
105. Tex. Ins. Code Ann. Art. 26.15.
106. Tex. Ins. Code Ann. Art. 3.80.
107. Tex. Ins. Code Ann. Art. 29.14.
108. Tex. Ins. Code Ann. Art. 21.58C § 2.
109. Tex. Ins. Code Ann. § 38.003.
110. Tex. Bus. & Com. Code Ann. §§ 20.01, *et. seq.*
111. Tex. Bus. & Com. Code Ann. § 35.58.
112. Tex. Bus. & Com. Code Ann. § 35.58(f).
113. Tex. Bus. & Com. Code Ann. § 35.58(e).